

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525262	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/11/2024
NAME OF PROVIDER OR SUPPLIER  Fort Atkinson Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  430 Wilcox St Fort Atkinson, WI 53538	
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 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are fully informed and understand their health status, care and treatments.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 38146</p> <p>Based on interview and record review the facility did not ensure residents the right to be informed of, and participate in, his or her treatment for 2 of 2 (R7 and R1) residents who received changes in medication.</p> <p>R7 was not informed of a newly ordered psychotropic medication.</p> <p>R1 was not informed of a change in their prescribed Oxycodone dosage and frequency.</p> <p>Findings include:</p> <p>The facility policy titled Use of Psychotropic Med implemented 4/24/24 documents (in part) .</p> <p>. Residents are not given psychotropic drugs unless the medication is necessary to treat a specific condition, as diagnoses and documented in the clinical record, and the medication is beneficial to the resident, as demonstrated by monitoring and documentation of the resident's response to the medication(s).</p> <p>5. Residents and/or representatives shall be educated on the risks and benefits of psychotropic drug use, as well as alternative treatments/non-pharmacological interventions.</p> <p>1.) R7 admitted to the facility on [DATE] and has diagnoses that include: Intracranial injury with loss of consciousness, nontraumatic intracerebral hemorrhage, hemiplegia affecting left non-dominant side, hypertension, anemia, major depressive disorder, anxiety, chronic pain, and dysphagia.</p> <p>R7's Quarterly Minimum Data Set, dated dated [DATE] documents a Brief Interview for Mental Status score of 11 indicating moderate cognitive impairment for daily decision making.</p> <p>R7 has a court appointed Guardian. The Letters of Guardianship, effective 11/29/23, documents (in part) .</p> <p>.D. The guardian of the person is authorized to exercise the following specific powers in full or in part to:</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 525262
		If continuation sheet Page 1 of 84

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525262	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/11/2024
NAME OF PROVIDER OR SUPPLIER  Fort Atkinson Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  430 Wilcox St Fort Atkinson, WI 53538	
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 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>1A. Give informed consent to the voluntary receipt by the ward if a medication, including any appropriate psychotropic medication and medical treatment that is in the ward's best interest, if the guardian has first made a good faith attempt to discuss with the ward the voluntary receipt of the medication and if the ward does not protest.</p> <p>Surveyor noted an X next to Partial Transfer: The ward retains the power to receive information and participate in decision with final authority resting with guardian.</p> <p>On 9/9/24, at 11:15 AM, Surveyor interviewed R7 who stated: They ordered Seroquel without my consent. They tried to be sneaky and told me the generic name (Quetiapine). I refused because it's not a medication that should be given for a stroke or brain injury. R7 stated, No-one asked me or talked to me about if before, they just ordered it and gave it to me.</p> <p>Facility progress note dated 7/1/24 documented: Verbal consent given by POA (power of attorney) to start new meds (medication) Seroquel.</p> <p>Surveyor review of R7's Medication Administration Record which revealed an order for Seroquel 50 mg (milligrams) TID (three times daily) started 7/1/24. Documentation indicates 14 doses were administered before the medication was discontinued on 7/11/24.</p> <p>Surveyor was unable to locate any evidence R7 participated in the decision to order Seroquel. There was no evidence the facility or Guardian discussed or advised R7 of the new order for Seroquel.</p> <p>On 9/10/24, Surveyor asked Regional Director of Clinical Operations-C if R7 was involved in or informed of the decision to order Seroquel. Regional Director of Clinical Operations-C stated: The doctor saw him and met with him in his room. I don't know what they talked about, but I'm sure he discussed the medications with him (R7) before he ordered it.</p> <p>R7's Advanced Practice Nurse Practitioner (APNP) Psych Initial Evaluation dated 6/28/24 documents (in part) .</p> <p>. Patient is a [age of R7] male being seen for an initial psychiatric evaluation. Provider was accompanied by RN (Registered Nurse) twice. Patient is seen sitting on the edge of the bed with his tv on and looking at his computer. He acknowledged this provider and asked three times what my profession was. He then pointed and asked is the RN who accompanied this provider in the room, was the reason I was here. Provider expressed I was present to aid with any concerns he has such as sleep. The patient then states Goodbye. Provider reapproached the patient later by myself in the room with the RN outside of door and out of site (sic). Patient stated he did not want me in his room, I'm not welcome, don't come back again and if I did, he would call the police.</p> <p>Documentation revealed R7 refused to meet with the Psych APNP. There is no evidence the APNP or facility discussed or advised R7 of the order for Seroquel.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525262	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/11/2024
NAME OF PROVIDER OR SUPPLIER  Fort Atkinson Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  430 Wilcox St Fort Atkinson, WI 53538	
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 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 9/11/24, Regional Director of Clinical Operations-C was advised of concern Seroquel was ordered for R7. There is no evidence R7 received information or participated in the decision to start Seroquel. Regional Director of Clinical Operations-C reported she thought R7 was actually seen and met with the psych doctor. Surveyor reviewed the APNP note which documents R7 refused to meet with the APNP. Regional Director of Clinical Operations-C stated: We have an issue with some providers just prescribing meds. It's something we're going to have to look into and work on. No additional information was provided.</p> <p>38829</p> <p>2) R1 was admitted to the facility on [DATE] with diagnoses of Post-Traumatic Stress Disorder, Major Depressive Disorder, Generalized Anxiety Disorder, Obsessive-Compulsive Personality Disorder, Malingering, Somatization Disorder, Morbid Obesity, Other Intervertebral Disc Displacement, Low Back Pain, Chronic Pain Syndrome, Chronic Kidney Disease, and Neuromuscular Dysfunction of Bladder. R1 is their own person.</p> <p>R1's Quarterly Minimum Data Set (MDS) completed 8/2/24 documents R1's Brief Interview for Mental Status (BIMS) score to be 13, indicating R1 is cognitively intact for daily decision making. R1's Patient Health Questionnaire (PHQ-9) score is 2, indicating minimal depressive symptoms and R1 demonstrates rejection of care 1-3 days during the assessment period. R1 has no range of motion impairments. R1 is independent with eating. R1 is independent with upper body dressing and dependent for lower body dressing. R1 requires partial/moderate assistance for mobility and transfers. R1's MDS documents R1 frequently has pain and it occasionally interferes with daily routine.</p> <p>R1's Annual MDS completed 5/4/24 does not assess R1's pain, therefore there is no Care Area Assessment (CAA) addressing R1's chronic pain issues. R1 was admitted to the facility on [DATE] with diagnoses of Post-Traumatic Stress Disorder.</p> <p>R1's physician orders printed for Surveyor on 9/9/24, at 3:22 PM, document R1's oxycodone HCl Oral Tablet 5 MG (milligrams): Give 2.5 mg by mouth as needed for pain; maximum of 3 doses per day. May have close together or hours apart, per MD (Medical Doctor) was started on 8/16/24.</p> <p>On 9/9/24, at 12:00 PM, Surveyor interviewed R1. R1 informed Surveyor R1's oxycodone is 2.5 mg every 8 hours. R1 stated that R1 is never informed of medication changes or changes in R1's plan of care.</p> <p>On 9/9/24, at 12:21 PM, Certified Nursing Assistant (CNA)-F who was passing medications as medical technician, verified R1's oxycodone off the medication cart computer screen to be 2.5 mg every 8 hours as needed.</p> <p>On 9/9/24, at 10:13 AM, Surveyor reviewed R1's discontinued and active physician orders in R1's electronic medical record (EMR). R1's order for oxycodone 2.5 mg, every 8 hours was started on 4/24/24 and changed to give 2.5 mg by mouth as needed for pain; maximum of 3 doses per day. May have close together or hours apart, per MD on 8/16/24.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525262	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/11/2024
NAME OF PROVIDER OR SUPPLIER  Fort Atkinson Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  430 Wilcox St Fort Atkinson, WI 53538	
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 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 9/10/24, at 10:35 AM, Surveyor discussed with R1, R1's current oxycodone physician order as of 8/16/24. R1 was unaware the physician order was documented as being able to have close together or hours apart instead of every 8 hours. R1 stated, That's the problem. There are old orders and some people are going off of that. R1 confirmed R1 had not been informed of R1's oxycodone medication order change.</p> <p>Surveyor notes the following update in R1's EMR on 9/10/24: Oxycodone HCl Oral Tablet 5 MG (Oxycodone HCl ; Give 5 mg by mouth every 6 hours as needed for pain increase oxycodone to 5 mg Q 6hrs prn (as needed) per MD AND Give 2.5 mg by mouth as needed for pain. May have one extra pain pill prior to appointments.</p> <p>On 9/11/24, at 11:37 AM, Surveyor interviewed R1 again. R1 stated current pain level is at a 10. R1 denies being notified of R1's oxycodone dosage and frequency being changed by the physician. R1 stated when would they have notified me if I was at the ER until late. R1 stated up until this interview, R1 understood R1's oxycodone to be 2.5 mg every 8 hours. R1 stated R1 last received R1's oxycodone at 5:10 AM. If I had known the oxycodone order was changed, I would have asked for it sooner. R1 confirmed R1 was not aware of any changes to R1's oxycodone stating, No one tells me anything about changes.</p> <p>Surveyor notes R1's last documented care conference is dated 9/22/22, indicating that R1 has not been given the opportunity to review any medication or plan of care changes with the Interdisciplinary Team (IDT).</p> <p>On 9/11/24, at 12:42 PM, Surveyor shared the concern with Regional Director of Clinical Operations (RDCO)-C the concern R1 has not been informed when R1's medication have been changed, treatment orders, or the opportunity to discuss and be included when plan of care changes are made. RDCO-C understands the concern and provided no further information at this time.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525262	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/11/2024
NAME OF PROVIDER OR SUPPLIER  Fort Atkinson Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 430 Wilcox St Fort Atkinson, WI 53538	
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 0553</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow resident to participate in the development and implementation of his or her person-centered plan of care.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 38829</p> <p>Based on interview and record review the facility did not provide the opportunity for 1 (R1) of 2 Residents reviewed to participate in the development and implementation of their person-centered plan of care by not facilitating the inclusion of R1 in the care planning process.</p> <p>R1 was admitted on [DATE], and R1's last documented care conference was on 9/22/22.</p> <p>Findings Include:</p> <p>The facility's policy entitled, Care Planning-Resident Participation, implemented 3/1/23 documents:</p> <p>Policy</p> <p>.This facility supports the Resident's right to be informed of, and participate in, his or her care planning and treatment (implementation of care).</p> <p>Policy Explanation and Compliance Guidelines:</p> <ol style="list-style-type: none"> <li>1. The facility will inform the Resident, in a language he or she can understand, of his or her rights regarding planning and implementing care, including the right to be informed of his or her total health status.</li> <li>3. The facility will notify the Resident and/or Resident representative, in advance, of the care to be furnished and the type of caregiver or professional that will furnish care, as well as changes to the plan of care.</li> <li>4. The facility will encourage and assist the Resident and/or Resident representative, to participate in choosing care and treatment options including:             <ol style="list-style-type: none"> <li>a. Initial decisions about treatment</li> <li>b. Decisions about changes</li> <li>c. The right to refuse treatment .</li> </ol> </li> <li>8. The facility will honor the Resident's right to participate in establishing the expected goals and outcome of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care.</li> </ol> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525262	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/11/2024
NAME OF PROVIDER OR SUPPLIER  Fort Atkinson Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  430 Wilcox St Fort Atkinson, WI 53538	
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 0553</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>10. The facility will discuss the plan of care with the Resident and/or representative at regularly scheduled care plan conferences, and allow them to see the care plan, initially, at routine intervals, and after significant changes. The facility will make an effort to schedule the conference at the best time of the day for the Resident/Resident's representative. The facility will obtain a signature from the Resident and/or Resident's representative after discussion of viewing of the care plan.</p> <p>R1 was admitted to the facility on [DATE] with diagnoses of Post-Traumatic Stress Disorder, Major Depressive Disorder, Generalized Anxiety Disorder, Obsessive-Compulsive Personality Disorder, Malingering, Somatization Disorder, Morbid Obesity, Other Intervertebral Disc Displacement, Low Back Pain, Chronic Pain Syndrome, Chronic Kidney Disease, and Neuromuscular Dysfunction of Bladder. R1 is their own person.</p> <p>R1's Quarterly Minimum Data Set (MDS) completed 8/2/24 documents, R1's Brief Interview for Mental Status (BIMS) score to be 13, indicating R1 is cognitively intact for daily decision making. R1's Patient Health Questionnaire (PHQ-9) score is 2, indicating minimal depressive symptoms and R1 demonstrates rejection of care 1-3 days during the assessment period. R1 has no range of motion impairments. R1 is independent with eating. R1 is independent with upper body dressing and dependent for lower body dressing. R1 requires partial/moderate assistance for mobility and transfers. R1's MDS documents R1 frequently has pain and occasionally interferes with daily routine.</p> <p>R1's Annual MDS completed 5/4/24 does not assess R1's pain, therefore there is no Care Area Assessment (CAA) addressing R1's Chronic Pain Syndrome issues.</p> <p>On 9/10/24, at 10:30 AM, Surveyor interviewed R1 who informed Surveyor R1 has not had a care conference to discuss R1's plan of care or any concerns that R1 has.</p> <p>On 9/10/24, at 12:17 PM, Surveyor interviewed Social Worker (SW)-D in regards to care conferences for R1. Surveyor shared that Surveyor is unable to locate documentation that R1 has been included in the development and implementation of R1's person centered plan of care. SW-D informed Surveyor that SW-D will need to look for documentation that R1 has had care conferences since admission. SW-D confirmed that care conferences are to be held on a quarterly basis for the Residents.</p> <p>On 9/10/24, at 3:21 PM, Surveyor shared the concern that there is no documentation that R1 has had a quarterly care conference since admission to the facility with Nursing Home Administrator (NHA)-A, Director of Nursing (DON)-B, and Regional Director of Clinical Operations (RDCO)-C. No further information was provided by the facility at this time.</p> <p>On 9/11/24, at 10:04 AM, Surveyor verified in R1's Electronic Medical Record (EMR), that R1's last documented care conference was held on 9/22/22. Surveyor notes that SW-D has not provided any documentation that R1 has had a care conference on a quarterly basis since 9/22/22.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525262	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/11/2024
NAME OF PROVIDER OR SUPPLIER  Fort Atkinson Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  430 Wilcox St Fort Atkinson, WI 53538	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38829</b></p> <p>Based on observation and interview the Facility did not ensure 1 (R1) of 1 Residents were provided with reasonable accommodations of Resident needs and preferences.</p> <p>The air conditioning unit located in R1's room was removed without explanation when R1 was at the emergency roiaonom on [DATE]. R1 then purchased R1's own air conditioner.</p> <p>Findings Include:</p> <p>R1 was admitted to the facility on [DATE] with diagnoses of Post-Traumatic Stress Disorder, Major Depressive Disorder, Generalized Anxiety Disorder, Obsessive-Compulsive Personality Disorder, Malingerer, Somatization Disorder, Morbid Obesity, Other Intervertebral Disc Displacement, Low Back Pain, Chronic Pain Syndrome, Chronic Kidney Disease, and Neuromuscular Dysfunction of Bladder. R1 is R1's own person.</p> <p>R1's Quarterly Minimum Data Set (MDS) completed 8/2/24 documents R1's Brief Interview for Mental Status (BIMS) score to be 13, indicating R1 is cognitively intact for daily decision making. R1's Patient Health Questionnaire (PHQ-9) score is 2, indicating minimal depressive symptoms and R1 demonstrates rejection of care 1-3 days during the assessment period. R1 has no range of motion impairments. R1 is independent with eating. R1 is independent with upper body dressing and dependent for lower body dressing. R1 requires partial/moderate assistance for mobility and transfers. R1's MDS documents R1 frequently has pain and occasionally interferes with daily routine.</p> <p>Surveyor notes R1's Annual MDS completed 5/4/24 does not assess R1's pain, therefore there is no Care Area Assessment (CAA) addressing R1's chronic pain syndrome issues.</p> <p>On 9/9/24, at 11:06 AM, Surveyor interviewed R1 in regards to the air conditioner. R1 explained that the air conditioner unit that had been in R1's room was removed when R1 went to the emergency roiaonom on [DATE]. R1 stated that when R1 returned to the facility, the air conditioner unit had been removed with no explanation. R1 stated R1 purchased R1's own air conditioner unit and was just recently installed last week. R1 stated R1 has a remote for the unit, but it won't turn on because R1's wheelchair is blocking it. R1 also stated R1 can't read the numbers on it because its too far from R1's bed. Surveyor notes R1's bed is located across the room from the air conditioner unit which is installed in the window of R1's room.</p> <p>On 9/9/24, at 1:37 PM, Surveyor interviewed Maintenance Director (MD)- G in regards to R1's concern with the removal of the window air conditioner unit when R1 was in the hospital. MD-G stated that MD-G installed R1's personal air conditioner in the window about 2 weeks ago. MD-G stated that parts needed to be ordered for the facility air conditioner unit and R1 did not want to wait.</p> <p>On 9/9/24, at 3:02 PM, asked Nursing Home Administrator (NHA)-A at the daily exit why the air conditioner unit was removed from R1's room while R1 was in the hospital. NHA-A stated the air conditioner unit was removed because the facility needed it. Regional Director of Clinical Operations (RDCO)-C informed Surveyor that it was R1's choice to purchase R1's own air conditioner unit.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525262	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/11/2024
NAME OF PROVIDER OR SUPPLIER  Fort Atkinson Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  430 Wilcox St Fort Atkinson, WI 53538	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 9/9/24, at 3:17 PM, Surveyor observed 2 air conditioner units in the dining room, and no Residents were present. Both air conditioner units are not on. Surveyor observed an air conditioner unit in the activity room that is on and there are no Residents in the activity room.</p> <p>On 9/10/24, at 9:00 AM, Surveyor conducted a complete tour of the facility. Surveyor observed 2 air conditioner units in the main dining room. One is on, and the 2nd one is not. No Resident were currently in the dining room. There is an air conditioner unit in the activity room that is not on at this time. Surveyor observed an air conditioner unit in the small lounge by the nurse's station which is on. Surveyor also observed an air conditioner unit in a Residents' room.</p> <p>On 9/10/24, at 10:30 AM, R1 confirmed to Surveyor that the facility did not inform R1 prior to removing the air conditioner unit or explain why the air conditioner unit needed to be removed.</p> <p>On 9/10/24, at 3:21 PM, NHA-A explained at the daily exit that the air conditioner unit was removed from R1's room and put in the therapy room because it was warm in there and no one wanted to work. NHA-A said the Resident who has the air conditioner unit in their room purchased the air conditioner unit from a store. Surveyor shared the concern at this time with NHA-A, Director of Nursing (DON)-B, and Regional Director of Clinical Operations (RDCO)-C that the air conditioner unit was removed from R1's room without explanation or advance knowledge to R1 and R1 ended up having to purchasing R1's personal air conditioner unit to allow the room to reach a comfortable temperature. No further information was provided by the facility at this time.</p> <p>On 9/11/24, at 11:28 AM, Surveyor interviewed R3, the Resident who had an air conditioner unit in R3's room. R3 confirmed that the air conditioner unit was R3's personal air conditioner unit. R3 informed Surveyor that R3's sister purchased the air conditioner unit for R3 for about \$400 from a store because it was so hot in the room and it was unbearable. R3 recalls it was about the time when there was a really hot spell.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525262	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/11/2024
NAME OF PROVIDER OR SUPPLIER  Fort Atkinson Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  430 Wilcox St Fort Atkinson, WI 53538	

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 0559</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 38829</p> <p>Based on interview and record review the facility did not ensure 2 (R1 and R6) of 2 Residents reviewed for a room change within the facility, were provided with prior written notice, including reason for the room change.</p> <p>R1 was transferred to another room on 8/30/24 and was not given prior written notice, reason for the room change, or given a choice of available rooms.</p> <p>R6 was transferred to another room on 6/11/24 and was not given prior written notice, reason for the room change, or given a choice of available rooms.</p> <p>Findings include:</p> <p>The Facility's policy entitled, Change of Room or Roommate, implemented 3/1/2019, documents:</p> <p>. It is the policy of this facility to conduct changes to room and/or roommate assignments when considered necessary and/or when requested by the resident or resident representative.</p> <p>Policy Explanation and Compliance Guidelines: .</p> <p>4. Prior to making a room change or roommate assignment, all persons involved in the change/assignment, such as residents and their representatives, will be given advance notice of such a change is possible.</p> <p>5. The notice of a change in room or roommate will be provided in writing, in a language and manner the resident and representative understands and will include the reason(s) why the move or change is required.</p> <p>6. The Social Service staff can assist the Resident to adjust to a new room or roommate by:</p> <p>a. Informing the Resident and family as soon as possible of the room or roommate change.</p> <p>b. Involving the Resident in the decision and selection of a room or roommate when possible.</p> <p>c. Allowing the Resident to ask questions about the move.</p> <p>d. Showing the Resident where the room is located.</p> <p>f. Introducing the Resident to the employees who will be providing care.</p> <p>g. Explaining to the Resident why the change is necessary, reassuring the Resident his/her personal possessions will be safeguarded.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525262	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/11/2024
NAME OF PROVIDER OR SUPPLIER  Fort Atkinson Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  430 Wilcox St Fort Atkinson, WI 53538	
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 0559</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>7. The Social Service designee or Licensed Nurse should inform the resident's sponsor/family in advance of a change in the resident's room or roommate.</p> <p>8. A Resident has the right to refuse a transfer to another room within the facility, if the purpose of the transfer is to relocate a Resident from the Medicare section of the facility to a non-Medicare section of the facility solely for financial or change in payer status reasons.</p> <p>1) R1 was admitted to the facility on [DATE] with diagnoses of Post-Traumatic Stress Disorder, Major Depressive Disorder, Generalized Anxiety Disorder, Obsessive-Compulsive Personality Disorder, Malingering, Somatization Disorder, Morbid Obesity, Other Intervertebral Disc Displacement, Low Back Pain, Chronic Pain Syndrome, Chronic Kidney Disease, and Neuromuscular Dysfunction of Bladder. R1 is their own person.</p> <p>R1's Quarterly Minimum Data Set (MDS) completed 8/2/24 documents R1's Brief Interview for Mental Status (BIMS) score to be 13, indicating R1 is cognitively intact for daily decision making. R1's Patient Health Questionnaire (PHQ-9) score is 2, indicating minimal depressive symptoms and R1 demonstrates rejection of care 1-3 days during the assessment period. R1 has no range of motion impairments. R1 is independent with eating. R1 is independent with upper body dressing and dependent for lower body dressing. R1 requires partial/moderate assistance for mobility and transfers.</p> <p>On 9/9/24, at 11:06 AM, R1 informed Surveyor R1 moved to a new room the Friday before the long weekend. R1 stated R1 was not given a choice of rooms to move to and was only given a couple of hours before the move took place. R1 stated R1 was not given an explanation for the room change. R1 informed Surveyor R1 did not want to move and has had a lot of distress with the room change and has been emotionally upset. R1 confirmed that R1 was not given written notification of the room change.</p> <p>On 9/10/24, at 10:30 AM, Surveyor interviewed R1 again. R1 stated, they came in and told me on the Thursday they needed to move today. R1 stated R1 told them not today and then they moved me on the Friday. R1 stated the room is not as functional as the previous room.</p> <p>On 9/10/24, at 12:17 PM, Surveyor spoke with Social Worker (SW)-D who stated that SW-D does not give advance written notice to Residents when a room change is initiated.</p> <p>Surveyor reviewed R1's electronic medical record (EMR) and notes SW-D documented R1 transferred rooms on 8/30/24 from a shared room to another shared room. SW-D documented on 8/29/24, SW-D discussed with R1 that R1 would need to downsize personal items for the room change. R1 was given less than 24 hours notice of the room change.</p> <p>Surveyor notes R1 was admitted to room [ROOM NUMBER] on 6/23/22 and had been in the same room until the room change on 8/30/24.</p> <p>Surveyor also reviewed R1's progress notes located in R1's EMR which documents:</p> <p>On 8/29/24, at 11:26 PM, written by Licensed Practical Nurse (LPN)-V, R1 stated R1 was depressed.</p> <p>On 8/30/24, at 8:37 AM, written by LPN-W that R1 declined breakfast.</p> <p>On 8/30/24, at 11:14 AM, written by LPN-W, R1 is upset that R1 is getting moved to a new room.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525262	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/11/2024
NAME OF PROVIDER OR SUPPLIER  Fort Atkinson Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  430 Wilcox St Fort Atkinson, WI 53538	
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 0559</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 8/30/24, at 12:32 PM, written by LPN-W, R1 refused house lunch.</p> <p>On 8/30/24, at 12:40 PM, written by LPN-W, R1 has complaints of pain and agitation due to move.</p> <p>On 8/30/24, at 12:40 PM, written by LPN-W, R1 has signs and symptoms of increased anxiety and restlessness as well as verbal aggression due to moving to new room.</p> <p>On 8/30/24, at 7:37 PM, written by LPN-W, R1 cannot set up oral care on R1's own because R1 is depressed.</p> <p>On 8/30/24, at 8:55 PM, written by LPN-W, R1 states R1 is too depressed to eat and cannot take R1's medications if R1 does not eat.</p> <p>On 8/30/24, at 9:20 PM, written by LPN-W, R1 expressed anger and depression related to move and states that R1 can't do oral care until R1 gets fresh ice and water.</p> <p>On 9/10/24, at 3:21 PM, at the daily exit Surveyor expressed concerns with Nursing Home Administrator, (NHA)-A, Director of Nursing, (DON)-B, and Regional Director of Clinical Operations, (RDCO)-C that R1 was transferred to another room without advance written notice of the reason for the room change or was provided the option of room choices. Surveyor shared that documentation indicates R1 was in distress related to the room change. NHA-A stated the facility needed to condense down and couldn't admit anyone. NHA-A stated the facility needed two people who have the same infection to share the same bathroom. NHA-A stated, it was census reasons. No further information was provided by the facility at this time.</p> <p>On 9/11/24, at 11:19 AM, Surveyor was provided information that the Facility census was 62 with 33 empty beds at the time of R1's room transfer on 8/30/24. R1 was transferred from room [ROOM NUMBER] to room [ROOM NUMBER], two rooms down. Surveyor notes that room [ROOM NUMBER] has no Residents residing in the room. Surveyor was also provided with Facility information related to new admissions since 8/30/24. Surveyor notes that there have been 4 new admissions since 8/30/24.</p> <p>49435</p> <p>2) R6 was admitted to the facility on [DATE] with diagnosis that include Hemiplegia/hemiparesis affecting the left side due to stroke, Depression, Anxiety, Hypertension and Heart Disease.</p> <p>R6's Quarterly Minimum Data Set Assessment (MDS) dated [DATE], documents R6 has a Brief Interview for Mental Status (BIMS) score of 13 out of 15, indicating R6 is cognitively intact.</p> <p>On 9/11/24, at 7:48 AM, R6 informed Surveyor that 3 months ago, R6 was forced to change to a different room. R6 stated, they just came in and said they were moving me. R6 stated R6 did not want to move. R6 indicated R6 did not receive any paperwork or any explanation as to why R6 was being moved. Surveyor asked how the room change made R6 feel. R6 stated, I didn't like that worth a crap. R6 stated the facility moved him from a private room to a room with a roommate. R6 stated again, I didn't like that.</p> <p>R6's Electronic Medical Record (EMR) documents R6 transferred rooms on 6/1/24.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525262	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/11/2024
NAME OF PROVIDER OR SUPPLIER  Fort Atkinson Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  430 Wilcox St Fort Atkinson, WI 53538	
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 0559</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R6's EMR contains no documentation that R6 was provided advance written notification of the room change, the reason for the room change, the opportunity to choose from a selection of roommates and the opportunity to meet any new potential roommates.</p> <p>On 9/11/24, at 9:16 AM, Surveyor interviewed Director of Social Services-D about the process of changing a resident's room. Director of Social Services-D informed Surveyor that Director of Social Services-D would talk to the resident, get the resident's consent, notify the Power of Attorney (if needed) and document this in a progress note. Surveyor asked why R6's room was changed on 6/1/24. Director of Social Services-D stated that R6 was no longer a rehab stay and was private-pay while in the process of applying for Medicaid. Surveyor asked if there was written notice given to R6 regarding the room change. Director of Social Services-D stated that Director of Social Services-D has never given written notice regarding a room change. Surveyor asked for any documentation regarding R6's room change. Director of Social Services-D stated if it is not documented, that's my fault.</p> <p>On 9/11/24, at 9:51 AM, Surveyor interviewed Nursing Home Administrator (NHA)-A regarding R6's room change. NHA-A stated NHA-A did not remember why R6's room was changed but stated that NHA-A would get back to Surveyor.</p> <p>On 9/11/24, at 10:40 AM, NHA-A returned to Surveyor and stated that R6's room was changed because R6 was changed to private pay while trying to get on Medicaid. Surveyor asked if written notification of room change was given to R6 or if that was an expectation prior to moving a resident. NHA-A stated that NHA-A has never done that and indicated that NHA-A would just expect that the interaction be documented.</p> <p>No further information was provided as to why R6 was not provided with prior written notice of a room change, including the reason for the room change, offered a selection of rooms or the opportunity to meet potential new roommates.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525262	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/11/2024
NAME OF PROVIDER OR SUPPLIER  Fort Atkinson Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  430 Wilcox St Fort Atkinson, WI 53538	
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 0563</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to receive visitors of his or her choosing, at the time of his or her choosing.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 38829</p> <p>Based on interviews and record review, the facility did not ensure the right of a Resident to receive visitors and at the time of their choosing for 1 (R8) of 1 Resident reviewed for visitation rights. The facility restricted a friend immediate access to R8 without any explanation to R8 or developing any strategies to continue safe and enjoyable visits for R8.</p> <p>Findings include:</p> <p>The facility's policy entitled, Resident Rights Access and Visitation, implemented 10/1/22 documents:</p> <p>. It is the policy of this facility to support and facilitate the Residents' right to receive visitors of their choosing, at the time of their choosing, subject to the Resident's right to deny visitation when applicable, and in a manner that does not impose on the rights of other Residents. Visitation will be person-centered, consider the Resident's physical, mental, and psychosocial well-being and support their quality of life.</p> <p>4. The facility will provide immediate access to a Resident by others who are visiting with the consent of the Resident, subject to a reasonable clinical and safety restrictions and the Resident's right to deny or withdraw consent at any time.</p> <p>5. The facility will provide reasonable access to a Resident by any entity or individual that provides health, social, legal, or other services to the Resident, subject to the Resident's right to deny or withdraw consent at any time. Facility staff will provide space and privacy for these visits.</p> <p>6. The facility will inform each Resident and/or Resident representative of his or her visitation rights and related facility policies and procedures, including any clinical or safety restriction or limitation of such rights, in a manner he or she understands.</p> <p>7. The facility will inform each Resident of the right, subject to his or her consent, to receive the visitors whom he or she designates as well as deny visitation, including but not limited to: e. A friend</p> <p>8. The facility will not restrict, limit, or otherwise deny visitation privileges based on race, color, national origin, religion, sex, gender identity, sexual orientation, or disability.</p> <p>R8 was admitted to the facility on [DATE] with diagnoses of Major Depressive Disorder, Generalized Anxiety Disorder, Interstitial Pulmonary Disease, Type 2 Diabetes Mellitus, Morbid Obesity, Immunodeficiency, Chronic Kidney Disease, and Dysphagia. R8's face sheet indicates R8 is her own person. R8's electronic medical record (EMR) contains documentation R8's Health Care Power of Attorney (HCPOA) was activated on 6/17/24. R8 enrolled in hospice on 6/5/24.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525262	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/11/2024
NAME OF PROVIDER OR SUPPLIER  Fort Atkinson Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  430 Wilcox St Fort Atkinson, WI 53538	
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 0563</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R8's Significant Change in Condition Minimum Data Set (MDS) completed on 6/10/24 documents R8's Brief Interview for Mental Status (BIMS) score to be 12, indicating R8 demonstrates moderately impaired skills for daily decision making. R8's MDS documents no mood or behavior concerns. R8's MDS also documents R8 has no range of motion impairments, requires partial/moderate assistance for upper dressing, substantial/maximum assistance for lower body dressing, substantial/maximum assistance for mobility, and is dependent for transfers.</p> <p>On 9/9/24, at 9:31 AM, Surveyor reviewed R8's EMR and notes there is no documentation of any concerns of any visitors that may be a safety concern/issue for R8 or other Residents.</p> <p>On 9/9/24, at 10:07 AM, Surveyor interviewed R8. R8 confirmed R8's friend can not visit R8. R8 stated that R8 has done nothing wrong. Visits consisted of R8's friend reading the bible to R8. R8 stated that the friend was helping R8 with R8's relationship with God. R8 informed Surveyor R8 misses R8's friend and is very sad R8 can not see their friend. R8 stated R8's friend did not do anything to R8 and R8 wants to see their friend. R8 stated R8 should be able to choose who visits me. R8 stated R8's friend is banned and the facility won't tell R8 why.</p> <p>On 9/9/24, at 3:02 PM, Surveyor asked Nursing Home Administrator (NHA)-A if the Facility has a list of restricted visitors. NHA-A responded, Not sure I know what you mean? Surveyor asked if there were any visitors not allowed at the Facility. NHA-A stated, No, not really. There is one guy we keep an eye on by the name of [name of visitor]. Surveyor asked what did this visitor do that the Facility would be keeping any eye on. NHA-A stated the visitor became very friendly and was not good with boundaries. NHA-A stated that the visitor hides in the neighbor's bushes and Residents visit with the visitor outside.</p> <p>On 9/9/24, at 3:19 PM, Surveyor interviewed Activity Director (AD)-E in regards to the banned visitor. AD-E stated the visitor was not an official volunteer so the visitor would not check in with AD-E. AD-E stated the visitor helped out with games and provided spiritual guidance. AD-E is not sure why the visitor is not allowed in. That was [NHA-A]'s decision. AD-E confirmed the visitor's visits were in the best interest of some Residents because the visitor's spiritual visits were positive. AD-E stated, What spiritual visits are not encouraging. AD-E confirmed the visitor was a friend of R8.</p> <p>On 9/10/24, at 10:35 AM, Surveyor interviewed R8 again. R8 informed Surveyor R8 is still upset that R8's friend can not visit. R8 confirmed R8 was not given an explanation as to why R8's friend can not visit. R8 is the Facility's Resident Council President, and stated that having any visitors restricted was never discussed at any of the Resident Council meetings. R8 believes R8's friend is not even allowed outside of the facility to visit, even if they helped me outside. R8 stated R8 had to arrange for a cab with R8's brother's help to take R8 to church this past Sunday so R8 could visit with R8's friend.</p> <p>On 9/10/24, at 12:21 PM, Surveyor interviewed Social Worker (SW)-D in regards to the restricted visitor. SW-D stated there was a couple of instances where the visitor asked for personal information in the dining room. SW-D stated the visitor was pressuring for information on Residents and was sketchy with Residents, but SW-D could not elaborate what was sketchy. SW-D confirmed that the visitor had been visiting with R8 and would have bible studies, but is not sure if other Residents wanted the bible studies. SW-D is not able to recall any other Residents that did not want this visitor visiting. SW-D stated that at a meeting R8's brother did not want the visitor visiting R8, but can not recall why.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525262	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/11/2024
NAME OF PROVIDER OR SUPPLIER  Fort Atkinson Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  430 Wilcox St Fort Atkinson, WI 53538	
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 0563</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 9/10/24, at 1:09 PM, SW-D provided Surveyor with documentation from R8's progress notes that on 7/25/24 at 8:17 AM, a family meeting was held. However, Surveyor notes this documentation does not address any concerns related to R8's friend visiting.</p> <p>On 9/10/24, at 3:17 PM, Surveyor spoke with NHA-A, Director of Nursing (DON-B), and Regional Director of Clinical Operations (RDCO)-C in regards to visitation of R8's friend being restricted. NHA-A stated, he was asking for information and sharing information. Surveyor asked what steps did the facility take before restricting visitation of R8's friend completely. NHA-A indicated no steps had been taken prior to restricting visitation, and there is no investigation as to why R8's friend can not visit. NHA-A stated, what difference does it make, she can go out and meet him at church. Surveyor shared the concern R8 has not been informed as to why R8's friend can not visit and is still upset R8's friend can not visit. Surveyor shared the facility restricted visitation of R8's friend and did not develop any strategies so R8 could continue with safe and enjoyable visits. No further information was provided by the facility at this time.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525262	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/11/2024
NAME OF PROVIDER OR SUPPLIER  Fort Atkinson Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  430 Wilcox St Fort Atkinson, WI 53538	
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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 20483</p> <p>Based on interview and record review the Facility did not ensure 1(R2) of 10 Resident's resident representative was notified when there was a need to alter treatment and transfer to the hospital.</p> <p>On 9/1/24, R2 had a change of condition and the NP (Nurse Practitioner) ordered CBC (complete blood count), CMP (comprehensive metabolic panel), BNP (B type natriuretic peptide), UA (urinalysis) with c/s (culture/sensitivity) and chest x-ray for R2. R2 was then subsequently transferred to the hospital on 9/1/24. R2's guardian was not notified of the labs &amp; chest x-ray ordered and was not notified of R2's transfer &amp; admission to the hospital until 9/2/24 when a family member for R2 came to visit and R2 was not in the facility.</p> <p>Findings include:</p> <p>The facility's policy titled, Notification of Changes Policy and implemented 3/1/19 under Policy documents, It is the policy of this facility that changes in a resident's condition or treatment are immediately shared with the resident and/or the resident representative, according to their authority, and reported to the attending physician or delegate (hereafter designated as the physician). The resident and/or their representative will be educated about treatment options and supported to make an informed choice about care preferences when there are multiple care options available. All pertinent information will be made available to the provider by the facility staff.</p> <p>Under procedure documents:</p> <ol style="list-style-type: none"> <li>1. The nurse will immediately notify the resident, resident's physician and the resident representative(s) for the following (list is not all inclusive):             <ol style="list-style-type: none"> <li>a. An accident involving the resident, which results in injury and has the potential for requiring physician intervention.</li> <li>b. A significant change in the resident's physical, mental, or psychosocial status that is a deterioration in the health,                 <p style="margin-left: 20px;">mental or psychosocial status in either life threatening conditions or clinical complications.</p> </li> <li>c. A need to alter treatment significantly (a need to discontinue or change an existing form of treatment due to                 <p style="margin-left: 20px;">adverse consequences or to commence a new form of treatment.</p> </li> <li>d. A decision to transfer or discharge the resident from the facility.</li> </ol> </li> <li>2. The nurse will notify the resident, resident's physician and the resident representative(s) for non-immediate</li> </ol> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525262	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/11/2024
NAME OF PROVIDER OR SUPPLIER  Fort Atkinson Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  430 Wilcox St Fort Atkinson, WI 53538	
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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>changes of condition on the shift the changes occurs unless otherwise directed by the physician.</p> <p>3. Document the notification and record any new orders in the resident's medical record.</p> <p>R2's diagnoses include atrial fibrillation, congestive heart failure, bipolar disorder, dementia, schizophrenia, depression, and diabetes mellitus. R2 has a legal guardian.</p> <p>The nurses note dated 9/1/24, at 23:07 (11:07 p.m.), documents This AM (morning) resident was slightly lethargic but responding. Resident was just staring. Resident had weakness. Residents PERRLA (pupils equal, round, reactive to light and accommodation). Resident able to raise both arms. Resident had equal strength in both hands. BP (blood pressure) 172/69, HR (heart rate) 99, O2 (oxygen) 94%, Resp (respirations) 30, Blood Glucose 119. resident weight 416.5 an increase from last month of 404.7. RN (Registered Nurse) present to assess resident. NP notified. Labs: CBC, CMP, BNP, and UA with c/s ordered. NP also ordered chest x-ray PA and lateral view. This nurses note was written by LPN (Licensed Practical Nurse)-R.</p> <p>There is no evidence R2's guardian was notified labs and x-ray were ordered for R2.</p> <p>The nurses note dated 9/1/24, at 23:30 (11:30 p.m.), documents Lab called facility above writer made aware that the Tech could not come out to draw the Labs until tomorrow, Radiology Tech already stated they could not come until tomorrow as well. v/s (vital signs)-158/81-75-T (temperature) 87.9-26-92% SPO2 (oxygen saturation) [first name] N/P (Nurse Practitioner) called back to update on labs and X-ray also Resident noted to be very diaphoretic R (respirations) 30 and very lethargic N/P gave order to send Resident to [Name] ER (emergency room ) 911 for evaluation. ER called reported given to RN (Registered Nurse) on duty 911 called ETA (estimated time arrival) 5 minutes 2 EMT (emergency medical technicians) in to transport resident to ER when above writer assisted EMTs with transfer to stretcher. Resident Rt (right) leg was noted to be very warm to touch. DON (Director of Nursing) called made aware to transfer. This note was written by Nursing-S.</p> <p>There is no evidence R2's guardian was notified of R2 being transferred to the hospital.</p> <p>The nurses note dated 9/2/24, at 06:08 (6:08 a.m.), documents [Name] Hospital called facility updated above writer that resident was admitted to [Name] Hospital for Cellulitis of Lft (left) leg and Sepsis. DON called and made aware. This nurses note was written by Nursing-S.</p> <p>The nurses note dated 9/2/24, at 09:27 (9:27 a.m.), documents Patient's sister, [Name], arrived and did not know patient was admitted to hospital; RN (Registered Nurse) call daughter to see if she was informed; daughter was not informed of admission to hospital [Name] now informed. This note was written by Nursing-T.</p> <p>On 9/9/24, at 1:29 p.m., Surveyor spoke with R2's guardian on the telephone. Surveyor asked R2's guardian if she was informed of the labs and x-ray ordered for R2 on 9/1/24. R2's guardian replied I don't think so. R2's guardian then informed Surveyor she hadn't known R2 had gone to the hospital until she heard from R2's sister. R2's guardian informed Surveyor communication can be tough with the facility and she's not surprised of him going to the hospital without being notified.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525262	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/11/2024
NAME OF PROVIDER OR SUPPLIER  Fort Atkinson Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  430 Wilcox St Fort Atkinson, WI 53538	

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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 9/10/24, at 10:33 a.m., Surveyor asked RN-I if the physician or NP orders lab work, x-ray, or sends a resident to the hospital who would notify the resident's representative. RN-I replied the nurse who receives the order. Surveyor asked if this would be documented any where. RN-I informed Surveyor it's documented in the progress notes.</p> <p>On 9/10/24, at 10:43 a.m., Surveyor asked LPN-O if the physician or NP orders lab work, x-ray or sends a resident to the hospital who would notify the resident's representative. LPN-O replied me because I got the order. Surveyor asked if this is documented. LPN-O informed Surveyor should go in nurses notes.</p> <p>On 9/11/24, at 12:06 p.m., Surveyor asked DON-B if a physician or NP orders labs, x-ray or sends a Resident out to the hospital who is responsible for notifying the resident's representative. DON-B informed Surveyor the nurse sending out the patient should be doing all that. DON-B informed Surveyor they have done a lot of education on that. Surveyor informed DON-B R2's guardian was not notified when the NP ordered lab work, an x-ray and then sent R2 to the hospital on 9/1/24.</p> <p>On 9/11/24, at 1:30 p.m., NHA (Nursing Home Administrator)-A was informed of the above. No additional information was provided to Surveyor why R2's guardian was not notified of the labs, x-ray, and transfer to the hospital.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525262	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/11/2024
NAME OF PROVIDER OR SUPPLIER  Fort Atkinson Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  430 Wilcox St Fort Atkinson, WI 53538	
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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49435</p> <p>Based on observation and interview, the facility did not ensure a clean, comfortable, and homelike environment which had the potential to affect 1 (R12) of 9 resident's rooms observed and a sample of residents that go outside on the facility's grounds.</p> <p>*R12's shared bathroom was observed to have a smeared brown material which appeared to BM (bowel movement) on the wall close to the call light and the bathroom floor was sticky. R12's room was observed to have paint scrapings and plaster gouges behind the headboard of R12's bed.</p> <p>*Surveyor observed the environment outside on facility grounds to be littered with various items and an abandoned wheelchair.</p> <p>Findings include:</p> <p>The facility policy entitled, Safe and Homelike Environment dated 3/1/2020, documents, in part: In accordance with resident's rights, the facility will provide a safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible . Environment refers to any environment in the facility that is frequented by residents, including (but not limited to) the residents' rooms, bathrooms, hallways, dining areas, lobby, outdoor patios, therapy areas and activity areas. A homelike environment is one that de-emphasizes the institutional character of the setting, to the extent possible . A determination of homelike should include the resident's opinion of the living environment. Orderly is defined as an uncluttered physical environment that is neat and well-kept. Sanitary includes, but is not limited to, preventing the spread of disease-causing organisms by keeping resident care equipment clean and properly stored. Resident care equipment includes, but is not limited to equipment used in the completion of the activities of daily living . The facility will create and maintain, to the extent possible, a homelike environment that de-emphasizes the institutional character of the setting . Housekeeping and maintenance services will be provided as necessary to maintain a sanitary, orderly, and comfortable environment .</p> <p>R12 was admitted to the facility on [DATE] with diagnosis that include Alzheimer's disease, Stroke, Type 2 Diabetes, Depression, and Anxiety.</p> <p>R12's Admission Minimum Data Set (MDS) assessment dated [DATE], documents R12 has a Brief Interview for Mental Status (BIMS) score of 3 out of 15, indicating that R12 is severely cognitively impaired.</p> <p>R12's progress note dated 8/21/24 documents that R12 is incontinent of bowel and bladder.</p> <p>R12's Electronic Medical Record documents R12's Power of Attorney (POA) is POA-X.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525262	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/11/2024
NAME OF PROVIDER OR SUPPLIER  Fort Atkinson Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  430 Wilcox St Fort Atkinson, WI 53538	
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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 9/9/2024, at 3:28 PM, Surveyor interviewed R12's Power of Attorney (POA)-X. POA-X informed Surveyor that the jack-and-[NAME] bathroom is shared with the resident in the next room. Surveyor noted that the adjoining room is currently empty. POA-X indicated that when the adjoining room was occupied by the previous resident, the bathroom would smell bad, there was urine on the floor and the bathroom was overall unclean. POA-X stated R12 does not use the bathroom due to incontinence and POA-X would use a bathroom down the hall because the bathroom attached to R12's room is unclean. POA-X stated that the building is not kept up and pointed at the wall behind R12's headboard. POA-X stated the paint is peeling and the wall is scuffed up.</p> <p>On 9/9/2024, at 3:38, Surveyor observed R12's shared bathroom. Surveyor noted an approximately 2 inch by 2 inch diagonal smear of a brown material which appeared to be BM. This brown material was located on the left wall near the call light string. The brown material was dried and crusted onto the wall. Surveyor noted the floor to be sticky and Surveyors shoes were sticking to the floor.</p> <p>On 9/9/2024, at 3:50 PM, Surveyor interviewed Certified Nursing Assistant (CNA)-Y. Surveyor pointed to the brown material in R12's shared bathroom and asked CNA-Y if they could identify what the brown material was. CNA-Y stated, that looks likes BM. Surveyor asked how long the adjoining room had been empty. CNA-Y stated CNA-Y thought the room had been empty for 3 to 4 days. CNA-Y stated that CNA-Y would get someone to clean the bathroom.</p> <p>On 9/10/2024, at 7:47 AM, Surveyor observed R12's bathroom. The brown material was no longer on the wall.</p> <p>On 9/11/2024, at 8:00 AM, Surveyor interviewed Housekeeping Director-H. Housekeeping Director-H reported that 2 housekeepers are staffed each day. The facility's housekeepers will start by cleaning the common areas first and then will clean resident's rooms. All rooms are cleaned by about 1 PM each day. Surveyor asked if shared bathrooms are cleaned every day even if one of the adjoining rooms is unoccupied. Housekeeping Director-H stated the expectation is that the shared bathrooms would be cleaned every day.</p> <p>Surveyor noted that when brown material was located on the wall of R12's bathroom it was 3:38 PM on 9/9/2024 and the bathroom should have been cleaned for the day. In addition, R12 does not use the bathroom and the adjoining room was unoccupied.</p> <p>On 9/10/24, at 3:18 PM, at the daily exit meeting, Nursing Home Administrator (NHA)-A, Director of Nursing (DON)-B, Regional Director of Clinical Operations-C and Regional Director of Clinical Operations-Q were made aware of the concerns regarding R12's unclean bathroom.</p> <p>On 9/9/2024, at 3:38 PM, Surveyor observed the wall behind the headboard of the R12's bed. Surveyor noted an approximately 6- foot section of wall that had multiple vertical plaster gouges and peeling paint.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525262	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/11/2024
NAME OF PROVIDER OR SUPPLIER  Fort Atkinson Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  430 Wilcox St Fort Atkinson, WI 53538	
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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 9/11/2024, at 1:13 PM, Surveyor interviewed Director of Maintenance-G. Surveyor asked how often painting of residents' rooms is completed at the facility. Director of Maintenance-G indicated that a color had just been selected for painting. Surveyor asked when the last time resident rooms were painted. Director of Maintenance-G stated that he did not know. Director of Maintenance-G indicated that when a resident is discharged from a room, Director of Maintenance- G will address any concerns like paint in the room. Director of Maintenance-G asked if there was a room that needed painting. Surveyor informed Director of Maintenance-G of the wall and paint concerns behind the headboard of R12's bed.</p> <p>On 9/11/2024, at 12:58 PM, Surveyor informed NHA-A of the wall and paint concerns behind the headboard of R12's bed.</p> <p>No further information was provided as to why the facility did not ensure a clean, comfortable, and homelike environment for R12.</p> <p>20483</p> <p>* On 9/10/24, at 9:32 a.m., Surveyor went outside building to tour the grounds due to a concern brought forward to Surveyor. Surveyor observed on the left side of the building, along the building there is a wooden bench. Under the wood bench there is a towel, hairnet, and multiple cigarette butts.</p> <p>* On 9/10/24, at 9:41 a.m., Surveyor observed in the back of the building there is a parking lot. Along the edge where the grass meets the asphalt there is a face mask and multiple blue gloves. There is a shed on the left side behind a dumpster. On the right side of the shed is a broken wheelchair.</p> <p>* On 9/10/24, at 9:45 a.m., Surveyor observed by door marked #2 there is a black mat which is in a pile on the sidewalk.</p> <p>On 9/10/24, at 2:08 p.m., Director of Maintenance (DOM)-G accompanied Surveyor outside. Surveyor showed DOM-G the multiple items around the building. Surveyor asked again who should be cleaning these areas. DOM-G replied I would say me and housekeeping. DOM-G informed Surveyor, Surveyor could speak with HD (Housekeeping Director)-H.</p> <p>On 9/10/24, at 2:14 p.m., Surveyor asked HD-H who should be cleaning outside around the dumpsters and building. HD-H replied it's suppose to be maintenance we don't do anything outside.</p> <p>On 9/11/24, at 1:30 p.m., NHA (Nursing Home Administrator)-A was informed of the above. No additional information was provided to Surveyor regarding the environmental concerns.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525262	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/11/2024
NAME OF PROVIDER OR SUPPLIER  Fort Atkinson Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  430 Wilcox St Fort Atkinson, WI 53538	
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 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>20483</p> <p>Based on observation, interview and record review the Facility did not ensure 1 (R2) of 17 residents reviewed had a comprehensive care plan that was reviewed and revised by the interdisciplinary team as determined by the resident's assessed needs.</p> <p>R2's care plan was not revised to accurately identify R2's fall prevention interventions.</p> <p>Evidenced by:</p> <p>* R2's diagnoses include atrial fibrillation, congestive heart failure, bipolar disorder, dementia, schizophrenia, depression, and diabetes mellitus.</p> <p>The quarterly MDS (minimum data set) with an assessment reference date of 6/12/24 has a BIMS (brief interview mental status) score of 13 which indicates cognitively intact. R2 is assessed as requiring substantial/maximal assistance to roll left &amp; right and partial/moderate assistance for chair/bed to chair transfer. R2 has not fallen since prior assessment.</p> <p>Surveyor did not note any falls after this MDS was completed.</p> <p>The CNA (Certified Nursing Assistant) Kardex as of 9/9/24 under the safety section includes mat on the floor next to bed.</p> <p>The risk for falls care plan initiated 2/13/24 includes interventions of fall mats placed initiated 2/17/23 and mat on the floor next to bed initiated 4/1/23 &amp; revised on 6/19/23.</p> <p>On 9/9/24, at 9:16 a.m., Surveyor observed CNA-J transfer R2 from the wheelchair into bed using a sit to stand. After R2 was transferred into bed, CNA-J removed R2's hat, asked R2 if he wanted a blanket &amp; covered R2 with a comforter, attached the call light to R2's shirt raised the head of the bed and gave R2 the bed controller. Surveyor observed CNA-J did not place a mat on the floor next to R2's bed.</p> <p>On 9/9/24, at 10:28 a.m., Surveyor observed R2 continues to be in bed on his back asleep. Surveyor observed there is still not a mat on the floor next to R2's bed.</p> <p>On 9/9/24, at 1:20 p.m., Surveyor observed R2 in bed on his back with his eyes closed. Surveyor observed there is not a mat on the floor next to R2's bed.</p> <p>On 9/10/24, at 10:47 a.m., Surveyor observed R2 in bed on his back sleeping. Surveyor did not observe a mat on the floor next to R2's bed.</p> <p>On 9/11/24, at 7:13 a.m., Surveyor observed R2 awake in bed on his back. Surveyor did not observe a mat on the floor next to R2's bed.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525262	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/11/2024
NAME OF PROVIDER OR SUPPLIER  Fort Atkinson Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  430 Wilcox St Fort Atkinson, WI 53538	

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 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 9/11/24, at 9:26 a.m., Surveyor asked CNA-F if R2 is suppose to have a mat on the floor next to the bed. CNA-F replied no. Surveyor informed CNA-F Surveyor had noted an intervention of a mat on the floor next to the bed in R2's care plan and also on the Kardex. CNA-F replied I've never seen him with a floor mat and then informed Surveyor of the names of other residents who have floor mats.</p> <p>On 9/11/24, at 12:07 p.m., Surveyor asked DON (Director of Nursing)-B if R2 is suppose to have a mat on the floor next to his bed. DON-B replied I'm not sure, not sure what would warrant it. Surveyor asked DON-B to look into whether R2 should have a mat on the floor or if this intervention wasn't removed from the care plan.</p> <p>On 9/11/24, at 1:54 p.m., DON-B informed Surveyor R2's care plan should have been revised and the fall mat taken off.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525262	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/11/2024
NAME OF PROVIDER OR SUPPLIER  Fort Atkinson Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  430 Wilcox St Fort Atkinson, WI 53538	
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 0660</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Plan the resident's discharge to meet the resident's goals and needs.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38829</b></p> <p>Based on interview and record review, the facility did not ensure they develop and implement an effective discharge planning process focusing on the Resident's discharge goal, ensuring discharge needs are identified and incorporated into a discharge planning care plan in preparation for transition for 1 (R1) of 1 Residents reviewed for discharge plans to effectively transition R1 to post-facility care.</p> <p>Findings Include:</p> <p>The facility's undated policy Discharge Planning Process documents:</p> <p>. It is the policy of this facility to develop and implement an effective discharge planning process that focuses on the Resident's discharge goals, the preparation of Residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions.</p> <p>Procedure:</p> <ol style="list-style-type: none"> <li>1. The facility will support each Resident in the exercise of his or her right to participate in his or her care and treatment, including planning for discharge.</li> <li>2. The facility will determine the Resident's expected goals and outcomes regarding discharge upon admission, routinely in accordance with Minimum Data Set (MDS) assessment cycle.             <ol style="list-style-type: none"> <li>b. Subsequent assessment information and discharge goals will be included in the Resident's comprehensive plan of care.</li> </ol> </li> <li>5. If discharge to community is a goal, an active discharge care plan will be implemented and will involve the interdisciplinary team, including the Resident and/or Resident representative.</li> <li>6. An active individualized discharge care plan will address, at a minimum:             <ol style="list-style-type: none"> <li>a. Discharge destination, with assurances the destination meets the Resident's health/safety needs and preferences.</li> <li>b. Identified needs, such as medical, nursing, equipment, educational, or psychosocial needs.</li> <li>c. Caregiver/support person availability and the Resident's or caregiver's/support person's capacity and capability to perform required care.</li> </ol> </li> <li>7. The ongoing process of developing the discharge plan will include a regular re-evaluation of the Resident to identify changes that require modification of the discharge plan, and updating of the discharge plan, as needed, to reflect the modifications.</li> </ol> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525262	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/11/2024
NAME OF PROVIDER OR SUPPLIER  Fort Atkinson Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  430 Wilcox St Fort Atkinson, WI 53538	
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 0660</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>8. The facility will document any referrals to local contact agencies or other appropriate entities made for the purpose of the Resident's interest in returning to the community.</p> <p>9. The facility will update a Resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities.</p> <p>10. The facility will assist Residents and their Resident representatives in choosing an appropriate post-acute care provider that will meet the Resident's needs, goals, and preferences.</p> <p>a. The Social Services Director, or designee, shall compile available data on other post-acute care options to present to the Resident, including, but not limited to:</p> <p>i. Data on providers within the Resident's desired geographic area, where available.</p> <p>11. The evaluation of the Resident's discharge needs and discharge plan will be completely documented on a timely basis in the clinical record.</p> <p>R1 was admitted to the facility on [DATE] with diagnoses of Post-Traumatic Stress Disorder, Major Depressive Disorder, Generalized Anxiety Disorder, Obsessive-Compulsive Personality Disorder, Malingering, Somatization Disorder, Morbid Obesity, Other Intervertebral Disc Displacement, Low Back Pain, Chronic Pain Syndrome, Chronic Kidney Disease, and Neuromuscular Dysfunction of Bladder. R1 is R1's own person.</p> <p>R1's Quarterly Minimum Data Set (MDS) completed 8/2/24 documents R1's Brief Interview for Mental Status (BIMS) score to be 13, indicating R1 is cognitively intact for daily decision making. R1's Patient Health Questionnaire (PHQ-9) score is 2, indicating minimal depressive symptoms and R1 demonstrates rejection of care 1-3 days during the assessment period. R1 has no range of motion impairments. R1 is independent with eating. R1 is independent with upper body dressing and dependent for lower body dressing. R1 requires partial/moderate assistance for mobility and transfers. R1's MDS documents R1 frequently has pain and occasionally interferes with daily routine.</p> <p>R1's Annual MDS completed 5/4/24 does not assess R1's pain, therefore there is no Care Area Assessment (CAA) addressing R1's chronic pain issues. R1's MDS also documents that active discharge planning is in the process.</p> <p>R1's comprehensive care plan includes the following documentation:</p> <p>Discharge Planning:</p> <p>At this time, R1 is anticipated for long term care to ensure R1's safety and needs are met. R1 wishes to discharge to an Assisted Living Facility if medically able to do so should R1's condition improve.</p> <p>Initiated 5/24/23.</p> <p>Interventions:</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525262	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/11/2024
NAME OF PROVIDER OR SUPPLIER  Fort Atkinson Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  430 Wilcox St Fort Atkinson, WI 53538	
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 0660</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Educate R1 or my care giver about R1's medications, their side effects and how and when R1 should take them. Help R1 make sure R1 have (sic) what R1 needs. Initiated 5/24/23.</p> <p>-Please help R1 arrange for equipment R1 needs. Initiated 5/24/23</p> <p>-Please help R1 arrange for services R1 needs. Initiated 5/24/23</p> <p>-Provide R1 with education on R1's medications. Initiated 5/24/23</p> <p>-Provide R1 with education on prevention and management of R1's disease. Initiated 5/24/23</p> <p>-Review discharge plans at minimum every quarter. Initiated 5/24/23</p> <p>Surveyor notes R1's discharge plan have not been updated since 5/24/23 and per documented care plan interventions it has not been updated at a minimum of every quarter.</p> <p>R1's Initial Psych Evaluation dated 12/6/23, written by APNP (Advanced Practice Nurse Practitioner) Psychiatric/Mental Health (APNP)-DD documents:</p> <p>.This patient presents with behaviors and thought processes aligned with a diagnosis of obsessive-compulsive personality disorder. A change in facility within the next 30 days is what this writer recommends for this patient.</p> <p>Follow-up: .Different living facility recommended-patient is profoundly unhappy here.</p> <p>Surveyor reviewed R1's Electronic Medical Record(EMR). Documentation of discharge plans being identified, developed, and implemented is 1/3/24, documented by Nursing Home Administrator (NHA)-A, R1 is requesting a transfer to another county and case manager team will be notified. Surveyor notes no further documentation of discharge planning has occurred for R1 since 1/3/2024.</p> <p>On 9/10/24, at 10:30 AM, Surveyor interviewed R1 in regards to discharge planning. R1 informed Surveyor R1 has wanted to leave since R1 first arrived at the facility. R1 has had little discussions about discharge and R1 stated R1 has rarely spoken with Social Worker (SW)-D. R1 stated in the few discussions, R1 has informed SW-D that R1 wants to go to another county. R1 stated SW-D did not take any action towards discharge because SW-D stated the county is large. R1 stated R1 had already informed SW-D what part of the county R1 wanted to go to. R1 stated R1 was informed by SW-D that it was up to R1 to find a place. R1 stated that R1 then lost Medicaid due to being over assets which has impacted a lot for R1. R1 stated R1 is working with the ADRC (Aging and Disability Resource Center) and the ADRC informed R1 they can never get a hold of SW-D to complete the Medicaid process. R1 stated to Surveyor, SW-D has never been a support and I have not had care conferences to discuss my concerns with discharge planning.</p> <p>On 9/10/24, at 12:17 PM, Surveyor interviewed SW-D in regards to discharge planning for R1. SW-D confirmed it has been awhile since SW-D has discussed discharge planning with R1 and stated SW-D will meet with R1 to discuss discharge planning and the Medicaid process. Surveyor shared the concern there has been no documentation since 1/24 about discharge planning for R1. SW-D stated, I started working here in February. Surveyor confirmed with SW-D that care conferences are completed quarterly at a minimum, and discharge planning would have been discussed at the care conferences.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525262	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/11/2024
NAME OF PROVIDER OR SUPPLIER  Fort Atkinson Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  430 Wilcox St Fort Atkinson, WI 53538	
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 0660</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 9/10/24, at 3:21 PM, Surveyor shared the concern with NHA-A, Director of Nursing (DON)-B, and Regional Director of Clinical Operations (RDCO)-C that R1 has not been assisted with developing and implementing an appropriate discharge plan to assist with the transition to a lesser restrictive environment. DON-B stated that numerous referrals were made and 2 locations agreed to talk with R1. R1 had virtual meetings with the 2 locations, 1 accepted R1, and that R1 chose to not go there because of an issue of getting into the bathroom. Surveyor shared there is no documentation of this and and that R1's care plan with discharge planning goals and interventions has not been updated. Surveyor shared there has been no care conferences or discharge planning meetings which would have discussed R1's discharge plans and goals to achieve discharge from the facility for R1. No further information was provided by the facility at this time.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525262	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/11/2024
NAME OF PROVIDER OR SUPPLIER  Fort Atkinson Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  430 Wilcox St Fort Atkinson, WI 53538	
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 0676</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49435</p> <p>Based on interview and record review, the facility did not ensure that 1 (R6) of 1 residents reviewed for ADL (Activities of Daily Living) assistance received the necessary services to maintain ability to practice good grooming and personal hygiene.</p> <p>R6 prefers showers weekly and did not receive weekly showers during the months of June, July, and August 2024.</p> <p>Findings include:</p> <p>The facility policy entitled, Resident Shower, dated 4/1/2024 documents, in part: It is the practice of this facility to assist residents with bathing to maintain proper hygiene, stimulate circulation and help prevent skin issues as per current standards of practice . Residents will be provided showers as per request or as per facility schedule protocols and based upon resident safety.</p> <p>R6 was admitted to the facility on [DATE] with diagnosis that include Hemiplegia/hemiparesis affecting the left side due to stroke, Depression, Anxiety and Heart Disease.</p> <p>R6's Quarterly Minimum Data Set Assessment (MDS) dated [DATE], documents R6 has a Brief Interview for Mental Status (BIMS) score of 13 out of 15, indicating R6 is cognitively intact. R6 requires partial/moderate assist for showering/bathing and personal hygiene.</p> <p>On 9/9/2024, at 10:16 AM, Surveyor interviewed R6. R6 informed Surveyor R6 gets a shower every 2 weeks. Surveyor asked if that is what R6 preferred. R6 replied, No, that's when they get to me. Surveyor asked how often R6 would prefer a shower. R6 stated R6 would like a shower once a week.</p> <p>R6's physical functioning deficit care plan with an initiated date of 1/8/2024, documents the following interventions for showers and hygiene: Encourage choices with care. Personal hygiene assistance of 1. Shower/bathe-one partial assist.</p> <p>R6's Personalized care care plan with an initiated date of 1/10/2024 documents the following intervention for showers: Bathing preference: Shower.</p> <p>R6's Certified Nursing Assistant (CNA) Kardex documents the following: Shower/bathe-one partial assist.</p> <p>Surveyor noted that neither R6's care plan nor the CNA Kardex documents the scheduled days R6 should receive a shower.</p> <p>R6's progress note dated 7/15/2024, at 9:29 AM, documents, in part: . How important is it to you to choose between a tub bath, shower, bed bath, or sponge bath: Very important. Resident prefers showering .</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525262	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/11/2024
NAME OF PROVIDER OR SUPPLIER  Fort Atkinson Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  430 Wilcox St Fort Atkinson, WI 53538	
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 0676</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 9/9/2024, at 11:30 AM, Surveyor interviewed CNA-J. CNA-J indicated that there is a shower list for the day that CNA's use to identify residents who get a shower that day. The nurse's station has a shower binder with the schedule of showers, shower sheets and further information regarding showers. CNA-J stated the CNA's will fill out the shower sheet with the skin observations and the nurse will sign the sheet before giving it to the unit manager. Surveyor asked how often resident's receive showers. CNA-J stated 2 times a week.</p> <p>Surveyor reviewed the shower binder at the North nurse's station. Surveyor noted R6 was scheduled for showers every Tuesday and Friday in the morning.</p> <p>R6's shower sheets documented completed showers for the following days in June 2024: 6/14/24, 6/18/24 and 6/25/24.</p> <p>Surveyor noted in June, R6 did not receive a shower weekly which is R6's preference.</p> <p>R6's shower sheets documented completed showers for the following days in July 2024: 7/9/24, and 7/16/24.</p> <p>Surveyor noted in July, R6 did not receive a shower weekly which is R6's preference.</p> <p>R6's shower sheets documented completed showers for the following days in August 2024: 8/13/24, 8/27/24 and 8/30/24.</p> <p>Surveyor noted in August, R6 did not receive a shower weekly which is R6's preference.</p> <p>On 9/10/2024, at 10:40 AM, Surveyor interviewed Director of Nursing (DON)-B about showers. DON-B indicated residents are scheduled for showers 2 days a week. DON-B indicated Central Supply Staff-U had put together a shower schedule and shower audit binder to help the facility track showers. Surveyor asked if shower days/schedule should be on resident's care plan and CNA Kardex. DON-B stated not sure about the care plan, but it should be on the CNA Kardex.</p> <p>On 9/10/2024, at 10:45 AM, Surveyor interviewed Central Supply Staff-U regarding resident showers. Central Supply Staff-U indicated residents are scheduled for showers 2 times a week. Central Supply Staff-U indicated that at least one shower a week is mandatory, and the other one could be a bed bath, but it all goes by resident preference.</p> <p>On 9/10/2024, at 3:18 PM, at the daily exit meeting, Nursing Home Administrator (NHA)-A, DON-B, Regional Director of Clinical Operations-C and Regional Director of Clinical Operations-Q were made aware of the concern that R6 did not receive a shower every week which is R6's preference.</p> <p>No further information was provided as to why the facility did not ensure R6 received the necessary services to maintain the ability to practice good grooming and personal hygiene.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525262	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/11/2024
NAME OF PROVIDER OR SUPPLIER  Fort Atkinson Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  430 Wilcox St Fort Atkinson, WI 53538	
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 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 20483</p> <p>Based on interview and record review the facility did not ensure residents who are unable to carry out activities of daily living receive the necessary services to maintain good grooming for 2 (R2 &amp; R1) of 3 residents reviewed for ADL's (Activity of Daily Living).</p> <p>R2 &amp; R1 did not consistently receive showers.</p> <p>Findings include:</p> <p>The facility's policy titled, Resident Shower and dated 4/1/24 under policy documents It is the practice of this facility to assist residents with bathing to maintain proper hygiene, stimulate circulation and help prevent skin issues as per current standards of practice.</p> <p>Under Policy Explanation and Compliance Guidelines includes documentation of:</p> <p>1. Residents will be provided showers as per request or as per facility schedule protocols and based upon resident safety.</p> <p>1.) R2's diagnoses include atrial fibrillation, congestive heart failure, bipolar disorder, dementia, schizophrenia, depression, and diabetes mellitus.</p> <p>The quarterly MDS (minimum data set) with an assessment reference date of 6/12/24 is assessed as not applicable for shower/bathe self.</p> <p>The CNA (Certified Nursing Assistant) Kardex as of 9/9/24 under the ADL (Activities Daily Living) section includes *Bathing is limited with upper body and extensive with lower body. This Kardex does not indicate what days R2 receives a shower.</p> <p>On 9/9/24, at 9:49 a.m., Surveyor spoke with an anonymous family member for R2 who informed Surveyor showers are not given to R2 and R2 does not get the kind of care desired.</p> <p>On 9/9/24, at 1:29 p.m., Surveyor spoke with R2's guardian. Surveyor inquired if there are any concerns with R2 receiving showers. R2's guardian informed Surveyor she is under the assumption R2 receives showers but doesn't know the schedule and can't say if R2 is receiving them.</p> <p>On 9/9/24, at 3:10 p.m., during the end of the day meeting with NHA (Nursing Home Administrator)-A, DON (Director of Nursing)-B, Regional Director of Clinical Operations-C &amp; Regional Director of Clinical Operations-Q Surveyor asked where Surveyor would be able to locate when R2 received showers. Surveyor was informed there are paper shower sheets which Surveyor requested.</p> <p>On 9/10/24, at 10:02 a.m., Surveyor asked CNA-F if R2 receives showers. CNA-F informed Surveyor R2 has showers two times a week on Tuesday and Friday.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525262	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/11/2024
NAME OF PROVIDER OR SUPPLIER  Fort Atkinson Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  430 Wilcox St Fort Atkinson, WI 53538	
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 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 9/10/24, at approximately 1:00 p.m., Surveyor reviewed R2's shower sheets provided by the facility. Surveyor noted there is no evidence R2 received a shower on 6/4/24, 6/11/24, 6/28/24, 7/5/24, 7/12/24, 7/23/24, 8/6/24, 8/9/24, &amp; 8/23/24.</p> <p>On 9/11/24, at 12:23 p.m., Surveyor asked DON-B how does she ensure residents are receiving their scheduled showers. DON-B informed Surveyor the scheduler used to do a shower audit but she went out on leave on 7/26/24. DON-B informed Surveyor MR (Medical Records)-AA recently took over. DON-B informed Surveyor they were making sure showers were being given but doesn't know the process. DON-B informed Surveyor she just knows there is an audit book.</p> <p>On 9/11/24, at 12:28 p.m., Surveyor asked MR-AA when she took over checking resident's showers. MR-AA informed Surveyor 3 weeks ago. MR-AA explained there is a binder with shower sheets. MR-AA explained she figures out who has showers for the day, goes to the CNA to remind them of the resident's shower and makes sure the shower sheets are filled out.</p> <p>On 9/11/24, at 1:04 p.m., Surveyor reviewed the shower binder provided to Surveyor. Surveyor was able to locate shower sheets for 7/12/24 and 7/22/24. Surveyor was not able to locate evidence R2 was provided a shower on 6/4/24, 6/11/24, 6/28/24, 7/5/24, 8/6/24, 8/9/24 &amp; 8/30/24.</p> <p>On 9/11/24, at 1:30 p.m., NHA (Nursing Home Administrator)-A was informed of the above. No additional information was provided to Surveyor as to why R2 was not provided with showers two times a week.</p> <p>38829</p> <p>2.) R1 was admitted to the facility on [DATE] with diagnoses of Post-Traumatic Stress Disorder, Major Depressive Disorder, Generalized Anxiety Disorder, Obsessive-Compulsive Personality Disorder, Malingering, Somatization Disorder, Morbid Obesity, Other Intervertebral Disc Displacement, Low Back Pain, Chronic Pain Syndrome, Chronic Kidney Disease, and Neuromuscular Dysfunction of Bladder. R1 is R1's own person.</p> <p>R1's Quarterly Minimum Data Set (MDS) completed 8/2/24 documents R1's Brief Interview for Mental Status (BIMS) score to be 13, indicating R1 is cognitively intact for daily decision making. R1's Patient Health Questionnaire (PHQ-9) score is 2, indicating minimal depression and R1 demonstrates rejection of care 1-3 days during the assessment period. R1 has no range of motion impairments. R1 is independent with eating. R1 is independent with upper body dressing and dependent for lower body dressing. R1 requires partial/moderate assistance for mobility and transfers. R1's MDS documents R1 frequently has pain and occasionally interferes with daily routine. R1's Annual MDS completed 5/4/24 does not assess R1's pain, therefore there is no Care Area Assessment (CAA) addressing R1's chronic pain issues.</p> <p>The annual 5/4/24 MDS for R1 also documents it is very important to R1 to choose between a tub bath, shower, bed bath, or sponge bath. R1's MDS also documents R1 is dependent for showers/bathing which is defined as: The ability to bathe self, including washing, rinsing, and drying self (excludes washing of back and hair). Does not include transferring in/out of tub/shower. R1 requires partial/moderate assistance for transferring to get in/out of tub/shower.</p> <p>On 9/9/24, at 12:00 PM, Surveyor interviewed R1. R1 stated R1's shower days are on Tuesday and Fridays and it is very rare to get a shower on Fridays.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525262	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/11/2024
NAME OF PROVIDER OR SUPPLIER  Fort Atkinson Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  430 Wilcox St Fort Atkinson, WI 53538	
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 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 9/9/24, at 1:35 PM, Surveyor observed the binder located at the nurse's station documents R1's showers are on Tuesday and Fridays on the PM shift.</p> <p>On 9/11/24, at 10:04 AM, Surveyor reviewed R1's recorded showers from June 2024-September 2024. Based on R1's shower schedule, R1 was not provided a shower on 6/14, 6/25, 7/2, 7/12, 7/19, 7/26, 8/2, 8/9, 8/13, 8/23, 8/30, and 9/3/24. A total of 12 showers were not provided to R1 in 3 months.</p> <p>On 9/11/24, at 11:37 AM, Surveyor interviewed R1 again. R1 stated that showers are not offered or completed on Fridays. R1 confirmed R1 prefers showers and wants showers at a minimum of two times per week.</p> <p>On 9/11/24, at 12:42 PM, Surveyor shared the concern with Regional Director of Clinical Operations (RDCO)-C that R1 has not had showers two times a week per R1's choice. No further information was provided by the facility at this time.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525262	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/11/2024
NAME OF PROVIDER OR SUPPLIER  Fort Atkinson Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  430 Wilcox St Fort Atkinson, WI 53538	
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 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**</b> 20483</p> <p>Based on interview and record review the facility did not ensure residents received treatment and care in accordance with assessment and medical recommendations for 3 (R2, R5, &amp; R1) of 11 residents.</p> <p>* R2 had a colonoscopy performed on 6/18/24. The facility did not follow up regarding the results of this colonoscopy when a large polyp was removed. R2 was transferred to the hospital on 9/6/24 and returned on the same day. The facility did not follow the hospital discharge recommendations and did not update the care plan with these recommendations. R2 also had a diagnosis of cellulitis as a change in condition the facility did not follow discharge recommendations for orders to monitor.</p> <p>* R5's physician orders were not consistently being followed. R5's heart rate was not being taken every shift, R5's legs were not being elevated, diabetic foot checks were not being completed at hour of sleep, and weights were not being obtained three times a week for monitoring.</p> <p>* R1 did not have a pain and halo enabler bar assessment completed quarterly.</p> <p>Findings include:</p> <p>1.) R2's diagnoses include atrial fibrillation, congestive heart failure, bipolar disorder, dementia, schizophrenia, depression, and diabetes mellitus.</p> <p>The nurses note dated 6/14/24, at 11:48 (11:48 a.m.), documents Writer spoke with [Name] R2's daughter to inform her about the new scheduled procedure on Tuesday @ (at) 11. This nurses note was written by Director of Nursing (DON)-B.</p> <p>The nurses note dated 6/14/24, at 11:49 (11:49 a.m.), documents Writer spoke with [Name] @ [Name] Associates and [R2] is all set up for procedure on Tuesday @ 1100 (11:00 a.m.). Awaiting on orders for prep. This nurses note was written by DON-B.</p> <p>The nurses note dated 6/14/24, at 11:54 (11:54 a.m.), documents [Name] NP (Nurse Practitioner) aware of procedure on 6/18/24, Eliquis on hold @ this time. This nurses note was written by DON-B.</p> <p>The late entry nurses note dated 6/18/24, at 15:29 (3:29 p.m.), documents [R2] returned back to building from procedure. Eliquis to be on hold until 6/25. Order held. POA (power of attorney) was updated. Large polyp was removed, no other results @ this time. This nurses note was written by DON-B.</p> <p>The consultation form dated 6/18/24 under progress note documents Large rectal polyp removed. Under new orders documents Will call with results.</p> <p>Surveyor reviewed R2's medical record and was unable to locate any follow up regarding R2's colonoscopy.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525262	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/11/2024
NAME OF PROVIDER OR SUPPLIER  Fort Atkinson Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  430 Wilcox St Fort Atkinson, WI 53538	
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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 9/9/24, at 3:10 p.m., during the end of the day meeting Surveyor informed NHA (Nursing Home Administrator)-A, DON (Director of Nursing)-B, Regional Director of Clinical Operations-C &amp; Regional Director of Clinical Operations-Q, Surveyor was unable to locate any follow up regarding the results of R2's colonoscopy when a large rectal polyp was removed.</p> <p>On 9/10/24, at 2:27 p.m., Surveyor asked DON-B if there is any further information regarding the results from R2's colonoscopy. DON-B informed Surveyor she called yesterday and saw on the discharge paper work they would be reaching out. DON-B informed Surveyor they didn't get back to her so she called today and they sent over the paperwork. Surveyor asked DON-B if the surgeon didn't get back to the Facility who should have followed up to see what the results of the polyp was. DON-B informed Surveyor she doesn't know because the consult wasn't signed when R2 returned.</p> <p>The nurses note dated 9/2/24, at 06:08 (6:08 a.m.), documents [Name] Hospital called facility updated above writer that resident was admitted to [Name] Hospital for Cellulitis of Lft (left) leg and Sepsis. DON called and made aware. This nurses note was written by Nursing-S.</p> <p>R2 returned to the facility on [DATE] with a diagnosis which included cellulitis.</p> <p>The infection actual related to cellulitis left lower leg care plan initiated 9/4/24 documents the following interventions:</p> <ul style="list-style-type: none"> <li>* Administer antibiotics and treatment as ordered. Initiated 9/4/24.</li> <li>* Encourage fluids unless contraindicated. Initiated 9/4/24.</li> <li>* Encourage proper rest. Initiated 9/4/24.</li> <li>* Follow contact precautions. Initiated 9/4/24.</li> <li>* Follow stand precautions refer to Living Center Infection Control Manual. Initiated 9/4/24.</li> <li>* Monitor vital signs as needed. Initiated 9/4/24.</li> <li>* Notify practitioner if symptoms worsen or do not resolve. Initiated 9/4/24.</li> <li>* Provide adequate nutrition. Initiated 9/4/24.</li> </ul> <p>The SBAR (situation, background, appearance, recommendation) dated 9/6/24 for the change in condition, symptoms, or signs observed and evaluated is/are: documents altered mental status. Under appearance documents Noted to have altered mental status, labored breathing and increased redness to LLE (left lower extremity) and back. More pronounced facial drooping to left side. Slurred speech. Equal upper and lower extremity strength. NP (nurse practitioner) participated in assessing res. (resident). Recommended to transfer res to ER (emergency room ). Res. out via paramedics at 1415 (2:15 p.m.) This SBAR was completed by RN (Registered Nurse)-I.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525262	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/11/2024
NAME OF PROVIDER OR SUPPLIER  Fort Atkinson Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  430 Wilcox St Fort Atkinson, WI 53538	
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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The nurses note dated 9/6/24, at 18:59 (6:59 p.m.), documents Resident reoriented to room and call light system. Noted incontinent to urine, large. 3x(times) staff assist with total cares in bed and ADL (activities daily living) cares. A + O x (alert and oriented times) person and place in pleasant mood. LLE (left lower extremity) noted with redness, warm to the touch and with pain with palpitation. LLE pedal pulse faint. LLE redness with in outlined area. RLE (right lower extremity) noted with 3+ pitting edema. Lungs clear to auscultation. Bowel sounds x 4 quadrants hypoactive. Resident with abdomen obese per baseline. Vital signs taken. This nurse note was written by LPN (Licensed Practical Nurse)-W.</p> <p>The nurses note dated 9/6/24, at 19:03 (7:03 p.m.), documents Returning diagnosis is left leg cellulitis. Discharge orders state to finish taking all antibiotics even when symptoms get better, monitor for fluid leaking from skin, if pain worsens, and red area spreads, monitor for fever &gt; (greater) 100.4. Resident to follow up with [Name] Health Care wound and edema clinic in 1-2 weeks at [address].</p> <p>Surveyor reviewed R2's medical record including progress notes, MAR &amp; TAR (medication administration record/treatment administration record) and was unable to locate evidence staff was monitoring R2's cellulitis and recommendations from the hospital discharge orders. Surveyor also noted there was no revision in R2's cellulitis care plan initiated on 9/4/24 to include these orders.</p> <p>On 9/10/24, at 1:57 p.m., Surveyor asked LPN-M how the facility is monitoring R2's cellulitis. LPN-M informed Surveyor she really doesn't know. LPN-M informed Surveyor R2 is on an antibiotic but there is no prompt in the TAR to look at or lay eyes on R2's legs.</p> <p>On 9/10/24, at 2:30 p.m., Surveyor asked DON (Director of Nursing)-B how the facility is monitoring R2's cellulitis. DON-B informed Surveyor she was out all last week and heard about it when she came back. DON-B informed Surveyor there should be an order and monitoring for R2's cellulitis.</p> <p>On 9/11/24, at 1:30 p.m., NHA (Nursing Home Administrator)-A was informed of the above. No additional information was provided to Surveyor as to why staff did not follow up on R2's colonoscopy on 6/18/24 and monitoring R2's cellulitis.</p> <p>2.) R5's diagnoses includes edema, congestive heart failure, atrial fibrillation, peripheral vascular disease, and diabetes mellitus.</p> <p>R5's quarterly MDS (minimum data set) with an assessment reference date of 6/21/24 has a BIMS (brief interview mental status) score of 11 which indicates moderate cognitive impairment.</p> <p>On 9/9/24, at 9:57 a.m., Surveyor spoke with an anonymous family member for R5. Surveyor was informed there was a concern R5's physician orders were not being followed including elevating R5's legs, monitoring his heart rate, diabetic foot checks as well as other orders.</p> <p>Surveyor reviewed R5's physician orders and noted an order dated 3/12/24 which documents Please notify MD (medical doctor) or NP if HR (heart rate) is less than 45 - every shift for Bradycardia resident does have a f/u (follow up) with cardiology.</p> <p>Surveyor reviewed R5's July 2024, August 2024 &amp; September 2024 MAR &amp; TAR (medication administration record and treatment administration record) and did not note this order.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525262	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/11/2024
NAME OF PROVIDER OR SUPPLIER  Fort Atkinson Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  430 Wilcox St Fort Atkinson, WI 53538	
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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Surveyor reviewed R5's medical record and noted under the weights/vitals tab there is documentation of R5's pulse being taken but not consistently each shift.</p> <p>For July 2024 Surveyor noted the following:</p> <p>7/1/24 there is only one entry on 13:46 (1:46 p.m.),</p> <p>7/2/24 there is no documented pulse,</p> <p>7/3/24 there is one entry at 13:31 (1:31 p.m.),</p> <p>7/4/24, 7/5/24, 7/6/24, &amp; 7/7/24 there is no documented pulse,</p> <p>7/8/24 there is one entry at 11:48 a.m.,</p> <p>7/9/24 there is no documented pulse,</p> <p>7/10/24 there is only one entry at 13:02 (1:02 p.m.),</p> <p>7/11/24 there is no documented pulse,</p> <p>7/12/24 there is one entry at 12:34 p.m.,</p> <p>7/13/24 there is one entry at 22:38 (10:38 p.m.),</p> <p>7/14/24 there is no documented pulse,</p> <p>7/15/24 there are two entries at 13:18 (1:18 p.m.) &amp; 15:30 (3:30 p.m.),</p> <p>7/17/24 there is no documented pulse,</p> <p>7/18/24 there is one entry at 12:16 p.m.,</p> <p>7/19/24 there is one entry at 10:46 a.m.,</p> <p>7/20/24 &amp; 7/21/24 there is no documented pulse,</p> <p>7/22/24 there is one entry at 11:21 a.m.,</p> <p>7/23/24 there is no documented pulse,</p> <p>7/24/24 there is one entry at 16:35 (4:35 p.m.),</p> <p>7/25/24 there is no documented pulse,</p> <p>7/26/24 there is one entry at 13:43 (1:43 p.m.),</p> <p>7/27/24 &amp; 7/28/24 there is no documented pulse,</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525262	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/11/2024
NAME OF PROVIDER OR SUPPLIER  Fort Atkinson Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  430 Wilcox St Fort Atkinson, WI 53538	

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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>7/29/24 there is one entry at 9:05 a.m., 7/30/24 there is no documented pulse,</p> <p>7/31/24 there is one entry at 8:52 a.m.</p> <p>For August 2024 Surveyor noted the following:</p> <p>8/1/24 there is no documented pulse,</p> <p>8/2/24 there is one entry at 8:21 a.m.,</p> <p>8/3/24 there is one entry at 15:06 (3:06 p.m.),</p> <p>8/4/24 there is no documented pulse,</p> <p>8/5/24 there is one entry at 14:37 (2:37 p.m.),</p> <p>8/6/24 there is no documented pulse,</p> <p>8/7/24 there is one entry at 18:01 (6:01 p.m.),</p> <p>8/8/24 there is no documented pulse,</p> <p>8/9/24 there is one entry at 14:00 (2:00 p.m.),</p> <p>8/10/24 there is one entry at 11:44 a.m.,</p> <p>8/11/24, 8/12/24, &amp; 8/13/24 there are no documented pulse,</p> <p>8/14/24 there is one entry at 9:42 a.m.,</p> <p>8/15/24 there is one entry at 12:43 p.m.,</p> <p>8/16/24 there are two entries at 13:36 (1:36 p.m.) &amp; 13:38 (1:38 p.m.),</p> <p>8/17/24 there are two entries at 1:29 a.m. &amp; 7:43 a.m.,</p> <p>8/21/24 there are two entries at 2:21 a.m. &amp; 12:37 p.m.,</p> <p>8/22/24 there is noc (night) pulse taken,</p> <p>8/23/24 there are two entries at 2:36 a.m. &amp; 13:04 (1:04 p.m.),</p> <p>8/24/24 there is one entry at 3:48 a.m.,</p> <p>8/25/24 there is one entry at 1:16 a.m.,</p> <p>8/26/24 there is no day pulse taken,</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525262	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/11/2024
NAME OF PROVIDER OR SUPPLIER  Fort Atkinson Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  430 Wilcox St Fort Atkinson, WI 53538	
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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>8/27/24 there are two entries at 1:47 a.m. &amp; 12:27 p.m.,</p> <p>8/28/24 physician orders were followed,</p> <p>8/29/24 there is one entry at 12:45 p.m.,</p> <p>8/30/24 there is an entry at 2:46 a.m., 14:16 (2:16 p.m.) &amp; 14:17 (2:17 p.m.),</p> <p>8/31/24 there are two entries at 15:23 (3:23 p.m.) &amp; 19:06 (7:06 p.m.).</p> <p>For September 2024 Surveyor noted the following:</p> <p>9/2/24 there were entries at 3:23 a.m., 16:18 (4:18 p.m.) &amp; 20:54 (8:54 p.m.),</p> <p>9/4/24 there is no documented pulse,</p> <p>9/7/24 there is one entry at 18:40 (6:40 p.m.)</p> <p>The physician orders dated 7/1/24 documents Elevate legs as often as possible every shift for Elevate legs Please write a prog (progress) note if resident refuses.</p> <p>Surveyor reviewed R5's July TAR and noted on 7/1/24, 7/4/24, &amp; 7/9/24, the evening shifts are blank. On 7/27/24 the day shift is blank. Surveyor noted a check mark with initials indicates this order was implemented.</p> <p>Surveyor reviewed R5's August TAR and noted on 8/14/24, 8/15/24, 8/23/24, 8/24/24, 8/25/24, 8/26/24, 8/27/24, 8/29/24, &amp; 8/30/24 evening shift are blank.</p> <p>Surveyor reviewed R5's September TAR and noted on 9/4/24 the day &amp; evening shift are blank.</p> <p>Surveyor reviewed R5's progress notes starting on 7/1/24 and did not note any progress notes regarding R5 refusing to elevate his legs.</p> <p>During the survey, Surveyor did not observe R5's legs being elevated. R5 does not have leg rests on his wheelchair as R5 uses his feet to propel his chair.</p> <p>On 9/10/24, at 10:31 a.m., Surveyor asked R5 if anyone ever spoke to him about putting his legs up. R5 replied they did once. Surveyor asked if anyone spoke to him today about elevating his legs. R5 replied no, then stated that would be a good idea.</p> <p>On 9/10/24, at 1:39 p.m., Surveyor asked CNA (Certified Nursing Assistant)-J if R5's legs need to be elevated. CNA-J replied no.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525262	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/11/2024
NAME OF PROVIDER OR SUPPLIER  Fort Atkinson Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  430 Wilcox St Fort Atkinson, WI 53538	
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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 9/10/24, at 1:58 p.m., Surveyor asked LPN (Licensed Practical Nurse)-M if R5's legs need to be elevated. LPN-M replied I don't know off the top of my head. I think so. I believe I have to prompt to tell him to elevate his legs. He has enema wraps. Surveyor asked LPN-M how she would have R5 elevate his legs. LPN-M informed Surveyor if he was in his wheelchair in his room she would have him place his feet on his bed or would find a chair. Surveyor asked LPN-M if she spoke with R5 about elevating his legs today. LPN-M replied I didn't my day kind of got away from me.</p> <p>During review of R5's September TAR, LPN-M on 9/10/24 for the day shift, checked &amp; initialed indicating R5's legs were elevated. This was not accurate charting.</p> <p>The physician orders dated 5/4/24 documents Diabetic foot check and are with application of foot cream q (every) HS (hour sleep) at bedtime related to Type 2 Diabetes mellitus with diabetic chronic kidney disease.</p> <p>Surveyor reviewed R5's July TAR and noted at 2000 (8:00 p.m.) is blank on 7/1/24, 7/4/24, &amp; 7/9/24.</p> <p>Surveyor reviewed R5's August TAR and noted at 2000 (8:00 p.m.) is blank on 8/14/24, 8/15/24, 8/20/24, 8/23/24, 8/24/24, 8/25/24, 8/26/24, 8/27/24, 8/28/24, 8/29/24 &amp; 8/30/24.</p> <p>Surveyor reviewed R5's September TAR and noted at 2000 (8:00 p.m.) 9/4/24 is blank.</p> <p>The physician orders dated 5/6/24 documents Weigh 3x (three times)/weekly - every day shift every Mon (Monday), Wed (Wednesday), Fri (Friday) for monitoring.</p> <p>Surveyor reviewed R5's July TAR and noted on 7/3/24 &amp; 7/5/24 there is a code 7 which equals Other/see nurses note. Surveyor reviewed R5's progress and e mar (electronic medication administration record) and noted there is no documentation as to why R5's weight was not obtained.</p> <p>Surveyor reviewed R5's August TAR and noted 8/2/24, 8/16/24, 8/30/24 are blank. Surveyor reviewed R5's progress notes and the weight/vitals tab but was unable to locate a weight for these dates.</p> <p>On 8/14/24 there is a code 7. Surveyor noted there is an emar note on 8/14/24 which documents did not get report for weight. On 8/28/24 code 7 is documented. On 8/28/24 there is an emar note which documents unable due to time constraint.</p> <p>Surveyor reviewed R5's September TAR and noted 9/2/24 &amp; 9/4/24 are blank. Surveyor reviewed the progress notes and under the weight/vital tab but was unable to locate a weight for these dates.</p> <p>On 9/11/24, at 12:12 p.m., Surveyor asked DON (Director of Nursing)-B if Surveyor was a nurse at the facility, if there is a check mark with my initials on the MAR or TAR this would indicate I completed what the physician orders stated. DON-B replied yes. Surveyor asked if anyone reviews the TARs to ensure physician orders are being completed. DON-B informed Surveyor she started and always got side tracked. DON-B informed Surveyor she hasn't finished going through all of them and they should be gone through more frequently. Surveyor informed DON-B of the concerns of R5's heart rate not being taken every shift, weights not obtained three times weekly, diabetic foot checks and R5's legs not being elevated. Surveyor informed DON-B, LPN-M on 9/10/24 checked and initialed R5's legs were elevated but when Surveyor asked her, LPN-M informed Surveyor she hadn't spoken to R5, as the day had gotten away from her.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525262	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/11/2024
NAME OF PROVIDER OR SUPPLIER  Fort Atkinson Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  430 Wilcox St Fort Atkinson, WI 53538	
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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 9/11/24, at 1:30 p.m., NHA (Nursing Home Administrator)-A was informed of the above.</p> <p>38829</p> <p>3.) The facility's policy Proper Use of Bed Rails, dated 10/1/22 documents:</p> <p>.Ongoing Monitoring and Supervision</p> <p>15. The facility will continue to provide necessary treatment and care to the Resident who has bed rails in accordance with professional standards of practice and the Resident's choices. This should be evidenced in the Resident's records, including their care plan, including but not limited to, the following information:</p> <p>a. The type of specific direct monitoring and supervision provided during the use of the bed rails, including documentation of the monitoring</p> <p>b. The identification of how needs will be met during use of the bed rails, such as for repositioning, hydration, meals, use of bathroom and hygiene</p> <p>c. Ongoing assessment to assure that the bed rail is used to meet the Resident's needs</p> <p>d. Ongoing evaluation of risks</p> <p>e. The identification of who may determine when the bed rail will be discontinued</p> <p>f. The identification and interventions to address any residual effects of the bed rail</p> <p>16. Responsibilities of ongoing monitoring and supervision are specified as follows:</p> <p>a. Direct care staff will be responsible for care and treatment in accordance with the plan of care</p> <p>b. A nurse assigned to the Resident will complete reassessments in accordance with the facility's assessment schedule, but not less than quarterly, upon a significant change in status, or change in the type of bed/mattress/rail.</p> <p>c. The interdisciplinary team will make decisions regarding when the bed rail will be used or discontinued, or when to revise the care plan to address any residual effects of the bed rail</p> <p>d. The maintenance director, or designee, is responsible for adhering to a routine maintenance and inspection schedule for all bed frames, mattresses, and bed rails .</p> <p>Surveyor also reviewed the facility's Pain Management Policy dated 10/1/22 which documents:</p> <p>.Recognition:</p> <p>1. In order to help a Resident attain or maintain his/her practicable level of physical, mental, and psychosocial well-being and to prevent or manage pain, the facility will:</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525262	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/11/2024
NAME OF PROVIDER OR SUPPLIER  Fort Atkinson Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  430 Wilcox St Fort Atkinson, WI 53538	
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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>a. Recognize when the Resident is experiencing pain and identify circumstances when the pain can be anticipated</p> <p>b. Evaluate the Resident for pain and the cause(s) upon admission, during ongoing scheduled assessments, and when a significant change in condition or status occurs</p> <p>c. Manager or prevent pain, consistent with comprehensive assessment and plan of care, current professional standards of practice, and the Resident's goals and preferences .</p> <p>R1 was admitted to the facility on [DATE] with diagnoses of Post-Traumatic Stress Disorder, Major Depressive Disorder, Generalized Anxiety Disorder, Obsessive-Compulsive Personality Disorder, Malingering, Somatization Disorder, Morbid Obesity, Other Intervertebral Disc Displacement, Low Back Pain, Chronic Pain Syndrome, Chronic Kidney Disease, and Neuromuscular Dysfunction of Bladder. R1 is R1's own person.</p> <p>R1's Quarterly Minimum Data Set (MDS) completed 8/2/24 documents R1's Brief Interview for Mental Status (BIMS) score to be 13, indicating R1 is cognitively intact for daily decision making. R1's Patient Health Questionnaire (PHQ-9) score is 2, indicating minimal depression and R1 demonstrates rejection of care 1-3 days during the assessment period. R1 has no range of motion impairments. R1 is independent with eating. R1 is independent with upper body dressing and dependent for lower body dressing. R1 requires partial/moderate assistance for mobility and transfers. R1's MDS documents R1 frequently has pain and occasionally interferes with daily routine.</p> <p>R1's Annual MDS completed 5/4/24 does not assess R1's pain, therefore there is no Care Area Assessment (CAA) addressing R1's chronic pain issues.</p> <p>R1's comprehensive care plan documents:</p> <p>-Needs pain management and monitoring related to chronic back pain, diagnosis including intervertebral disc displacement, low back pain, Obesity, spondylosis, chronic pain syndrome, neuromuscular dysfunction of the bladder-Initiated 5/24/23</p> <p>New interventions have not been initiated to address R1's pain since 1/9/24</p> <p>-On 2/5/24, bilateral halos to bed to maximize independence with bed mobility/independence was initiated to address R1's physical functioning deficit</p> <p>Surveyor notes per current physician orders, R1's chronic pain is being addressed by the administration of oxycodone and Tylenol as needed and fentanyl patch, every day shift, every 3 days. R1's physician orders also document bilateral halos to bed to maximize independence with bed mobility/independence.</p> <p>On 9/9/24, at 11:06 AM, Surveyor first interviewed R1. R1 discussed at length, R1's concern with R1's pain and having to wait for a long period of time to receive as needed pain medication after asking for it.</p> <p>On 9/9/24, at 12:00 PM, Surveyor observed R1 had halo bars on R1's bed. Surveyor interviewed R1 who stated R1 uses the bars to boost herself up in bed.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525262	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/11/2024
NAME OF PROVIDER OR SUPPLIER  Fort Atkinson Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  430 Wilcox St Fort Atkinson, WI 53538	
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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 9/9/24, at 1:00 PM, Surveyor reviewed R1's electronic medical record (EMR) to investigate R1's pain concerns and verify the facility's assessment of both R1's pain and the halo bars on R1's bed.</p> <p>R1's pain assessment completed on 3/14/24, documents: (R1) has almost constant pain and has made it hard for (R1) to sleep at night and has limited (R1's) day to day activities. Surveyor notes there were no updates to (R1's) comprehensive care plan based on the pain assessment.</p> <p>R1's bed rail assessment completed on 2/2/24 documents R1 has enabler bars to promote independence in bed or with transfers.</p> <p>Surveyor notes both the pain and the bed rail assessment were not completed on a quarterly basis per facility written policy and procedure.</p> <p>On 9/9/24, at 3:02 PM, at daily exit meeting with Nursing Home Administrator (NHA)-A, Director of Nursing (DON-B), and Regional Director of Clinical Operations (RDCO)-C, Surveyor shared the concern that R1's bed rail and pain assessment was last completed 2/2/24, and had not been completed on a quarterly basis. DON-B confirmed that both assessments should be completed on a quarterly basis. No further information was provided by the facility at this time.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525262	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/11/2024
NAME OF PROVIDER OR SUPPLIER  Fort Atkinson Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  430 Wilcox St Fort Atkinson, WI 53538	
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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>20483</p> <p>Based on interview and record review the Facility did not ensure each Resident received adequate supervision to prevent accidents for 1 (R2) of 3 Residents.</p> <p>* On 9/9/24 CNA (Certified Nursing Assistant)-K did not use a gait belt when transferring R2 from the bed to the wheelchair.</p> <p>Findings include:</p> <p>The facility's policy titled, Use of Gait Belt Policy and not dated under policy documents It is the policy of this facility to use gait belts with residents that cannot independently ambulate or transfer for the purpose of safety. Under Policy Explanation and Compliance Guidelines documents:</p> <ol style="list-style-type: none"> <li>1. Each nursing department employee will be given a gait belt during orientation.</li> <li>2. All employees will receive education on the proper use of gait belt during orientation and annually.</li> <li>3. It is the responsibility of each employee to ensure they have it available for use at all times when at work.</li> </ol> <p>R2's diagnoses include atrial fibrillation, congestive heart failure, bipolar disorder, dementia, schizophrenia, depression, and diabetes mellitus.</p> <p>The quarterly MDS (minimum data set) with an assessment reference date of 6/12/24 has a BIMS (brief interview mental status) score of 13 which indicates cognitively intact. R2 is assessed as requiring partial/moderate assistance for chair/bed to chair transfer.</p> <p>R2 is 6 feet 3 inches tall and on 9/6/24 R2 weighed 405 pounds.</p> <p>The CNA (Certified Nursing Assistant) Kardex as of 9/9/24 under the ADL's (activities daily living) section includes documentation of *Assistive devices EZ stand and *Transfer status (1-2) stand pivot with 2WW (wheeled walker), supervision/partial assist, CGA (contact guard assist) usually.</p> <p>The physical functioning deficit care plan initiated 2/13/23 documents interventions of:</p> <p>* Assistive devices EZ stand. Initiated 2/13/23 &amp; revised on 5/2/23.</p> <p>* Transfer status- (1-2) - stand pivot with 2WW, supervision/partial assist, CGA. Initiated 2/13/23 &amp; revised on 4/25/24.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525262	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/11/2024
NAME OF PROVIDER OR SUPPLIER  Fort Atkinson Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  430 Wilcox St Fort Atkinson, WI 53538	

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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 9/9/24, at 9:12 a.m., Surveyor observed CNA (Certified Nursing Assistant)-J in R2's room wearing gloves. CNA-J placed a gait belt around R2 who was sitting in a wheelchair and moved a two wheeled walker in front of R2. CNA-J assisted R2 with standing up but then R2 sat back down in the wheelchair. CNA-J stated to R2 you don't feel it today let me get the sit to stand. CNA-J removed his gloves and left R2's room.</p> <p>At 9:16 a.m. CNA-J entered R2's room with the sit to stand and placed gloves on. The sit to stand was placed in front of R2, R2's feet were placed on the foot platform and CNA-J placed the sling around R2 &amp; attached the sling to the lift. R2 was then transferred over to the bed.</p> <p>On 9/9/24, at 11:16 a.m., Surveyor observed R2's call light on. A housekeeper who was leaving R2's room stated he wants to get up in his chair. Surveyor observed CNA-K enter R2's room. R2 stated to CNA-K I just want to get up now. CNA-K lowered the bed, removed a pillow from R2's upper right side and informed R2 she would put his shoes on after he sits up. CNA-K assisted R2 with sitting on the edge of the bed and placed sneakers on R2. CNA-K placed the two wheeled walker in front of R2, stated one, two, three and assisted R2 to stand up by holding under R2's arm. R2 took a couple steps and sat in the wheelchair. CNA-K removed her gloves and cleansed her hands.</p> <p>Surveyor observed CNA-K did not place a gait belt on R2 during this observation.</p> <p>On 9/9/24, at 1:24 p.m., Surveyor asked CNA-J if R2 isn't transferred with the sit to stand and is transferred using the two wheeled walker should a gait belt be placed on R2 prior to the transfer. CNA-J replied I do he's a big man.</p> <p>On 9/10/24, at 9:27 a.m., Surveyor asked CNA-F when transferring R2 if she doesn't use the sit to stand lift how should R2 be transferred. CNA-F replied suppose to be walker with gait belt. Surveyor asked CNA-F if they should always use a gait belt. CNA-F replied yes when I use the walker.</p> <p>On 9/11/24, at 12:07 p.m., Surveyor asked DON (Director of Nursing)-B how staff should be transferring R2. DON-B informed Surveyor she wasn't sure as she wasn't sure if R2 was a Hoyer or EZ stand. Surveyor asked DON-B if R2 is transferred with a wheeled walker should a gait belt be used with the transfer. DON-B replied yes with any transfer. Surveyor informed DON-B of the transfer with CNA-K not using a gait belt with R2.</p> <p>On 9/11/24, at 1:30 p.m., NHA (Nursing Home Administrator)-A was informed of the above. No additional information was provided to Surveyor as to why R2 was not transferred with a gait belt.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525262	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/11/2024
NAME OF PROVIDER OR SUPPLIER  Fort Atkinson Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  430 Wilcox St Fort Atkinson, WI 53538	

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 0699</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care or services that was trauma informed and/or culturally competent.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 38829</p> <p>Based on interview and record review the Facility did not comprehensively assess 1 (R1) of 1 Residents for trauma informed care and care plan approaches to mitigate any triggers to prevent re-traumatization.</p> <p>*R1 was admitted [DATE] and during R1's admission psychosocial assessment, the facility did not identify R1 as having a history of post traumatic stress disorder (PTSD). On 12/7/23, R1 had an initial psychiatric evaluation that identified R1's PTSD to be physical and sexual trauma. The facility completed Trauma Informed Care Assessments for all high risk residents on 5/20/24. R1's past history of physical and sexual trauma was not addressed with person centered interventions. A care plan and approaches to mitigate any triggers to prevent re-traumatization was not put in place after the assessment for R1 had been completed.</p> <p>Findings Included:</p> <p>According to Substance Abuse and Mental Health Services Administration (SAMHSA, 2014) (<a href="https://www.ncbi.nlm.nih.gov/books/NBK207191/">https://www.ncbi.nlm.nih.gov/books/NBK207191/</a>), The impact of trauma can be subtle, insidious, or outright destructive. How an event affects an individual depends on many factors, including characteristics of the individual, the type and characteristics of the event(s), developmental processes, the meaning of the trauma, and sociocultural factors. SAMHSA explains trauma causes immediate and delayed emotional, behavioral, physical, cognitive, and existential reactions.</p> <p>The facility's assessment approved 8/8/24 documents:</p> <p>Purpose Statement:</p> <p>The purpose of this assessment is to determine what resources are necessary to care for our Resident competently during both day-to-day operations and emergencies.</p> <p>The facility assessment also documents that the facility can provide care to those Residents with Psychiatric/Mood Disorders including PTSD.</p> <p>The facility documents under services and care the facility offers based on Resident's needs that the facility can provide Behavioral and Mental Health which is defined by the facility as:</p> <p>Manage the medical conditions and medication related issues causing psychiatric symptoms and behavior, identify and implement interventions to help support individuals with issues such as dealing with anxiety, care of someone with cognitive impairment, trauma/PTSD, referral to outside services as needed: other psychiatric diagnoses, intellectual or developmental disabilities.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525262	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/11/2024
NAME OF PROVIDER OR SUPPLIER  Fort Atkinson Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  430 Wilcox St Fort Atkinson, WI 53538	
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 0699</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Specific Care or Practices Build relationship with Resident/get to know him/her, engage Resident in conversation. Find out what Resident's preferences and routines are. what makes a good day for Resident, what upsets him/her and incorporate information into the care planning process. Make sure staff caring for the Resident have this information. Record and discuss treatment and care preferences. Support emotional and mental well-being, support helpful coping mechanisms. Support Resident having familiar belongings. Provide culturally competent care, learn about Resident preferences and practices with regard to culture and religion, stay open to requests and preferences and work to support those as appropriate.</p> <p>Training Program Evaluation</p> <p>Education and Competencies</p> <p>Caring for Residents with mental and psychosocial disorders, as well as Residents with history of trauma and/or PTSD, and implementing non-pharmacological interventions.</p> <p>R1 was admitted to the facility on [DATE] with diagnoses of Post-Traumatic Stress Disorder (PTSD), Major Depressive Disorder (MDD), Generalized Anxiety Disorder, Obsessive-Compulsive Personality Disorder, Malingering, Somatization Disorder, Morbid Obesity, Other Intervertebral Disc Displacement, Low Back Pain, Chronic Pain Syndrome, Chronic Kidney Disease, and Neuromuscular Dysfunction of Bladder. R1 is R1's own person.</p> <p>R1's Quarterly Minimum Data Set (MDS) completed 8/2/24 documents R1's Brief Interview for Mental Status (BIMS) score to be 13, indicating R1 is cognitively intact for daily decision making. R1's Patient Health Questionnaire (PHQ-9) score is 2, indicating minimal depression and R1 demonstrates rejection of care 1-3 days during the assessment period.</p> <p>R1's comprehensive care plan documents:</p> <p>-I get nervous and anxious around men. In new situations. I do not like men to do my cares.-Initiated 5/24/23</p> <p>-I sometimes have behaviors which include manipulating staff, fabricating statements, refusals of cares and meals, self limiting, self sabotaging. I sometime embellish the truth and have exaggerations, makes false accusations, and kicks staff out of room, and refuses to be cared for by certain staff</p> <p>10/23-(R1) refusing cares for most staff then complains no one is taking care of her. Multiple staff offered and refused. (R1) will call the police</p> <p>4/2/24-(R1) refuses cares from staff whom are different ethnicities (sic)</p> <p>4/2/24-(R1) uses the word abuse inappropriately. Generalizes it and uses it anytime (R1) is asked to complete a task that (R1) does not want participate in</p> <p>5/24/23-(R1) puts on call light and falls asleep. Has no sense of time and when staff answers call light, (R1) yells at staff as (R1) thinks its been a longer time than it really has.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525262	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/11/2024
NAME OF PROVIDER OR SUPPLIER  Fort Atkinson Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  430 Wilcox St Fort Atkinson, WI 53538	

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 0699</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Behaviors: Hoarding:</p> <p>Diagnosis PTSD, major depressive disorder, hypochondriasis (sic), obsessive compulsive personality disorder, malingerer</p> <p>(R1) is known to hoard food items in room. (R1) is not receptive when provided education on the importance of maintaining an environment that promotes health and safety. (R1) requires frequent interventions from staff to ensure safety in this area.</p> <p>Initiated 5/24/23</p> <p>-Behaviors: Manipulation:</p> <p>Diagnosis PTSD, major depressive disorder, hypochondriasis, obsessive compulsive personality disorder, malingerer</p> <p>(R1) presents with long-standing dysfunctional social skills and personality traits yielding manipulative symptoms as evidenced staff splitting, perseverating, false allegations, frequent complaints with accepting resolutions, refusing to participate in treatment/therapy then blaming therapy for declines, refusing to participate in ADLS (activities of daily living) (R1) is capable of doing and becoming hostile/demanding to staff that they do it for her</p> <p>Behavior symptoms concerning inappropriate personal boundaries</p> <p>Inappropriate and manipulating behaviors, makes inappropriate phone calls to DQA (Division of Quality Assurance) and case management team when (R1) is aware of grievance process.</p> <p>Refuses cares</p> <p>(R1) will call the police</p> <p>Initiated 9/27/23</p> <p>-Psychosocial Well-Being and Trauma</p> <p>(R1) holds psychiatric diagnoses of PTSD and MDD recurrent. (R1) refuses to engage in discussions about what lead to diagnosis of PTSD and therefore the facility has poor history in this area. (R1) is not pushed to discuss the incidents leading to this diagnosis in efforts to adhere to standardized practices of trauma-informed care and avoid re-traumatization.</p> <p>(R1) presents with lack of insight, emotional dysregulation, and poor social skills. (R1) has frequent complaints with no resolve and is frequently speaking poorly of staff members, keeping logs of others, and making false allegations to follow. (R1) chooses to spend majority of days independently and does not appear motivated for social interactions with others.</p> <p>Initiated 5/24/23</p> <p>-Mood State</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525262	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/11/2024
NAME OF PROVIDER OR SUPPLIER  Fort Atkinson Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  430 Wilcox St Fort Atkinson, WI 53538	
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 0699</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>(R1) holds diagnosis of MDD recurrent and PTSD which yield alterations in mood state as evidenced by agitation, dysthymic mood, apathy, anhedonia, hopelessness, feelings of anxiety, loss of control, insomnia, fluctuating appetite, an overall sense of anger towards others due to a psychological external loss of control which causes (R1) to place blame for (R1's) health condition on others rather working towards acceptance.</p> <p>(R1) lacks insight into condition and lacks motivation for treatment. (R1) will refuse psychotherapy, refuse counseling from social services, treatment team and refuse psychotropic medications. (R1) will then complain nothing is being done for (R1).</p> <p>Initiated 5/24/23</p> <p>Surveyor notes there have been no updated person centered interventions for R1 since 5/24/23. Surveyor notes that R1's comprehensive care plan is concentrated on R1's behaviors and what is perceived as R1's negative responses to facility interventions. The facility has not examined why R1 may be responding to triggering situations or boundaries in what the facility perceives as 'behaviors', thus the facility has not facilitated R1 to increase self independence physically and emotionally or promote physical and emotional health overall.</p> <p>R1's psychosocial social history dated 6/23/22 does not identify R1 as having a diagnosis of PTSD and areas of concerns and triggers related to the PTSD diagnosis.</p> <p>On 12/6/23, APNP (advanced practice nurse practitioner) Psychiatric/Mental Health (APNP)-DD evaluated R1 for an initial Psych Evaluation. APNP-DD documents in regards to R1's trauma:</p> <p>.Writer asked patient to describe any history of trauma in her life. Patient asked writer to define what kind of trauma she meant. Writer said physical, psychological, emotional, sexual. Volume of patient's voice was barely audible to writer. She said it is suspected that I have sexual trauma. But I do not remember any of it. Physical trauma too .Psychological .My mom. Patient paused and then whispered New Hampshire.</p> <p>APNP-DD also recommended .for the facility to put into place and enforce boundaries to promote independence for (R1). Enforcing boundaries also medicates power beyond what she says she has .</p> <p>The facility did not complete a 'Trauma Informed Care Assessment' for R1 until 5/20/24. R1 answered YES to having experienced a traumatic event. R1 answered YES to having nightmares or thought about the event when you did not want to in the past month, answered YES to tried hard not to think about the event or went out of way to avoid situations that reminded of the event, and YES to feeling numb or detached from people, activities, or surroundings.</p> <p>Surveyor notes that based on R1 answering YES to these questions, person-centered interventions were not put into place as evidenced by no interventions documented in R1's comprehensive care plan.</p> <p>As documented on R1's current physician orders, as of 7/26/24, R1 is being administered Diazepam, 1 tablet by mouth - 3 times a day - for anxiety.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525262	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/11/2024
NAME OF PROVIDER OR SUPPLIER  Fort Atkinson Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  430 Wilcox St Fort Atkinson, WI 53538	
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 0699</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 9/9/24, at 11:06 AM, Surveyor interviewed R1. Within the conversation, R1 stated R1 lost Medicaid benefits because R1 was over assets. R1 stated R1 has been in emotional paralysis: for taking any action.</p> <p>On 9/9/24, at 12:00 PM, Surveyor interviewed R1. R1 was laying in bed, head of bed slightly elevated, with sheet and blanket pulled up to R1's chin. Overbed table was across R1 and Surveyor observed a notebook on the table. R1 spoke in a very quiet, soft spoken voice to Surveyor and demonstrated a flat affect during the whole interview. R1 shared several concerns with Surveyor. R1 stated that the facility forced cares in pairs which has been very anxiety inducing for R1. R1 stated that R1 is very uncomfortable in the shower with 2 staff. R1 has had a lot of distress about things like getting R1's food heated up, the room change that occurred, having to wait for long periods of time for R1's as needed pain medications. R1 informed Surveyor that R1 has been emotionally upset. R1 stated the facility has never been a support to R1. Surveyor shared with R1 at the end of the interview that it was nice to see R1 smile. R1 responded, its because you showed me respect and dignity.</p> <p>On 9/10/24, at 12:17 PM, Surveyor interviewed Director of Social Services (DSS)-D. DSS-D was not able to state what the facility has done to address R1's PTSD issues.</p> <p>On 9/11/24, at 12:42 PM, Surveyor had a discussion with Regional Director of Clinical Operations, (RDCO)-C in regards to R1. Surveyor shared that based on R1's diagnoses of PTSD, Major Depressive Disorder, Generalized Anxiety Disorder, and Obsessive-Compulsive Personality Disorder, the facility has not put into place person-centered interventions for R1 in order to promote increased independence and decrease any crippling psychosocial outcome. Surveyor discussed that per staff interviews and documentation, R1 has the ability to be extremely independent and with no positive interventions by the facility, R1 is becoming dependent on staff for everything. Surveyor shared the concern that the facility has not attempted to re-approach R1 to gain trust in order to work with R1 to develop a care plan with approaches to mitigate any triggers to prevent re-traumatization. Surveyor discussed that R1 is displaying actions of feeling powerless. RDCO-C agreed with Surveyor and understands the concerns. RDCO-C agreed that the facility needs to develop non-pharmacological approaches and interventions in order to maximize R1's physical and emotional independence. No further information was provided by the facility at this time.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525262	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/11/2024
NAME OF PROVIDER OR SUPPLIER  Fort Atkinson Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  430 Wilcox St Fort Atkinson, WI 53538	

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 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 20483</p> <p>Based on observation and interview the facility did not ensure sufficient nursing staff to meet resident care needs. This has the potential to affect R11, R2, R1, R12, R4, R6, and multiple residents residing on the north unit.</p> <p>On 9/9/24 CNA (Certified Nursing Assistant)-F was pulled from her CNA assignment to pass medication. The facility did not reassign staff to CNA-F's assignment resulting in R11's call light being on for over two hours. When R11's call light was answered &amp; her needs addressed R11 was visibly upset &amp; crying.</p> <p>On 9/9/24 R1's call light was observed on for over 30 minutes.</p> <p>Pulling CNA-F to pass medications rather than care for the residents impacted the residents residing on the north wing of the facility.</p> <p>R12, R4, and R6 all described waiting long lengths of time waiting to have call lights answered and needs met due to lack of staff in the facility.</p> <p>Findings include:</p> <p>1.) R11's diagnoses includes coronary artery disease, congestive heart failure, hypertension, diabetes mellitus, anxiety disorder and depression.</p> <p>The annual MDS (minimum data set) with an assessment reference date of 7/2/24 has a BIMS (brief interview mental status) score of 14 which indicates cognitively intact. R11 is assessed as being dependent for toileting hygiene and substantial/maximal assistance for rolling left &amp; right. R11 is assessed as always continent of urine and bowel.</p> <p>On 9/9/24 at 9:05 AM, Surveyor observed Certified Nursing Assistant (CNA)-F standing at the medication cart outside of R11's room. Surveyor noted R11's call light was on.</p> <p>On 9/9/24 at 9:37 AM, Surveyor observed an (unknown) staff member enter R11's room for the first time. Surveyor was unable to hear the conversation, but noted the staff member was in R11's room for less than 30 seconds before exiting and did not turn off the call light.</p> <p>On 9/9/24 at 10:02 AM, Surveyor noted R11's call light remained on, and no staff had entered her room. Surveyor interviewed R11 who reported CNA-F was the aide, but she was pulled from the floor to pass meds. R11 reported her call light is on because she needs to go to the bathroom. Surveyor asked R11 if it was usual to wait this long for her call light to be answered. R11 stated: Oh my God, yes. It's typical to wait at least a half hour. Last night I waited an hour and a half and a few nights ago I waited 3 hours because agency was working.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525262	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/11/2024
NAME OF PROVIDER OR SUPPLIER  Fort Atkinson Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  430 Wilcox St Fort Atkinson, WI 53538	
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 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 9/9/24 at 10:05 AM, Surveyor asked CNA-F who is the aide assigned to the unit. CNA-F stated: I don't know, they pulled me to pass meds, I was the aide. At this time R11 called out: You better find someone quick, I got to go - or you will have a mess to clean up. Surveyor continued to observe CNA-F pass medications on the unit and as of 10:40 AM, CNA-F had not advised any other staff of R11's request and need to use the bathroom.</p> <p>On 9/9/24, at 10:33 a.m., Surveyor observed R11's call light on.</p> <p>On 9/9/24 at 10:48 AM, Surveyor observed R11 in bed and R11's call light was on. R11 grimaced and called out, I've been on the call light since 9 AM. I need the bed pan.</p> <p>On 9/9/24, at 10:49 a.m., Surveyor observed AD (Activities Director)-E enter R11's room. Surveyor noted AD-E was in R11's room for less than one minute.</p> <p>On 9/9/24, at 10:54 a.m., Surveyor asked AD-E what R11 needed. AD-E informed Surveyor R11 needs the bed pan.</p> <p>On 9/9/24, at 11:06 a.m., Surveyor observed CNA-L enter R11's room. R11 stated to CNA-L she has been on the call light since 9:00 a.m. Surveyor observed R11 was visibly upset &amp; crying while telling CNA-L about the call light wait time. CNA-L stated to R11 relax, don't be upset. R11 replied I shouldn't of had to wait. CNA-L replied all you need to do was let someone know. R11 replied I have been.</p> <p>At 11:07 a.m. CNA-L asked R11 to turn on her side. R11 replied I don't know if I can turn, I have been holding it so long. CNA-L stated to R11 I wish you knew I was here. I was working on the south side. R11 stated to CNA-L if [first name of CNA-F] is doing meds (medication) they should have gotten someone, because of that we have to suffer. After CNA-L placed a bed pan under R11 and a towel between R11's legs, CNA-L stated to R11 you don't have to get upset I'm here for you. R11 replied that's not the point.</p> <p>On 9/10/24, at 12:00 p.m., Surveyor interviewed CNA-F to inquire about yesterday when she was pulled from her assignment to pass medication. Surveyor asked CNA-F if she was the only CNA on the unit. CNA-F explained she had rooms up to room [ROOM NUMBER] and then the front section was covered by CNA-J. Surveyor asked CNA-F after she was pulled from being an aide to passing medications who was suppose to cover her unit. CNA-F informed Surveyor they said they were going to have others pick up and switch around.</p> <p>On 9/10/24, at 12:24 p.m., Surveyor spoke with R11. Surveyor was informed R11 has had to wait for two hours for the bed pan and call lights are not answered for over two hours. R11 informed Surveyor one night she had her call light on at 11:00 p.m. At 11:30 p.m. the staff had still not answered her call light and she had to wet the bed. R11 explained a CNA came in at 2:30 a.m. to change her sheets. R11 informed Surveyor at 4:00 a.m. she had to go again and placed her call light on. R11 indicated her call light was on for an hour before a CNA told her she would be back in five minutes but never returned. R11 informed Surveyor at 6:00 a.m. CNA-N came in and changed her sheets.</p> <p>2.) On 9/9/24, at 9:10 AM, a Surveyor observed 3 call lights on the north unit.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525262	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/11/2024
NAME OF PROVIDER OR SUPPLIER  Fort Atkinson Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  430 Wilcox St Fort Atkinson, WI 53538	
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 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 9/9/24, at 9:15 AM, Surveyor observed 1 staff member at the medication cart to the right of the 3 rooms, and another staff member to the left of the 3 rooms, down the hallway. Neither staff member answered any of the 3 call lights.</p> <p>On 9/9/24, at 9:25 AM, Surveyor observed Social Worker (SW)-D walk by all 3 call lights that are still on, and did not answer any of the 3 lights.</p> <p>On 9/9/24, at 9:27 AM, Activity Director (AD)-E answered 1 of 3 call lights.</p> <p>On 9/9/24, at 9:29 AM, SW-D answered 1 of 2 call lights and then answered the 3rd call light.</p> <p>3.) On 9/9/24, at 10:35 a.m., Surveyor observed R1's call light on.</p> <p>On 9/9/24, at 10:49 a.m., Surveyor observed AD (Activities Director)-E enter R1's room and came out a minute later. Surveyor observed when AD-E left R1's room the call light remained on.</p> <p>On 9/9/24, at 10:54 a.m., Surveyor asked AD-E what R1 wanted. AD-E informed Surveyor R1 wants her water glass dumped &amp; filled, wants 7 up, and wants to speak with [first name of Regional Director of Operations-C].</p> <p>On 9/9/24, at 11:02 a.m., Surveyor observed a staff member enter R1's room and the call light was shut off.</p> <p>Surveyor noted R1's call light was on for approximately 27 minutes.</p> <p>On 9/11/24, at 1:30 p.m., NHA (Nursing Home Administrator)-A was informed of the above. No additional information was provided to Surveyor.</p> <p>49435</p> <p>4.) R12 was admitted to the facility on [DATE] with diagnoses that include Stroke, Alzheimer's disease, Type 2 Diabetes.</p> <p>R12's Admission Minimum Data Set (MDS) assessment dated [DATE], documents R12 has a Brief Interview for Mental Status (BIMS) score of 3 out of 15, indicating that R12 is severely cognitively impaired. R12 is incontinent of bowel and bladder.</p> <p>R12's Electronic Medical Record documents R12's Power of Attorney (POA) is POA-X.</p> <p>On 9/9/24 at 3:28 PM, Surveyor interviewed POA-X. POA-X informed Surveyor that POA-X is at the facility every day with R12 from about 8AM until R12 goes to bed, which is usually around 8PM. POA-X informed Surveyor that call light wait times can vary. POA-X stated last Saturday (9/7/24), it took about 45 min for R12's call light to be answered because there was not enough staff. POA-X stated that when she arrived at the facility last Saturday, POA-X did not see any staff on her walk to R12's room, which POA-X noted to be very unusual. POA-X looked at POA-X's handwritten notes in a spiral notebook and stated that R12 turned R12's call light on at 945 AM and it was not answered until 1025 AM. Surveyor asked why R12 turned the call light on. POA-X stated R12's incontinence brief needed to be changed. POA-X stated most of the staff are great, there just are not enough of them.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525262	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/11/2024
NAME OF PROVIDER OR SUPPLIER  Fort Atkinson Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  430 Wilcox St Fort Atkinson, WI 53538	

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 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>5.) R4 was admitted to the facility on [DATE] with diagnoses that include Type 2 Diabetes, Morbid obesity, and Congestive heart failure.</p> <p>R4's Quarterly Minimum Data Set Assessment (MDS) dated [DATE], documents R4 has a Brief Interview for Mental Status (BIMS) score of 12 out of 15, indicating R4's cognition is moderately impaired.</p> <p>On 9/9/24 at 10:30 AM, Surveyor interviewed R4. R4 stated that the facility needs more Certified Nursing Assistants (CNAs) per resident to help with our cares. R4 informed Surveyor that call light wait times can be from 60 to 90 minutes or longer. R4 stated the other day one unknown CNA informed R4 that unknown CNA had 20 residents to take care of and that is why the call light was not answered as fast as R4 would like. R4 indicated that there was not enough staff to care for everyone at the facility.</p> <p>6.) R6 was admitted to the facility on [DATE] with diagnosis that include Hemiplegia/hemiparesis affecting the left side due to stroke, Depression, Anxiety and Heart Disease.</p> <p>R6's Quarterly Minimum Data Set Assessment (MDS) dated [DATE], documents R6 has a Brief Interview for Mental Status (BIMS) score of 13 out of 15, indicating R6 is cognitively intact.</p> <p>On 9/9/24 at 10:16 AM, Surveyor interviewed R6. R6 informed Surveyor that R6 does use the call light button when R6 needs help. R6 stated that call light wait times can vary. R6 indicated that sometimes the response times are better when there is more staff in the building, but sometimes the call light will take 90 minutes or longer to be answered. R6 stated that he prefers to receive a shower once a week but only gets a shower every other week because that's when they get to me. R6 indicated if the facility had more staff, R6 could get a shower every week.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525262	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/11/2024
NAME OF PROVIDER OR SUPPLIER  Fort Atkinson Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  430 Wilcox St Fort Atkinson, WI 53538	
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 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p>38146</p> <p>Based on observation, interview, and record review the facility did not have sufficient nursing staff with the appropriate competencies and skill sets to provide nursing and related nursing services to assure resident safety. This deficient practice had the potential to affect all 16 residents residing on the unit.</p> <p>An unqualified medication aide (Certified Nursing Assistant) was observed administering medications to residents.</p> <p>Findings include:</p> <p>The Facility Policy titled Medication Administration implemented 3/1/19 documents (in part) .</p> <p>. Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection.</p> <p>On 9/9/24 at 9:51 AM, Surveyor observed Certified Nursing Assistant (CNA)-F standing at the medication cart on the North unit. Surveyor advised CNA-F of the need to complete medication pass observation. CNA prepared R14's morning medications administered them to the resident at 10:00 AM.</p> <p>On 9/9/24 at 10:05 AM, Surveyor interviewed CNA-F who reported she was the aide on the unit but was pulled to pass meds (medications). Surveyor asked when she was pulled from the aide position to pass medications. CNA-F stated Just a little while ago. I didn't start passing meds until just a little while ago, I haven't done this for 2 years. Surveyor asked how many residents were on the unit, CNA-F reported she did not know.</p> <p>On 9/9/24 at 10:15 AM, Surveyor observed CNA-F prepare medications for R15. Medications were administered at 10:40 AM.</p> <p>Surveyor confirmed 16 residents currently reside on the North unit.</p> <p>On 9/9/24 at 11:10 AM, Surveyor spoke with CNA-F and asked if she was still passing morning medications. CNA-F stated: Yes. I just asked if they have anyone to replace me, but not yet. I guess I'll just have to go right into the noon meds. Surveyor asked who pulled her from the aide position to pass meds. CNA-F stated: Registered Nurse (RN)-I. I think the other nurse said I was a med tech and then (RN-I) told me to pass meds. Surveyor confirmed with CNA-F she has not passed medications for 2 years. CNA-F stated: Yeah, they had training on the computer, but I couldn't access the med tech part and told them. They said they'd fix it, but never got back do me. Surveyor confirmed with CNA-F she has not completed any training or in-services for over a year, and she has not passed medications for at least 2 years.</p> <p>Surveyor review of CNA-F's employee file included no evidence of training or certification to indicate CNA-F is qualified to administer medications.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525262	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/11/2024
NAME OF PROVIDER OR SUPPLIER  Fort Atkinson Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  430 Wilcox St Fort Atkinson, WI 53538	

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 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 9/11/24 Surveyor advised Director of Nursing (DON)-B of concern unqualified staff was observed administering medications to residents. No additional information was provided.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525262	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/11/2024
NAME OF PROVIDER OR SUPPLIER  Fort Atkinson Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  430 Wilcox St Fort Atkinson, WI 53538	
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 0745</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide medically-related social services to help each resident achieve the highest possible quality of life.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 38146</p> <p>2.) R7 admitted to the facility on [DATE] and has diagnoses that include: Intercranial injury with loss of consciousness, nontraumatic intracerebral hemorrhage, hemiplegia affecting left non-dominant side, hypertension, anemia, major depressive disorder, anxiety, chronic pain, and dysphagia.</p> <p>R7's Quarterly Minimum Data Set, dated dated dated [DATE] documents a Brief Interview for Mental Status score of 11.</p> <p>R7's care plan initiated 3/21/24 documents: I sometimes have behaviors which include name calling to staff, yelling at staff; refuses vital signs, states the machine is not accurate; Inappropriate comments and inappropriate racial comments towards staff; Resident has conversations with people who are not there, answers the conversations as well; Is not an accurate historian when recalling events; Perseverates on topics, statements, stories; Behavior can be very disruptive at times and can be hard to redirect; I prefer my trays to be left in my room at times even when staff want to remove them when I am done eating; SSD (Social Service Director) and NHA (Nursing Home Administrator) go to speak with resident related to concerns, resident does not provide responses to questions regarding concerns, thoughts are erratic and answers are off topic and do not relate; Resident refusing medications, treatments and participation in ADL's (Activity of Daily Living) at times.</p> <p>Interventions include: Attempt interventions before my behaviors begin; Encourage, educate resident on the importance of taking medications, allowing treatments and participating in ADL's for resident's overall well-being; Give me my medications as my doctor has ordered; Help me to avoid situations or people that are upsetting to me; Let my physician know if my behaviors are interfering with my daily living; make sure I am not in pain or uncomfortable; Offer me something I like as a diversion; Ongoing reassurance; Refer me to my psychologist/psychiatrist as needed; Tell me what you are going to do before you begin; Provide positive feedback to resident; Provide stress and relaxation techniques; Speak to me unhurriedly and in a calm voice. Surveyor noted the interventions do not appear to be individualized to reflect the negative description/behaviors identified in the care plan. Additionally, the interventions do not address the role NHA-A and SW-D are to play in the plan of care for R7.</p> <p>On 9/9/24 at 11:15 AM, during Surveyor interview with R7, he stated: They ordered Seroquel without my consent. They tried to be sneaky and told me the generic name (Quetiapine). I refused because it's not a medication that should be given for a stroke or brain injury. R7 stated: No-one asked me or talked to me about if before, they just ordered it and gave it to me. (Cross-reference F758).</p> <p>Documentation revealed R7 refused to meet with the Psych APNP (Advanced Practice Nurse Practitioner). The APNP Psych Initial Evaluation dated 6/28/24 documents (in part) .</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525262	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/11/2024
NAME OF PROVIDER OR SUPPLIER  Fort Atkinson Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  430 Wilcox St Fort Atkinson, WI 53538	
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 0745</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>. Patient is a [AGE] year-old male being seen for an initial psychiatric evaluation. Provider was accompanied by RN (Registered Nurse) twice. Patient is seen sitting on the edge of the bed with his tv on and looking at his computer. He acknowledged this provider and asked three times what my profession was. He then pointed and asked is the RN who accompanied this provider in the room, was the reason I was here. Provider expressed I was present to aid with any concerns he has such as sleep. The patient then states Goodbye. Provider reapproached the patient later by myself in the room with the RN outside of door an out of site. Patient stated he did not want me in his room, I'm not welcome, don't come back again and if I did, he would call the police.</p> <p>Patient discussed with DON (Director of Nursing)-B and the executive admin (NHA-A). DON reports that the patient has been getting progressively worse with his behavior. He is becoming more and more verbally aggressive to the point of the possibility of physical aggression and is scaring staff. Patient has been aggressive and agitated with all staff members that approach him in any way. He does not engage in conversation or assessments with most staff. Nursing has documentation of the patient refusing medications and when given throws on the floor even when he states he does want it. He does not vocalize any symptoms but anger toward everyone. Also, he has been making accusatory statements about staff trying to give him pills off the ground and other insignificant things. Nursing report patient has been lashing out and repeatedly calling the hotline provided for patient grievances. Patient states during conversations almost every time he will call the police if the person does not leave the room. Staff report patient has not allowed them to perform things like basic ADL's (Activities of Daily Living) or supplies for ADL's. Due to aggressive and threatening behavior the patient has to have 2 people present in the room. Nursing management has implemented this for staff protection.</p> <p>Surveyor reviewed R7's progress notes for the month of June 2024. Surveyor located only 1 entry on 6/14/24 which documented: Verbal aggression toward staff and refusing HS (hour of sleep) ADL care. There was no documentation of R7 verbally aggressive to the point of the possibility of physical aggression and is scaring staff as documented by the Psych APNP after discussion with DON-B and NHA-A.</p> <p>Surveyor review of the Certified Nursing Assistant Point of Care (POC) documentation for the month of June 2024 documents: Monitor - behavior symptoms every shift. Surveyor noted the behavior list is a template and not specific to R7.</p> <p>The list of behavior symptoms to choose from are: 0 - Frequent crying, 2 -repeats movements, 3 - yelling/screaming, 4 - kicking/hitting, 13 - pushing, 14 - grabbing, 5 - pinching/scratching/spitting, 6 - biting, 7 - wandering, 8 - abusive language, 9 - threatening behavior, 10 - sexually inappropriate, 11 - rejection of care, and 12 - None of the above observed.</p> <p>Surveyor noted of the possible 90 entries to document R7's behaviors, 41 areas were blank, 1 entry documented 8 (abusive language), 2 entries documented N/A, 4 entries documented 11 (rejection of care) and 42 entries documented 12 (None of the above observed).</p> <p>Surveyor located no evidence of the alleged behaviors reported to the Psych APNP that warranted the order for Seroquel.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525262	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/11/2024
NAME OF PROVIDER OR SUPPLIER  Fort Atkinson Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  430 Wilcox St Fort Atkinson, WI 53538	
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 0745</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 9/11/24 Regional Director of Clinical Operations-C was advised of concern Seroquel was ordered for R7 without clear indication for use. The resident refused to be seen by the Psych APNP and there is no evidence of the alleged behavior verbally aggressive to the point of the possibility of physical aggression and is scaring staff that was reported to the Psych APNP by DON-B and NHA-A. Surveyor reviewed R7's POC behavior documentation for June 2024 which revealed only 1 entry of abusive language and 4 entries of rejection of care. The remaining entries documented none of the behaviors were observed. Regional Director of Clinical Operations-C stated: We have an issue with some providers just prescribing meds. It's something we're going to have to look into and work on. No additional information was provided as to why SW-D had not developed individualized behavior monitoring or interventions for R7.</p> <p>38829</p> <p>Based upon observation, interview and record review, the facility did not ensure 2 (R1 and R7) of 2 residents reviewed received medically related social services to address individual resident needs.</p> <p>* R1 has a history of trauma as identified in a trauma assessment completed on 5/20/24. R1 also has a diagnosis that includes post traumatic stress disorder. The facility social worker (SW)-D has not established an individualized plan of care to address R1's trauma. Additionally, R1's Nurse Practitioner (NP)-DD identified R1 is miserable residing at the facility and alternate placement should be pursued. SW-D has not actively assisted R1 to identify and prepare for alternate placement.</p> <p>* R7 was prescribed Seroquel by NP-DD to address behaviors verbally expressed by facility staff. R7 refused to take the medication as ordered. Review of R7's behavior monitoring indicates an individualized behavior monitoring program was not created for R7 by SW-D.</p> <p>R1 and R7 are both noted to have care plans the describe the residents in negative, and behaviorally defined terms without individualized interventions to address the behaviors.</p> <p>Findings include:</p> <p>The facility's assessment approved 8/8/24 documents:</p> <p>Purpose Statement:</p> <p>The purpose of this assessment is to determine what resources are necessary to care for our Resident competently during both day-to-day operations and emergencies.</p> <p>The facility assessment also documents that the facility can provide care to those Residents with Psychiatric/Mood Disorders including PTSD.</p> <p>The facility documents under services and care the facility offers based on Resident's needs that the facility can provide Behavioral and Mental Health which is defined by the facility as:</p> <p>Manage the medical conditions and medication related issues causing psychiatric symptoms and behavior, identify and implement interventions to help support individuals with issues such as dealing with anxiety, care of someone with cognitive impairment, trauma/PTSD, referral to outside services as needed: other psychiatric diagnoses, intellectual or developmental disabilities.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525262	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/11/2024
NAME OF PROVIDER OR SUPPLIER  Fort Atkinson Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  430 Wilcox St Fort Atkinson, WI 53538	
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 0745</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Specific Care or Practices Build relationship with Resident/get to know him/her, engage Resident in conversation. Find out what Resident's preferences and routines are. what makes a good day for Resident, what upsets him/her and incorporate information into the care planning process. Make sure staff caring for the Resident have this information. Record and discuss treatment and care preferences. Support emotional and mental well-being, support helpful coping mechanisms. Support Resident having familiar belongings. Provide culturally competent care, learn about Resident preferences and practices with regard to culture and religion, stay open to requests and preferences and work to support those as appropriate.</p> <p>1.) R1 was admitted to the facility on [DATE] with diagnoses of Post-Traumatic Stress Disorder (PTSD), Major Depressive Disorder (MDD), Generalized Anxiety Disorder, Obsessive-Compulsive Personality Disorder, Malingering, Somatization Disorder, Morbid Obesity, Other Intervertebral Disc Displacement, Low Back Pain, Chronic Pain Syndrome, Chronic Kidney Disease, and Neuromuscular Dysfunction of Bladder. R1 is R1's own person.</p> <p>R1's Quarterly Minimum Data Set (MDS) completed 8/2/24 documents R1's Brief Interview for Mental Status (BIMS) score to be 13, indicating R1 is cognitively intact for daily decision making. R1's Patient Health Questionnaire (PHQ-9) score is 2, indicating minimal depression and R1 demonstrates rejection of care 1-3 days during the assessment period.</p> <p>R1's comprehensive care plan documents:</p> <p>-I get nervous and anxious around men. In new situations. I do not like men to do my cares.-Initiated 5/24/23</p> <p>-I sometimes have behaviors which include manipulating staff, fabricating statements, refusals of cares and meals, self limiting, self sabotaging. I sometime embellish the truth and have exaggerations, makes false accusations, and kicks staff out of room, and refuses to be cared for by certain staff</p> <p>10/23-(R1) refusing cares for most staff then complains no one is taking care of her. Multiple staff offered and refused. (R1) will call the police</p> <p>4/2/24-(R1) refuses cares from staff whom are different ethnicities (sic)</p> <p>4/2/24-(R1) uses the word abuse inappropriately. Generalizes it and uses it anytime (R1) is asked to complete a task that (R1) does not want participate in</p> <p>5/24/23-(R1) puts on call light and falls asleep. Has no sense of time and when staff answers call light, (R1) yells at staff as (R1) thinks its been a longer time than it really has.</p> <p>-Behaviors: Hoarding:</p> <p>Diagnosis PTSD, major depressive disorder, hypochondriasis (sic), obsessive compulsive personality disorder, malingering</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525262	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/11/2024
NAME OF PROVIDER OR SUPPLIER  Fort Atkinson Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  430 Wilcox St Fort Atkinson, WI 53538	
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 0745</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>(R1) is known to hoard food items in room. (R1) is not receptive when provided education on the importance of maintaining an environment that promotes health and safety. (R1) requires frequent interventions from staff to ensure safety in this area.</p> <p>Initiated 5/24/23</p> <p>-Behaviors: Manipulation:</p> <p>Diagnosis PTSD, major depressive disorder, hypochondriasis, obsessive compulsive personality disorder, malingerer</p> <p>(R1) presents with long-standing dysfunctional social skills and personality traits yielding manipulative symptoms as evidenced staff splitting, perseverating, false allegations, frequent complaints with accepting resolutions, refusing to participate in treatment/therapy then blaming therapy for declines, refusing to participate in ADLS (activities of daily living) (R1) is capable of doing and becoming hostile/demanding to staff that they do it for her</p> <p>Behavior symptoms concerning inappropriate personal boundaries</p> <p>Inappropriate and manipulating behaviors, makes inappropriate phone calls to DQA (Division of Quality Assurance) and case management team when (R1) is aware of grievance process.</p> <p>Refuses cares</p> <p>(R1) will call the police</p> <p>Initiated 9/27/23</p> <p>-Psychosocial Well-Being and Trauma</p> <p>(R1) holds psychiatric diagnoses of PTSD and MDD recurrent. (R1) refuses to engage in discussions about what lead to diagnosis of PTSD and therefore the facility has poor history in this area. (R1) is not pushed to discuss the incidents leading to this diagnosis in efforts to adhere to standardized practices of trauma-informed care and avoid re-traumatization.</p> <p>(R1) presents with lack of insight, emotional dysregulation, and poor social skills. (R1) has frequent complaints with no resolve and is frequently speaking poorly of staff members, keeping logs of others, and making false allegations to follow. (R1) chooses to spend majority of days independently and does not appear motivated for social interactions with others.</p> <p>Initiated 5/24/23</p> <p>-Mood State</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525262	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/11/2024
NAME OF PROVIDER OR SUPPLIER  Fort Atkinson Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  430 Wilcox St Fort Atkinson, WI 53538	
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 0745</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>(R1) holds diagnosis of MDD recurrent and PTSD which yield alterations in mood state as evidenced by agitation, dysthymic mood, apathy, anhedonia, hopelessness, feelings of anxiety, loss of control, insomnia, fluctuating appetite, an overall sense of anger towards others due to a psychological external loss of control which causes (R1) to place blame for (R1's) health condition on others rather working towards acceptance.</p> <p>(R1) lacks insight into condition and lacks motivation for treatment. (R1) will refuse psychotherapy, refuse counseling from social services, treatment team and refuse psychotropic medications. (R1) will then complain nothing is being done for (R1).</p> <p>Initiated 5/24/23</p> <p>Surveyor notes there have been no updated person centered interventions for R1 since 5/24/23. Surveyor notes that R1's comprehensive care plan is concentrated on R1's behaviors and what is perceived as R1's negative responses to facility interventions. The facility has not examined why R1 may be responding to triggering situations or boundaries in what the facility perceives as 'behaviors', thus the facility has not facilitated R1 to increase self independence physically and emotionally or promote physical and emotional health overall. (Cross-reference F699).</p> <p>R1's psychosocial social history dated 6/23/22 does not identify R1 as having a diagnosis of PTSD and areas of concerns and triggers related to the PTSD diagnosis.</p> <p>On 12/6/23, APNP (advanced practice nurse practitioner) Psychiatric/Mental Health (APNP)-DD evaluated R1 for an initial Psych Evaluation. APNP-DD documents in regards to R1's trauma:</p> <p>.Writer asked patient to describe any history of trauma in her life. Patient asked writer to define what kind of trauma she meant. Writer said physical, psychological, emotional, sexual. Volume of patient's voice was barely audible to writer. She said it is suspected that I have sexual trauma. But I do not remember any of it. Physical trauma too .Psychological .My mom. Patient paused and then whispered New Hampshire.</p> <p>APNP-DD also recommended .for the facility to put into place and enforce boundaries to promote independence for (R1). Enforcing boundaries also medicates power beyond what she says she has .</p> <p>The facility did not complete a 'Trauma Informed Care Assessment' for R1 until 5/20/24. R1 answered YES to having experienced a traumatic event. R1 answered YES to having nightmares or thought about the event when you did not want to in the past month, answered YES to tried hard not to think about the event or went out of way to avoid situations that reminded of the event, and YES to feeling numb or detached from people, activities, or surroundings.</p> <p>Surveyor notes that based on R1 answering YES to these questions, person-centered interventions were not put into place as evidenced by no interventions documented in R1's comprehensive care plan.</p> <p>As documented on R1's current physician orders, as of 7/26/24, R1 is being administered Diazepam, 1 tablet by mouth - 3 times a day - for anxiety.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525262	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/11/2024
NAME OF PROVIDER OR SUPPLIER  Fort Atkinson Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  430 Wilcox St Fort Atkinson, WI 53538	
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 0745</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 9/9/24, at 12:00 PM, Surveyor interviewed R1. R1 was laying in bed, head of bed slightly elevated, with sheet and blanket pulled up to R1's chin. Overbed table was across R1 and Surveyor observed a notebook on the table. R1 spoke in a very quiet, soft spoken voice to Surveyor and demonstrated a flat affect during the whole interview. R1 shared several concerns with Surveyor. R1 stated that the facility forced cares in pairs which has been very anxiety inducing for R1. R1 stated that R1 is very uncomfortable in the shower with 2 staff. R1 has had a lot of distress about things like getting R1's food heated up, the room change that occurred, having to wait for long periods of time for R1's as needed pain medications. R1 informed Surveyor that R1 has been emotionally upset. R1 stated the facility has never been a support to R1. Surveyor shared with R1 at the end of the interview that it was nice to see R1 smile. R1 responded, its because you showed me respect and dignity.</p> <p>On 9/10/24, at 12:17 PM, Surveyor interviewed Director of Social Services (DSS)-D. DSS-D was not able to state what the facility has done to address R1's PTSD issues.</p> <p>On 9/11/24, at 12:42 PM, Surveyor had a discussion with Regional Director of Clinical Operations, (RDCO)-C in regards to R1. Surveyor shared that based on R1's diagnoses of PTSD, Major Depressive Disorder, Generalized Anxiety Disorder, and Obsessive-Compulsive Personality Disorder, the facility has not put into place person-centered interventions for R1 in order to promote increased independence and decrease any crippling psychosocial outcome. Surveyor discussed that per staff interviews and documentation, R1 has the ability to be extremely independent and with no positive interventions by the facility, R1 is becoming dependent on staff for everything. Surveyor shared the concern that the facility has not attempted to re-approach R1 to gain trust in order to work with R1 to develop a care plan with approaches to mitigate any triggers to prevent re-traumatization. Surveyor discussed that R1 is displaying actions of feeling powerless. RDCO-C agreed with Surveyor and understands the concerns. RDCO-C agreed that the facility needs to develop non-pharmacological approaches and interventions in order to maximize R1's physical and emotional independence. No further information was provided by the facility at this time.</p> <p>Discharge Planning:</p> <p>R1's Annual MDS completed 5/4/24 documents that active discharge planning is in the process.</p> <p>R1's comprehensive care plan includes the following documentation:</p> <p>Discharge Planning:</p> <p>At this time, (R1) is anticipated for long term care to ensure (R1's) safety and needs are met. (R1) wishes to discharge to an Assisted Living Facility if medically able to do so should (R1's) condition improve.</p> <p>Initiated 5/24/23.</p> <p>Interventions:</p> <p>-Educate (R1) or my care giver about (R1's) medications, their side effects and how and when (R1) should take them. Help (R1) make sure (R1) have (sic) what (R1) needs. Initiated 5/24/23.</p> <p>-Please help (R1) arrange for equipment (R1) needs. Initiated 5/24/23</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525262	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/11/2024
NAME OF PROVIDER OR SUPPLIER  Fort Atkinson Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  430 Wilcox St Fort Atkinson, WI 53538	

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 0745</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Please help (R1) arrange for services (R1) needs. Initiated 5/24/23</p> <p>-Provide (R1) with education on (R1's) medications. Initiated 5/24/23</p> <p>-Provide (R1) with education on prevention and management of (R1's) disease. Initiated 5/24/23</p> <p>-Review discharge plans at minimum every quarter. Initiated 5/24/23</p> <p>Surveyor notes R1's discharge plans have not been updated since 5/24/23 and per documented care plan interventions it has not been updated at a minimum of every quarter.</p> <p>R1's Initial Psych Evaluation dated 12/6/23, written by APNP (Advanced Practice Nurse Practitioner) Psychiatric/Mental Health (APNP)-DD documents:</p> <p>.This patient presents with behaviors and thought processes aligned with a diagnosis of obsessive-compulsive personality disorder. A change in facility within the next 30 days is what this writer recommends for this patient.</p> <p>Follow-up: .Different living facility recommended-patient is profoundly unhappy here.</p> <p>Surveyor reviewed R1's Electronic Medical Record(EMR). Documentation of discharge plans being identified, developed, and implemented is 1/3/24, documented by Nursing Home Administrator (NHA)-A, R1 is requesting a transfer to another county and case manager team will be notified. Surveyor notes no further documentation of discharge planning has occurred for R1 since 1/3/2024. (Cross-reference F660).</p> <p>On 9/10/24, at 10:30 AM, Surveyor interviewed R1 regarding discharge planning. R1 informed Surveyor R1 has wanted to leave since R1 first arrived at the facility. R1 has had little discussions about discharge and R1 stated R1 has rarely spoken with Social Worker (SW)-D. R1 stated in the few discussions, R1 has informed SW-D that R1 wants to go to another county. R1 stated SW-D did not take any action towards discharge because SW-D stated the county is large. R1 stated R1 had already informed SW-D what part of the county R1 wanted to go to. R1 stated R1 was informed by SW-D that it was up to R1 to find a place. R1 stated that R1 then lost Medicaid due to being over assets which has impacted a lot for R1. R1 stated R1 is working with the ADRC (Aging and Disability Resource Center) and the ADRC informed R1 they can never get a hold of SW-D to complete the Medicaid process. R1 stated to Surveyor, (SW-D) has never been a support and I have not had care conferences to discuss my concerns with discharge planning.</p> <p>On 9/10/24, at 12:17 PM, Surveyor interviewed SW-D in regards to discharge planning for R1. SW-D confirmed it has been awhile since SW-D has discussed discharge planning with R1 and stated SW-D will meet with R1 to discuss discharge planning and the Medicaid process. Surveyor shared the concern there has been no documentation since 1/24 about discharge planning for R1. SW-D stated, I started working here in February. Surveyor confirmed with SW-D that care conferences are completed quarterly at a minimum, and discharge planning would have been discussed at the care conferences.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525262	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/11/2024
NAME OF PROVIDER OR SUPPLIER  Fort Atkinson Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  430 Wilcox St Fort Atkinson, WI 53538	
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 0745</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 9/10/24, at 3:21 PM, Surveyor shared the concern with NHA-A, Director of Nursing (DON)-B, and Regional Director of Clinical Operations (RDCO)-C that R1 has not been assisted with developing and implementing an appropriate discharge plan to assist with the transition to a lesser restrictive environment. DON-B stated that numerous referrals were made and 2 locations agreed to talk with R1. R1 had virtual meetings with the 2 locations, 1 accepted R1, and that R1 chose to not go there because of an issue of getting into the bathroom. Surveyor shared there is no documentation of this and that R1's care plan with discharge planning goals and interventions has not been updated. Surveyor shared there has been no care conferences or discharge planning meetings which would have discussed R1's discharge plans and goals to achieve discharge from the facility for R1. No further information was provided by the facility at this time.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525262	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/11/2024
NAME OF PROVIDER OR SUPPLIER  Fort Atkinson Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  430 Wilcox St Fort Atkinson, WI 53538	
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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 38146</p> <p>Based on observation, interview, and record review the facility did not provide pharmaceutical services (including procedures that assure the accurate dispensing and administering of all drugs) to meet the needs of each resident for 5 of 5 residents (R5, R6, R12 and R13) who did not receive evening medications, 1 of 1 residents (R13) who received their morning medications late and 1 of 1 residents (R1) who did not receive their medication as ordered. This deficient practice also had the potential to affect all 16 residents residing on the North unit who received their morning medications late.</p> <p>On 9/9/24 Residents residing on the North unit were administered their morning medications more than 2 hours after the times ordered.</p> <p>R1 was not administered Oxycodone on 9/9/24 as ordered by the Physician.</p> <p>R5, R6, R12 and R13 did not receive evening medications on 9/6/24.</p> <p>R13 was administered morning medications late on 9/10/24.</p> <p>Findings include:</p> <p>The Facility Policy titled Medication Administration implemented 3/1/19 documents (in part) .</p> <p>. Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection.</p> <p>Policy Explanation and Compliance Guidelines:</p> <p>10. Review MAR (Medication Administration Record) to identify medication to be administered.</p> <p>11. Compare medication source (bubble pack, vial, etc.) with MAR to verify resident name, medication name, form, dose, route, and time).</p> <p>b. Administer within 60 minutes prior to or after scheduled time unless otherwise ordered by physician.</p> <p>1.) On 9/9/24 at 9:51 AM, Surveyor observed Certified Nursing Assistant (CNA)-F standing at the medication cart on the North unit. Surveyor advised CNA-F of the need to complete medication pass observation. CNA prepared R14's morning medications administered them to the resident at 10:00 AM.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525262	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/11/2024
NAME OF PROVIDER OR SUPPLIER  Fort Atkinson Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  430 Wilcox St Fort Atkinson, WI 53538	
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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 9/9/24 at 10:05 AM, Surveyor interviewed CNA-F who reported she was the aide on the unit but was pulled to pass meds (medications). Surveyor asked when she was pulled from the aide position to pass medications. CNA-F stated Just a little while ago. I didn't start passing meds until just a little while ago, I haven't done this for 2 years. Surveyor asked how many residents were on the unit, CNA-F reported she did not know. Surveyor asked CNA-F how many residents she has left to complete med pass. CNA-F stated: I just started, (R14) was the first one.</p> <p>On 9/9/24 at 10:15 AM, Surveyor observed CNA-F prepare medications for R15. Medications were administered at 10:40 AM.</p> <p>Surveyor confirmed 16 residents currently reside on the North unit.</p> <p>On 9/9/24 at 11:10 AM, Surveyor spoke with CNA-F and asked if she was still passing morning medications. CNA-F stated: Yes, I just asked if they have anyone to replace me, but not yet. I guess I'll just have to go right into the noon meds.</p> <p>On 9/10/24 at 1:10 PM, R13 asked to speak to Surveyor. R13 reported medications are not given timely, they are always late. R13 stated: Just today, it was 10:30 AM and I hadn't gotten any morning meds. I finally called and she brought them in, but I refused and said it was too late, all I wanted was my pain pill. In addition, Surveyor review of R13's MAR indication no medications were administered on the evening of 9/6/24.</p> <p>On 9/10/24 at 4:00 PM Surveyor interviewed the Medication Technician, (unknown name) assigned to R13 on day shift. The Med Tech reported she was slower today because it was her first time at the facility. She reported she was still passing meds at 10:30 AM when R13 asked for his morning meds. She confirmed R13 refused all the morning meds except for his pain pill.</p> <p>On 9/11/24 at 10:30 AM, Director of Nursing (DON)-B was advised of the above concern regarding residents residing on the north unit receiving their morning medications late. Surveyor asked if physicians were notified or if the times of medications were adjusted to accommodate the late administration time, DON-B reported she did not think so. No additional information was provided.</p> <p>38829</p> <p>2.) R1 was admitted to the facility on [DATE] with diagnoses of Post-Traumatic Stress Disorder, Major Depressive Disorder, Generalized Anxiety Disorder, Obsessive-Compulsive Personality Disorder, Malingering, Somatization Disorder, Morbid Obesity, Other Intervertebral Disc Displacement, Low Back Pain, Chronic Pain Syndrome, Chronic Kidney Disease, and Neuromuscular Dysfunction of Bladder. R1 is R1's own person.</p> <p>R1's Quarterly Minimum Data Set (MDS) completed 8/2/24 documents R1's Brief Interview for Mental Status (BIMS) score to be 13, indicating R1 is cognitively intact for daily decision making. R1's Patient Health Questionnaire (PHQ-9) score is 2, indicating minimal depression and R1 demonstrates rejection of care 1-3 days during the assessment period. R1's MDS documents R1 frequently has pain and occasionally interferes with daily routine. R1's Annual MDS completed 5/4/24 does not assess R1's pain, therefore there is no Care Area Assessment(CAA) addressing R1's chronic pain issues.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525262	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/11/2024
NAME OF PROVIDER OR SUPPLIER  Fort Atkinson Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  430 Wilcox St Fort Atkinson, WI 53538	
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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>R1's current physician orders documents on 8/10/24 R1's oxycodone is to be administered 2.5 mg by mouth, as needed for pain, maximum of 3 doses per day. May have close together or hours apart, per MD.</p> <p>On 9/9/24, at 12:00 PM, Surveyor interviewed R1 regarding R1's pain. R1 stated this morning, R1 asked a little before 10:00 AM for R1's oxycodone. R1 informed Surveyor that R1's pain is currently at a 10, 10 being the most severe pain. While Surveyor was interviewing R1, Surveyor observed medication technician, (MT)-F come into R1's room and administer R1's oxycodone at 12:15 PM.</p> <p>On 9/9/24, at 12:21 PM, Surveyor interviewed Director of Nursing (DON)-B and MT-F who were both standing at the medication cart in the hallway. MT-F stated that R1's oxycodone order is 2.5 mg as needed every 8 hours and stated that MT-F informed R1 around 10:00 AM that R1 would need to wait for 40 minutes before MT-F could administer R1's oxycodone. DON-B confirmed with Surveyor that R1 last received R1's oxycodone at 3:25 AM.</p> <p>Surveyor noted if R1 requested the oxycodone at 10:00 AM, MT-F did not administer the oxycodone 40 minutes after but actually administered the oxycodone at 12:15 PM, making R1 wait about a little over an hour and half for the medication. Surveyor also noted MT-F and DON-B shared R1's oxycodone order was 2.5 mg every 8 hours, as needed; when R1's physicians order allows for R1 to receive doses of the medication close together or separate administrations spread out - not to exceed 3 administrations.</p> <p>On 9/10/24, at 3:21 PM, Surveyor shared with Nursing Home Administrator (NHA)-A, Director of Nursing (DON)-B, and Regional Director of Clinical Operations (RDCO)-C the concern that R1 did not receive R1's oxycodone as prescribed on 9/9/24 by MT-F per R1's physician orders. MT-F administered R1's oxycodone 2.5 mg every 8 hours instead of oxycodone 2.5 mg by mouth as needed for pain, maximum of 3 doses per day. May have close together or hours apart, per MD. No further information was provided by the facility at this time.</p> <p>20483</p> <p>3.) On 9/11/24, at 7:55 a.m., a Surveyor interviewed RN (Registered Nurse)-I regarding the events which occurred on 9/6/24. RN-I informed the Surveyor she worked the day shift, was then called to come back to the Facility and arrived at the facility at approximately 9:00 p.m. to work as LPN-P was unable to return to work. RN-I informed the Surveyor she did not administer any Resident's medication when she returned to the facility as she was unsure what medication LPN-P had administered as medication had not been signed out.</p> <p>R5's diagnoses includes edema, congestive heart failure, atrial fibrillation, peripheral vascular disease, and diabetes mellitus.</p> <p>Surveyor reviewed R5's September MAR (medication administration record) and noted the following PM (evening) medications are not initialed as being administered on 9/6/24:</p> <p>* Atorvastatin Calcium tablet 40 mg (milligrams) with directions to give 1 tablet by mouth at bedtime for hyperlipidemia. Time of administration is 2000 (8:00 p.m.).</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525262	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/11/2024
NAME OF PROVIDER OR SUPPLIER  Fort Atkinson Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  430 Wilcox St Fort Atkinson, WI 53538	
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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>* Apixaban oral tablet 2.5 mg with directions to give 2.5 mg by mouth two times a day related to unspecified atrial fibrillation. Time of administration is 1600 (4:00 p.m.).</p> <p>* Furosemide oral tablet with directions to give 120 mg by mouth two times a day for edema. Time of administration is 1600 (4:00 p.m.).</p> <p>* Senna-Docusate Sodium tablet 8.5-50 mg (Sennosides-Docusate Sodium) with directions to give 2 tablet by mouth two times a day for bowel program related to other specified diseases of liver. Time of administration is 1700 (5:00 p.m.).</p> <p>* Acetaminophen tablet 500 mg with directions to give 1 tablet by mouth three times a day for knee pain. Time of administration is 1700 (5:00 p.m.).</p> <p>* NovoLog Flex Pen Solution Pen injector 100 unit/ml (milliliter) (Insulin Aspart) with directions to inject 12 unit subcutaneously before meals related to type 2 diabetes mellitus with diabetic chronic kidney disease hold if not eating a meal or glucose &lt; (less than) 100. Time of administration is 1700 (5:00 p.m.).</p> <p>On 9/11/24 at 3:12 p.m. NHA (Nursing Home Administrator)-A, DON (Director of Nursing)-B, Regional Director of Clinical Operations-D &amp; Regional Director of Clinical Operations-Q were informed of R5 not receiving his evening medication as ordered by R5's physician.</p> <p>49435</p> <p>4.) R6 was admitted to the facility on [DATE] with diagnoses that include Hemiplegia/hemiparesis affecting the left side due to stroke, Depression, Anxiety, Hypertension, Heart Disease, Atrial Fibrillation (A-fib) and Hyperlipidemia (HLD).</p> <p>R6's Quarterly Minimum Data Set Assessment (MDS) dated [DATE], documents R6 has a Brief Interview for Mental Status (BIMS) score of 13 out of 15, indicating R6 is cognitively intact.</p> <p>R6's Medical Doctor Orders include:</p> <p>-Dated 5/22/24, Buspirone HCL Oral Tablet 5 Milligrams (MG). Give 3 tablets by mouth at bedtime (8PM) related to anxiety disorder.</p> <p>-Dated 6/28/24, Mirtazapine Oral Tablet 7.5 MG. Give one tablet by mouth at bedtime (8PM) related to depression.</p> <p>-Dated 1/5/24, Rosuvastatin Calcium Oral Tablet 10 MG. Give 1 tablet by mouth every evening shift for HLD.</p> <p>-Dated 1/5/24, Carvedilol Oral Tablet 3.125 MG. Give one tablet by mouth every day and evening shift for a-fib.</p> <p>-Dated 1/8/24, Eliquis Oral Tablet 2.5 MG. Give 1 Tablet by mouth two times a day (8AM and 4PM) related to a-fib.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525262	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/11/2024
NAME OF PROVIDER OR SUPPLIER  Fort Atkinson Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  430 Wilcox St Fort Atkinson, WI 53538	
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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Surveyor reviewed R6's Medication Administration Record. For the date of 9/6/24, the following medication administrations are blank, indicating that the medication was not given: Buspirone 8PM dose, Mirtazapine 8PM dose, Rosuvastatin evening dose, Carvedilol evening dose, Eliquis 4PM dose.</p> <p>5.) R12 was admitted to the facility on [DATE] with diagnosis that include Stroke, Alzheimer's disease, Type 2 Diabetes, Insomnia, Hyperlipidemia, Depression and Anxiety.</p> <p>R12's Admission Minimum Data Set (MDS) assessment dated [DATE], documents R12 has a Brief Interview for Mental Status (BIMS) score of 3 out of 15, indicating that R12 is severely cognitively impaired.</p> <p>R12's Electronic Medical Record documents R12's Power of Attorney (POA) is POA-X.</p> <p>On 9/9/24 at 3:28 PM, Surveyor interviewed POA-X. POA-X informed Surveyor that medications are sometimes given very close together and the timing of medications are not always as ordered. POA-X informed Surveyor that R12 did not receive R12's evening medications on 9/6/24. POA-X stated that Registered Nurse (RN)-I informed POA-X that RN-I did not know if the previous nurse (Licensed Practical Nurse (LPN)-P) had given R12 the evening medications or not and RN-I did not feel comfortable administering more medications.</p> <p>R12's Medical Doctor Orders dated 8/21/24, include:</p> <ul style="list-style-type: none"> <li>-Atorvastatin Calcium Oral Tablet 80 Milligrams (MG). Give one tablet by mouth at bedtime (8PM) for cholesterol.</li> <li>-Melatonin Oral Tablet 3 MG. Give 2 tablets by mouth at bedtime (8PM) for insomnia.</li> <li>-Quetiapine Fumarate Oral Tablet 50 MG. Give one tablet by mouth in the afternoon (2PM) for agitation.</li> <li>-Quetiapine Fumarate Oral Tablet 50 MG. Give one tablet by mouth in the evening (6PM) for agitation.</li> <li>-Quetiapine Fumarate Oral Tablet 25 MG. Give 3 tablets by mouth at bedtime (8PM) for agitation.</li> <li>-Apixaban Oral Tablet 5 MG. Give one tablet by mouth two times a day (8AM and 4PM) for recurrent strokes.</li> <li>-Humalog Injection Solution 100 unit/ML (milliliters). Inject as per sliding scale subcutaneously four times a day (8AM, 12PM, 5PM and 8PM) related to Type 2 Diabetes Mellitus.</li> </ul> <p>Surveyor reviewed R12's Medication Administration Record. For the date of 9/6/24, the following medication administrations are blank, indicating that the medication was not given: Atorvastatin 8PM dose, Melatonin 8PM dose, Quetiapine 2PM, 6PM and 8PM dose, Apixaban 4PM dose, and Humalog injection 5PM dose.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525262	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/11/2024
NAME OF PROVIDER OR SUPPLIER  Fort Atkinson Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  430 Wilcox St Fort Atkinson, WI 53538	
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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 9/11/24 at 7:55 AM, Surveyor interviewed RN-I regarding the events which occurred on 9/6/24. RN-I informed Surveyor that RN-I worked the day shift and was called to come back to the Facility at approximately 9 PM. RN-I stated that LPN-P was working the PM shift, left the facility for a break and LPN-P was unable to return to work after the break. RN-I informed Surveyor RN-I did not administer any resident's medication (except for evening insulin) when RN-I returned to the facility because RN-I was unsure what medication LPN-P had administered.</p> <p>On 9/11/24 at 7:59 AM, RN-I returned to Surveyor. RN-I informed Surveyor that sometimes staff will combine the 2 PM and 8 PM medication administration passes. When RN-I arrived at the facility on 9/6/24 around 9 PM, it appeared like LPN-P was preparing the medications for some residents on the south hall, but RN-I was, again, not sure what was and was not given. RN-I stated that RN-I was not comfortable administering any medications to the residents in the South Hall.</p> <p>Surveyor noted LPN-P was not available for interview.</p> <p>On 9/11/24 at 8:45 AM, Surveyor interviewed Director of Nursing (DON)-B. DON-B confirmed that LPN-P was working the PM shift on 9/6/24 and that LPN-P had left the building for a break and was unable to return. DON-B stated that DON-B believed that LPN-P had administered the medication to the residents in the South hallway, but DON-B stated that LPN-P did not sign any of the medications as given. DON-B indicated LPN-P's medication pass practice would be to prepare and give the medications to residents and then sign them out as given later during her shift.</p> <p>Surveyor noted that LPN-P did not follow the standard of practice for administering and signing out medications which led to confusion if medications were given or not given.</p> <p>On 9/11/24 at 12:58 PM, Surveyor informed Nursing Home Administrator-A of the following concerns regarding medication administration on 9/6/24: The standard of practice for administering and documenting medications was not followed. POA-X informed surveyor that R12 did not receive ordered evening medications on 9/6/24. RN-I informed Surveyor that RN-I was not sure if medications were given or not and RN-I stated that RN-I did not administer any evening medications (except insulin) on 9/6/24.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525262	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/11/2024
NAME OF PROVIDER OR SUPPLIER  Fort Atkinson Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  430 Wilcox St Fort Atkinson, WI 53538	
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 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 38146</p> <p>Based on comprehensive assessment of a resident, the facility did not ensure that residents were not given psychotropic drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record for 1 of 1 (R7) residents reviewed for unnecessary medications.</p> <p>R7 was prescribed Seroquel without clear indication for use.</p> <p>Findings include:</p> <p>The facility policy titled Use of Psychotropic Med implemented 4/24/24 documents (in part) .</p> <p>. Residents are not given psychotropic drugs unless the medication is necessary to treat a specific condition, as diagnoses and documented in the clinical record, and the medication is beneficial to the resident, as demonstrated by monitoring and documentation of the resident's response to the medication(s).</p> <p>1. A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. Psychotropic drugs include but are not limited to the following categories: Antipsychotic's, antidepressants, anti-anxiety and hypnotics.</p> <p>2. The indications for initiating medication(s), as well as the use of non-pharmacological approaches, will be determined by:</p> <p>a. Assessing the resident's underlying condition, current signs, symptoms, expressions, and preferences and goals for treatment.</p> <p>b. Identification of underlying causes (when possible).</p> <p>4. The indications for use of any psychotropic drug will be documented in the medical record.</p> <p>b. For psychotropic drugs that are initiated after admission to the facility, documentation shall include the specific condition as diagnosed by the physician.</p> <p>i. Psychotropic medications shall be initiated only after medical, physical, functional, psychosocial, and environmental causes have been identified and addressed.</p> <p>ii. Non-pharmacological interventions that have been attempted, and the target symptoms for monitoring shall be included in the documentation.</p> <p>7. Residents who use psychotropic drugs shall also receive non-pharmacological interventions to facilitate reduction or discontinuation of the psychotropic drugs.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525262	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/11/2024
NAME OF PROVIDER OR SUPPLIER  Fort Atkinson Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 430 Wilcox St Fort Atkinson, WI 53538	
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 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>14. Use of psychotropic medications in specific circumstances:</p> <p>a. Acute or emergency situations (i.e., acute onset or exacerbation of symptoms or immediate threat to health or safety of resident or others):</p> <p>i. A clinician in conjunction with the IDT (Interdisciplinary Team) shall evaluate and document the situation to identify and address any contributing and underlying causes of the acute condition and verify the need for psychotropic medication.</p> <p>b. Enduring conditions (i.e., non-acute, chronic, or prolonged):</p> <p>i. The resident's symptoms and therapeutic goals shall be clearly and specifically identified and documented.</p> <p>ii. An evaluation shall be documented to determine that the resident's expressions or indications of distress are: Not due to a medical condition or problems that can be expected to improve or resolve as the underlying condition is treated or the offending medication(s) are discontinued; Not due to environmental stressors alone, that can be addressed to improve the symptoms or maintain safety; Not due to psychological stressors, anxiety, or fear stemming from misunderstanding related to his or her cognitive impairment that can be expected to improve or resolve as the situation is addressed; and persistent, and negatively affect his or her quality of life.</p> <p>R7 admitted to the facility on [DATE] and has diagnoses that include: Intercranial injury with loss of consciousness, nontraumatic intracerebral hemorrhage, hemiplegia affecting left non-dominant side, hypertension, anemia, major depressive disorder, anxiety, chronic pain, and dysphagia.</p> <p>R7's Quarterly Minimum Data Set, dated dated dated [DATE] documents a Brief Interview for Mental Status score of 11.</p> <p>R7's care plan initiated 3/21/24 documents: I sometimes have behaviors which include name calling to staff, yelling at staff; refuses vital signs, states the machine is not accurate; Inappropriate comments and inappropriate racial comments towards staff; Resident has conversations with people who are not there, answers the conversations as well; Is not an accurate historian when recalling events; Perseverates on topics, statements, stories; Behavior can be very disruptive at times and can be hard to redirect; I prefer my trays to be left in my room at times even when staff want to remove them when I am done eating; SSD (Social Service Director) and NHA (Nursing Home Administrator) go to speak with resident related to concerns, resident does not provide responses to questions regarding concerns, thoughts are erratic and answers are off topic and do not relate; Resident refusing medications, treatments and participation in ADL's (Activity of Daily Living) at times.</p> <p>Interventions include: Attempt interventions before my behaviors begin; Encourage, educate resident on the importance of taking medications, allowing treatments and participating in ADL's for resident's overall well-being; Give me my medications as my doctor has ordered; Help me to avoid situations or people that are upsetting to me; Let my physician know if my behaviors are interfering with my daily living; make sure I am not in pain or uncomfortable; Offer me something I like as a diversion; Ongoing reassurance; Refer me to my psychologist/psychiatrist as needed; Tell me what you are going to do before you begin; Provide positive feedback to resident; Provide stress and relaxation techniques; Speak to me unhurriedly and in a calm voice.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525262	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/11/2024
NAME OF PROVIDER OR SUPPLIER  Fort Atkinson Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  430 Wilcox St Fort Atkinson, WI 53538	
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 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 9/9/24 at 11:15 AM, during Surveyor interview with R7, he stated: They ordered Seroquel without my consent. They tried to be sneaky and told me the generic name (Quetiapine). I refused because it's not a medication that should be given for a stroke or brain injury. R7 stated: No-one asked me or talked to me about if before, they just ordered it and gave it to me.</p> <p>Documentation revealed R7 refused to meet with the Psych APNP (Advanced Practice Nurse Practitioner). The APNP Psych Initial Evaluation dated 6/28/24 documents (in part) .</p> <p>. Patient is a [AGE] year-old male being seen for an initial psychiatric evaluation. Provider was accompanied by RN (Registered Nurse) twice. Patient is seen sitting on the edge of the bed with his tv on and looking at his computer. He acknowledged this provider and asked three times what my profession was. He then pointed and asked is the RN who accompanied this provider in the room, was the reason I was here. Provider expressed I was present to aid with any concerns he has such as sleep. The patient then states Goodbye. Provider reapproached the patient later by myself in the room with the RN outside of door an out of site. Patient stated he did not want me in his room, I'm not welcome, don't come back again and if I did, he would call the police.</p> <p>Patient discussed with DON (Director of Nursing)-B and the executive admin (NHA-A). DON reports that the patient has been getting progressively worse with his behavior. He is becoming more and more verbally aggressive to the point of the possibility of physical aggression and is scaring staff. Patient has been aggressive and agitated with all staff members that approach him in any way. He does not engage in conversation or assessments with most staff. Nursing has documentation of the patient refusing medications and when given throws on the floor even when he states he does want it. He does not vocalize any symptoms but anger toward everyone. Also, he has been making accusatory statements about staff trying to give him pills off the ground and other insignificant things. Nursing report patient has been lashing out and repeatedly calling the hotline provided for patient grievances. Patient states during conversations almost every time he will call the police if the person does not leave the room. Staff report patient has not allowed them to perform things like basic ADL's (Activities of Daily Living) or supplies for ADL's. Due to aggressive and threatening behavior the patient has to have 2 people present in the room. Nursing management has implemented this for staff protection.</p> <p>Surveyor reviewed R7's progress notes for the month of June 2024. Surveyor located only 1 entry on 6/14/24 which documented: Verbal aggression toward staff and refusing HS (hour of sleep) ADL care. There was no documentation of R7 verbally aggressive to the point of the possibility of physical aggression and is scaring staff as documented by the Psych APNP after discussion with DON-B and NHA-A.</p> <p>Surveyor review of the Certified Nursing Assistant Point of Care (POC) documentation for the month of June 2024 documents: Monitor - behavior symptoms every shift. Surveyor noted the behavior list is a template and not specific to R7.</p> <p>The list of behavior symptoms to choose from are: 0 - Frequent crying, 2 -repeats movements, 3 - yelling/screaming, 4 - kicking/hitting, 13 - pushing, 14 - grabbing, 5 - pinching/scratching/spitting, 6 - biting, 7 - wandering, 8 - abusive language, 9 - threatening behavior, 10 - sexually inappropriate, 11 - rejection of care, and 12 - None of the above observed.</p> <p>Surveyor noted of the possible 90 entries to document R7's behaviors, 41 areas were blank, 1 entry documented 8 (abusive language), 2 entries documented N/A, 4 entries documented 11 (rejection of care) and 42 entries documented 12 (None of the above observed).</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525262	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/11/2024
NAME OF PROVIDER OR SUPPLIER  Fort Atkinson Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  430 Wilcox St Fort Atkinson, WI 53538	
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 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Surveyor located no evidence of the alleged behaviors reported to the Psych APNP that warranted the order for Seroquel.</p> <p>On 9/11/24 Regional Director of Clinical Operations-C was advised of concern Seroquel was ordered for R7 without clear indication for use. The resident refused to be seen by the Psych APNP and there is no evidence of the alleged behavior verbally aggressive to the point of the possibility of physical aggression and is scaring staff that was reported to the Psych APNP by DON-B and NHA-A. Surveyor reviewed R7's POC behavior documentation for June 2024 which revealed only 1 entry of abusive language and 4 entries of rejection of care. The remaining entries documented none of the behaviors were observed. Regional Director of Clinical Operations-C stated: We have an issue with some providers just prescribing meds. It's something we're going to have to look into and work on. No additional information was provided.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525262	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/11/2024
NAME OF PROVIDER OR SUPPLIER  Fort Atkinson Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  430 Wilcox St Fort Atkinson, WI 53538	
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 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>38146</p> <p>Based on observation, interview, and record review the facility did not ensure its medication error rates are not 5 percent or greater. The facility medication error rate was 53.33%.</p> <p>The Facility Policy titled Medication Administration implemented 3/1/19 documents (in part) .</p> <p>. Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection.</p> <p>Policy Explanation and Compliance Guidelines:</p> <p>11. b. Administer within 60 minutes prior to or after scheduled time unless otherwise ordered by physician.</p> <p>Findings include:</p> <p>On 9/9/24 at 9:51 AM, Surveyor observed Certified Nursing Assistant (CNA)-F passing medications. CNA-F prepared the following medications for R14: Gabapentin 100 mg (milligrams) - 1 tablet, Clindamycin 300 mg - 1 tablet, Aspirin 81 mg enteric coated - 1 tablet, Pantoprazole 40 mg - 1 tablet, Duloxetine 20 mg - 1 tablet, and Oxycodone 10 mg - 1 tablet. CNA-F reported Multivitamin was not available. Surveyor verified the number of tablets with CNA-F and R14 was administered the medications at 10:00 AM.</p> <p>Surveyor reconciled R14's medications. R14's September 2024 Medication Administration Record (MAR) indicated the following medications (which are ordered more than once daily) were ordered to be given at the following times: Gabapentin - 7:00 AM, Clindamycin - 7:30 AM, Pantoprazole -Day 6 (6:00 AM) and Duloxetine -8:00 AM. R14 was administered these medications at 10:00 AM, greater than 2 hours past the ordered times.</p> <p>On 9/9/24 at 10:15 AM, Surveyor observed Certified Nursing Assistant (CNA)-F passing medications. CNA-F prepared the following medications for R15: Potassium Chloride 20 meq (milliequivalents) powder packet - 2 packets, Gabapentin 100 mg - 2 tablets, Levetiracetam oral solution 100 mg/ml (milliliters) - 10 ml, Benzotropine 0.5 mg - 1 tablet, Oxybutynin ER (extended release) 5 mg - 1 tablet, Divalproex 125 mg - 4 tablets, Olanzapine 2.5 mg - 1 tablet, allergy relief 10 mg - 1 tablet, Torsemide 20 mg - 1 tablet (label documented 4 tablets to be given) , Jardiance 25 mg - 1 tablet, Multivitamin with minerals - 1 tablet, and Miralax 17 grams.</p> <p>Surveyor verified the number of tablets with CNA-F. As CNA-F picked up the cup of medications to administer to R15, Surveyor confirmed with CNA-F there was only 1 tablet of Torsemide. CNA-F then viewed the MAR and read aloud Oh, she gets 3 more and added 3 tablets of Torsemide to the medication cup. R15 was administered the medications at 10:40 AM.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525262	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/11/2024
NAME OF PROVIDER OR SUPPLIER  Fort Atkinson Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  430 Wilcox St Fort Atkinson, WI 53538	
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 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Surveyor reconciled R15's medications. R15's September 2024 indicated the following medications (which are ordered more than once daily) were ordered to be given at the following times: Potassium Chloride -7:00 AM, Gabapentin - 8:00 AM, Levetiracetam -8:00 AM, Benztropine - 8:00 AM, Divalproex - 8:00 AM, Olanzapine - 8:00 AM, Torsemide 8:00 AM and Miralax - 8:00 AM. R15 was administered these meds at 10:40 AM, greater than 2 hours past the ordered times. In addition, CNA-F prepared only 1 tablet of Torsemide 20 mg versus the 4 tablets ordered. CNA-F corrected the omission of the ordered tablets after she was advised by Surveyor.</p> <p>On 9/11/24 at 10:30 AM, Director of Nursing (DON)-B was advised of the above concerns. No additional information was provided.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525262	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/11/2024
NAME OF PROVIDER OR SUPPLIER  Fort Atkinson Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  430 Wilcox St Fort Atkinson, WI 53538	
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 0814</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Dispose of garbage and refuse properly.</p> <p>20483</p> <p>Based on observation and record review the facility did not ensure the garbage and refuse were properly disposed in the outside garbage storage receptacles. This deficient practice had the potential to affect all 58 residents residing at the facility.</p> <p>Findings include:</p> <p>1.) On 9/10/24, at 9:34 a.m., Surveyor observed behind the dumpster located on the side of the building a wood pallet, gray sock, multiple blue gloves, black plastic platform, garbage bag, and a piece of foam material. There are also pieces of wood and multiple tree branches which have the potential to harbor rodents.</p> <p>2.) On 9/10/24, at 9:38 a.m., Surveyor observed in the back of the building there are two dumpsters. The left dumpster is not closed as the lids on the back half are open. Behind the dumpster there are 25+ blue gloves on the ground along with a soda can, two black garbage cans tipped over, an empty glove box, and two pieces of paper. There are two cardboard boxes which have the appearance of being out in the weather for an extended period of time. One of the cardboard boxes is flat with leaves and the other is collapsed in. On the right side of the dumpster the ground is littered with a fork, papers, and gloves.</p> <p>3.) On 9/10/24 at 9:41 a.m., Surveyor observed on the left side of the right dumpster located behind the building there are multiple gloves on the ground. Behind this dumpster there is a large clear garbage bag filled with empty blister packs, cups, a glove box, &amp; other items. There are two blue gloves on the ground.</p> <p>On 9/10/24, at 2:02 p.m., Surveyor asked DOM (Director of Maintenance)-G who is responsible for cleaning outside around the dumpsters. DOM-G informed Surveyor who ever throws the trash away. DOM-G indicated he usually doesn't throw trash away unless its a toilet.</p> <p>On 9/10/24, at 2:08 p.m., DOM-G accompanied Surveyor outside. Surveyor showed DOM-G the multiple items around the one dumpster on the side and the two dumpsters in the back. DOM-G stated to Surveyor there are gloves like everywhere. Surveyor asked again who should be cleaning this area. DOM-G replied I would say me and housekeeping. DOM-G informed Surveyor, Surveyor could speak with HD (Housekeeping Director)-H.</p> <p>On 9/10/24, at 2:14 p.m., Surveyor asked HD-H who should be cleaning outside around the dumpsters and building. HD-H replied it's suppose to be maintenance we don't do anything outside.</p> <p>On 9/11/24, at 1:30 p.m., NHA (Nursing Home Administrator)-A was informed of the above. No additional information was provided to Surveyor as to why the dumpster areas were not clean.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525262	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/11/2024
NAME OF PROVIDER OR SUPPLIER  Fort Atkinson Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  430 Wilcox St Fort Atkinson, WI 53538	
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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>20483</p> <p>Based on observation, interview, and record review the facility did not maintain an infection prevention and control program designed to reduce the transmission of disease and infection for 2 (R11 &amp; R5) of 2 Residents.</p> <p>* Staff did not wear appropriate PPE (personal protective equipment) when placing R11 on a bed pan. R11 is on EBP (enhanced barrier precautions).</p> <p>* Appropriate hand hygiene was not observed during incontinence cares and staff was not wearing a gown during this care observation for R5 who is on EBP.</p> <p>Findings include:</p> <p>The facility's policy titled, Enhanced Barrier Precautions and implemented 8/1/22 under policy documents It is our policy to take appropriate precautions, including isolation, to prevent transmission of Multi Drug Resistant Organisms. Updated guidance from CDC (Centers for Disease Control and Prevention) indicates that more than 50% of nursing home residents have MDSROs sic MDRO (multidrug resistant organism) on or in their body. These germs can be transferred from one resident to another on staff hands and clothing. This policy specifies when Enhanced barrier precautions will be used in the facility.</p> <p>Under Policy Explanation and Compliance Guidelines includes documentation of:</p> <p>4. Gowns and gloves are required to be worn by all staff while performing high-contact care activities with all residents at higher risk of acquiring or spreading and MDRO. These activities include</p> <ul style="list-style-type: none"> <li>a. Bathing/Showering</li> <li>b. Transferring residents from one position to another</li> <li>c. Providing hygiene</li> <li>d. Changing bed linens</li> <li>e. Changing briefs or assisting with toileting</li> <li>f. Caring for or using an indwelling medical device</li> <li>g. Performing wound care.</li> </ul> <p>8. Prior to entering the room to provide high-contact care activities, staff will perform hand hygiene and don gowns</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525262	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/11/2024
NAME OF PROVIDER OR SUPPLIER  Fort Atkinson Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  430 Wilcox St Fort Atkinson, WI 53538	
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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>and gloves.</p> <p>The facility's policy titled, Hand Hygiene and implemented 10/1/23 under policy documents All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. This applies to all staff working in all locations within the facility.</p> <p>Under Policy Explanation and Compliance Guidelines includes documentation of:</p> <p>6. Additional considerations:</p> <p>a. The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves.</p> <p>1.) R11's diagnoses includes coronary artery disease, congestive heart failure, hypertension, diabetes mellitus, anxiety disorder and depression.</p> <p>R11 is on enhanced barrier precautions.</p> <p>The annual MDS (minimum data set) with an assessment reference date of 7/2/24 has a BIMS (brief interview mental status) score of 14 which indicates cognitively intact. R11 is assessed as being dependent for toileting hygiene and substantial/maximal assistance for rolling left &amp; right. R11 is assessed as always continent of urine and bowel.</p> <p>On 9/9/24, at 11:06 a.m., Surveyor observed CNA (Certified Nursing Assistant)-L answer R11's call light. Surveyor observed there is an enhanced barrier precaution sign and a PPE (personal protective equipment) cart outside R11's room. R11 informed CNA-L she needs the bed pan. CNA-L placed gloves on and asked R11 if she can turn. R 11 stated I don't know if I can turn I've been holding it so long. R11 grabbed the right bar and CNA-L assisted R11 with turn on the right side. CNA-L placed a bed pan under R11. R11 informed CNA-L the bed pan is up too far. CNA-L adjusted the bed pan and R11 rolled back onto her back. CNA-L placed a towel between R11's legs, removed her gloves, and washed her hands.</p> <p>At 11:11 a.m. CNA-L left R11's room. Surveyor observed CNA-L was not wearing the appropriate PPE as CNA-L was only wearing gloves and did not don a gown.</p> <p>On 9/10/24, at 2:26 p.m., Surveyor asked DON (Director of Nursing)-B how would staff know a resident is on EBP and what PPE should staff wear for a resident on EBP. DON-B informed Surveyor there is a brownish colored sign outside room and staff should be gowning and gloving anytime doing patient care. Surveyor informed DON-B of the observation of CNA-L not wearing a gown while placing R11 on the bed pan.</p> <p>2.) R5's diagnoses includes metabolic encephalopathy, diabetes mellitus, atrial fibrillation, congestive heart failure and peripheral vascular disease.</p> <p>On 9/9/24, at 9:01 a.m., Surveyor observed an enhanced barrier precaution sign and PPE (personal protective equipment) cart outside R5's room.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525262	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/11/2024
NAME OF PROVIDER OR SUPPLIER  Fort Atkinson Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  430 Wilcox St Fort Atkinson, WI 53538	
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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 9/10/24, at 9:43 a.m., Surveyor observed CNA (Certified Nursing Assistant)-J enter R5's room. R5 is in bed on the left side and CNA-J is only wearing gloves. CNA-J is not wearing a gown. CNA-J placed compression stockings and Velcro wraps on R5's lower extremities.</p> <p>At 7:50 a.m., CNA-K entered R5's room with the sit to stand lift and then left. CNA-J unfastened R5's incontinence product, washed R5's face, and removed an incontinence product from the closet. CNA-J informed R5 he was going to wipe his lower area and using a wash cloth washed R5's frontal perineal area and inner thighs to remove stool. CNA-J assisted R5 with rolling on his left side. Stool was observed in the incontinence product and CNA-J informed Surveyor it's light must of been from overnight. CNA-J removed his gloves and placed new gloves on. CNA-J did not perform any hand hygiene. CNA-J used a disposable wipe to remove stool from R5's rectal area, removed his gloves &amp; placed gloves on. CNA-J did not perform any hand hygiene. CNA-J removed a towel from the sink which was partially wet and washed R5's buttocks. CNA-J placed the towel in a plastic bag, removed his gloves, asked R5 if he felt refreshed, and placed gloves on. CNA-J did not perform any hand hygiene. CNA-J placed an incontinence product &amp; pants on R5 and then sat R5 on the edge of the bed. CNA-J removed R5's T-shirt, placed a new shirt &amp; shoes on R5. The sit to stand was placed in front of R5 and a sling around R5.</p> <p>At 8:01 a.m., PT (Physical Therapist)-CC entered R5's room and R5 was transferred into the wheelchair.</p> <p>After the transfer, PT-CC left R5's room with the sit to stand lift. CNA-J placed R5's hearing aides in and combed R5's hair.</p> <p>At 8:08 a.m., CNA-J removed his gloves and left R5's room.</p> <p>On 9/10/24, at 1:37 p.m., Surveyor asked CNA-J how he knows if a resident is on enhanced barrier precautions. CNA-J informed Surveyor there should be a sign outside the door. Surveyor asked what should he wear if a resident is on enhanced barrier precautions. CNA-J said it depends and explained a mask, visor, gown and gloves. Surveyor asked why he didn't wear the appropriate PPE when he was taking care of R5 this morning. CNA-J replied my fault, trying to hurry to get people up.</p> <p>On 9/10/24, at 2:26 p.m., Surveyor asked DON (Director of Nursing)-B how would staff know a resident is on EBP and what PPE should staff wear for a resident on EBP. DON-B informed Surveyor there is a brownish colored sign outside room and staff should be gowning and gloving anytime doing patient care. Surveyor asked DON-B when would she expect staff to perform hand hygiene during cares. DON-B informed Surveyor before and anytime they take their gloves off, when entering &amp; exiting a room should be doing hand hygiene. Surveyor informed DON-B of the observation of CNA-J not wearing the a gown during morning/incontinence cares and not performing any hand hygiene after removing his gloves when R5 was incontinent of stool.</p> <p>On 9/11/24, at 1:30 p.m., NHA (Nursing Home Administrator)-A was informed of the above. No additional information was provided to Surveyor.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525262	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/11/2024
NAME OF PROVIDER OR SUPPLIER  Fort Atkinson Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  430 Wilcox St Fort Atkinson, WI 53538	
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 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49435</p> <p>Based on observation, interview and record review, the facility did not maintain an effective pest control program to address the flies in the facility.</p> <p>*R4 informed Surveyor that the facility has a problem with flies and R4 had purchased sticky fly strips to place in his room to help with the fly problem.</p> <p>*R6 informed Surveyor that the facility has a problem with flies and R6 has started to keep a fly swatter with him while in bed.</p> <p>*The facility did not have a pest control company to service the facility for the months of June and July of 2024.</p> <p>*Surveyors observed flies in resident unit hallways, the common dining room for residents, the conference room and in a resident's bathroom.</p> <p>This deficient practice has the potential to affect all 58 of 58 residents residing in the facility at the time of the survey.</p> <p>Findings include:</p> <p>The facility policy entitled, Pest Control Program, dated 4/10/24, documents: It is the policy of this facility to maintain an effective pest control program that eradicates and contains common household pests and rodents. Definition: Effective pest control program is defined as measures to eradicate and contain common household pests (e.g., bed bugs, lice, roaches, ants, mosquitos, flies, mice, and rats) . Facility will maintain a written agreement with a qualified outside pest service to provide comprehensive pest control services on a regular and scheduled basis . Facility will maintain a report system of issues that may arise in between scheduled visits with the outside pest service and treat as indicated . Facility will utilize a variety of methods in controlling certain seasonal pests, i.e. flies. These will involve indoor and outdoor methods that are deemed appropriate by the outside pest service and state and federal regulations .</p> <p>*R4 was admitted to the facility on [DATE].</p> <p>R4's Quarterly Minimum Data Set Assessment (MDS) dated [DATE], documents R4 has a Brief Interview for Mental Status (BIMS) score of 12 out of 15, indicating R4's cognition is moderately impaired.</p> <p>On 9/9/24 at 10:30 AM, Surveyor interviewed R4. R4 indicated that the facility has a problem with flies for a long time. R4 pointed to a box on his bedside table and stated that R4 had ordered some sticky fly strips to help with the flies in his room. R4 stated that the previous night there were 2 flies in his room that were bothering him while he tried to sleep. At time of interview, Surveyor did not observe a fly in R4's room.</p> <p>*R6 was admitted to the facility on [DATE].</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525262	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/11/2024
NAME OF PROVIDER OR SUPPLIER  Fort Atkinson Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  430 Wilcox St Fort Atkinson, WI 53538	
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 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>R6's Quarterly Minimum Data Set Assessment (MDS) dated [DATE], documents R6 has a Brief Interview for Mental Status (BIMS) score of 13 out of 15, indicating R6 is cognitively intact.</p> <p>On 9/10/2024 at 12:16 PM, Surveyor observed R6 holding a fly swatter while laying in bed. Surveyor asked why R6 had a fly swatter in bed. R6 indicated that the flies are irritating him and R6's son got him a fly swatter to help. R6 stated that he killed 2 flies yesterday. R6 stated that the facility has had an issue with flies for as long as R6 can remember.</p> <p>On 9/11/2024 at 7:48 AM, Surveyor observed R6 holding a fly swatter while laying in bed.</p> <p>On 9/11/2024 at 9:09 AM, Surveyor observed R6 in bed and a fly swatter was laying on his lap.</p> <p>*The facility did not ensure a pest control company was servicing the building in June or July 2024.</p> <p>On 9/10/2024 at 12:50 PM, Surveyor interviewed Director of Maintenance-G. Director of Maintenance-G indicated that the facility currently has a contract with [name of pest control company]. Director of Maintenance-G stated that the pest control company comes to the facility monthly. Surveyor asked for the pest control company invoices for the months of April, May, June, July, August, and September of 2024.</p> <p>On 9/10/2024 at 1:35 PM, Director of Maintenance-G returned with pest control invoices for the months of April, May, August, and September. Surveyor asked if Director of Maintenance-G had invoices for June and July. Director of Maintenance-G stated the pest control company that serviced the facility in April and May was a different company and they must have forgotten about us. Director of Maintenance-G stated that the current pest control company started servicing the building in August.</p> <p>The facility's pest control invoice, dated 4/16/2024, documents: Service description: common ants.</p> <p>The facility's pest control invoice, dated 5/21/2024, documents: Service Description: platinum protection plan.</p> <p>Surveyor noted that for the months of June and July, no pest control invoices were available.</p> <p>The facility's pest control invoice, dated 8/7/2024, documents: Pest initial Service. Targeted pests: Mice, Deer Mouse, Mice, House mouse. General comments: . No major issues were brought up to resolve at this time . Please call with any concerns between now and your next visit.</p> <p>The facility's pest control invoice, dated 9/4/2024, documents: Pest Management Maintenance. General comments: . Checked in with staff, no pest issues as of today's services .</p> <p>Surveyor noted that flies were not mentioned in any of the Pest control invoices reviewed.</p> <p>On 9/10/2024 at 3:50 PM, Surveyor interviewed Business Office staff-BB about invoices. Surveyor asked if Business Office staff-BB had record of pest control company invoices for the months of June and July 2024. Business Office staff-BB stated Director of Maintenance-G would oversee the pest control invoices. Business Office staff-BB stated that they would try to locate the pest control company invoices for June and July 2024.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525262	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/11/2024
NAME OF PROVIDER OR SUPPLIER  Fort Atkinson Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  430 Wilcox St Fort Atkinson, WI 53538	
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 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On 9/11/2024 at 9:51 AM, Nursing Home Administrator (NHA)-A stated the facility switched pest control companies after May and the facility does not have invoices for the months of June and July 2024.</p> <p>*Surveyors noted flies throughout the facility.</p> <p>On 9/9/2024, at 3:28 PM, Surveyor observed the bathroom shared between resident rooms [ROOM NUMBERS]. Surveyor noted a fly flying in the bathroom and then landing on the toilet.</p> <p>On 9/10/2024 at 12:09 PM, Surveyor noted 2 flies in the conference room.</p> <p>On 9/11/2024, at 9:07 AM, Surveyor walked each unit in the facility. Surveyor noted 2 flies while walking the North unit. Surveyor noted 1 fly while walking the East unit. Surveyor noted 1 fly while walking the South unit.</p> <p>On 9/10/24 at 9:50 AM, Surveyor interviewed Certified Nursing Assistant (CNA)-N in the South hallway. Surveyor asked CNA-N if the facility has an issue with flies. CNA-N stated that there are flies all over and on every unit of the building. CNA-N indicated that the flies are worse on the North hallway. While walking away from the interview, a fly landed on Surveyor's face.</p> <p>On 9/10/2024 at 1:30 PM, Surveyor interviewed Licensed Practical Nurse (LPN)-O about flies in the facility. LPN-O stated that LPN-O does not work at the facility often but did hear residents complaining about flies during lunch service today. Surveyor asked where the residents were eating lunch. LPN-O stated the residents that were complaining about flies had eaten in the Common Dining Room.</p> <p>On 9/10/2024 at 1:32 PM, Surveyor observed the common dining room. Surveyor counted 3 flies on different tables. Surveyor observed a plate of half-eaten food sitting on a table with a fly on it. Surveyor located a dead fly on a windowsill in the dining room.</p> <p>On 9/10/2024, at 3:18 PM, During the daily exit meeting, Surveyors were swatting at a fly. Director of Nursing (DON)-B stated, you need a fly swatter in here. NHA-A, DON-B, Regional Director of Clinical Operations-C and Regional Director of Clinical Operations-Q were made aware of the above concerns with flies in the facility.</p> <p>No further information was given as to why the facility did not maintain an effective pest control program to address the flies in the facility.</p> <p>20483</p> <p>* On 9/9/24, at 11:16 a.m., Surveyor observed CNA (Certified Nursing Assistant)-K transfer R2 from his bed into the wheelchair. After R2 was sitting in the wheelchair, Surveyor observed a fly buzzing around and landing on the soaker pad on R2's bed.</p> <p>* On 9/9/24, at 12:48 p.m., Surveyor observed flies flying around R17 who was in bed eating lunch. Surveyor asked R17 if there is a problem with flies in his room. R17 informed Surveyor the flies are a pest and asked Surveyor can you get me a strip.</p> <p>* On 9/10/24, at 8:06 a.m., Surveyor observed in a fly swatter in chair in R5's room. Surveyor asked R5 if there is a problem with flies. R5 replied there's a few flying around here.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525262	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/11/2024
NAME OF PROVIDER OR SUPPLIER  Fort Atkinson Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  430 Wilcox St Fort Atkinson, WI 53538	
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 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>* On 9/10/24, at 8:07 a.m., Surveyor asked CNA-J if there is a problem with flies in the building. CNA-J replied yes. Surveyor then observed a fly land on R5.</p> <p>* On 9/10/24, at 9:00 a.m., Surveyor observed R2 sitting in a wheelchair in his room. Surveyor observed there is a fly buzzing around R2's head.</p> <p>* On 9/10/24, from 9:04 a.m. to 9:26 a.m., Surveyor observed CNA-Z &amp; CNA-F transfer R2 from the wheelchair into bed using a sit to stand lift and then provide incontinence care to R2. During this observation Surveyor observed multiple flies in R2 and a fly land on R2 multiple times.</p> <p>* On 9/10/24, at 12:05 p.m., Surveyor observed R2 in bed on his back with the head of the bed up high drinking from a coffee cup. Surveyor observed a fly buzzing around R2.</p> <p>* On 9/10/24, at 12:07 p.m., Surveyor asked CNA-W if there is a problem with flies in the facility. CNA-W replied yes and explained there has been a problem with flies on and off all summer. CNA-W, pointing to the north unit, stated they seem to be worse over there.</p> <p>* On 9/10/24, at 2:04 p.m., Surveyor asked DOM (Director of Maintenance)-G if there have been any complaints regarding flies. DOM-G informed Surveyor a gentleman from the other side of the building complained. Surveyor inquired if the pest control company takes care of the flies. DOM-G informed Surveyor if he puts in a special order they will come in. Surveyor asked DOM-G if he has spoken to the pest control company about the flies. DOM-G replied no.</p> <p>On 9/10/24, at approximately 2:50 p.m., DOM-G informed Surveyor he called their pest control company and provided Surveyor with a copy of an email dated 9/10/24 from [name of pest control company].</p> <p>* On 9/10/24, at approximately 3:24 p.m., during the end of the day meeting with NHA (Nursing Home Administrator)-A, DON (Director of Nursing)-B, Regional Director of Operations-C and Regional Director of Operations-Q, there were flies buzzing around the survey team. DON-B stated you need a fly swatter in here.</p> <p>* On 9/11/24, at 7:13 a.m., Surveyor observed R2 in bed on his back. Surveyor observed there are two flies on R2's bed spread.</p> <p>On 9/11/24, at 1:30 p.m., NHA (Nursing Home Administrator)-A was informed of the above.</p>		