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No. 0938-0391

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 01/15/2025
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)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20483 Based on interview and record review the facility did not ensure a residents physician and/or resident representative was notified for 2 (R4 & R3) of 6 residents reviewed. * On 11/14/24 R4's guardian was not notified of a KUB (kidney, ureter and bladder) x-ray, stool culture & labs ordered for R4. R4's physician was not notified when R4 received medication late for medication received BID/TID (two times a day/three times a day) daily from 10/27/24 to 11/30/24, with the exception of 11/8/24. * R3's physician was not notified when R3 received medication late for medication received BID/TID on 9/7/24 & 9/8/24 and on 11/1/24 to 11/11/24. Findings include: 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 designed 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. Under procedure #3 documents Document the notification and record any new orders in the resident's medical record. 1.) R4 was admitted to the facility on [DATE] and discharged on [DATE]. R4 was reviewed as a closed record. R4's diagnoses includes non traumatic intracerebral hemorrhage, hemiplegia, hypertension, anxiety disorder, depressive disorder, and polyneurapathy. The nurses note dated 11/14/24, at 10:43 a.m., documents Resident c/o (complained of) diarrhea abd (abdomen) discomfort and nausea. BS+ x 4 (bowel sounds positive times four). Abd soft. discomfort noted around umbilical region pt (patient) with hx (history) of hernia no bulging noted in umbilical region. Resident recently c/o constipation Senna S and MOM given as requested. [Physician Name] made aware of above. New orders received resident aware and agrees. This nurses note was written by LPN (Licensed Practical Nurse)-E. (continued on next page)

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The e-interact SBAR (situation, background, assessment and recommendation) Summary for Providers dated 11/14/24, at 10:51 a.m., under primary care provider feedback for recommendations documents KUB (kidney, ureters, bladder) stool cx (culture) of norovirus & Cdiff (clostridioides difficile). This SBAR note was written by LPN-E. The nurses note dated 11/14/24, at 18:30 (6:30 p.m.), documents KUB done at 1420 (2:20 p.m.). results - unremarkable. resident aware and [Physician name] aware. Per [Name of] Labs no tech available to draw blood for labs today. Labs to be drawn 11/15/24. [Physician name] aware. This nurses note was written by LPN-E. On 1/7/25, at 1:21 p.m., Surveyor informed LPN/UM (Licensed Practical Nurse/Unit Manager)-F on 11/14/24 R4's physician ordered a KUB, stool, and blood work. Surveyor asked if R4's guardian should have been notified of the new orders. LPN/UM-F replied absolutely. On 1/7/25, at 2:00 p.m., Surveyor showed LPN-E R4's notes dated 11/14/24 and asked LPN-E if she notified R4's guardian of the KUB, stool and labs ordered. LPN-E informed Surveyor she didn't think R4 had a guardian and didn't remember if she contacted R4's guardian. On 1/7/25, at 3:46 p.m., NHA (Nursing Home Administrator)-A and DON (Director of Nursing)-B were informed of the above. No information was provided to Surveyor as to why R4's guardian was not notified on 11/14/24 of the KUB, stool culture, and lab work ordered by R4's physician. * On 10/27/24 Carvedilol 25 mg (milligrams) two times a day and Magnesium Oxide 500 mg twice daily were scheduled at 6:00 a.m. R4 received these medications at 7:37 a.m. On 10/27/24 Magnesium Oxide 500 mg two times a day and Carvedilol 25 mg two times a day were scheduled at 1400 (2:00 p.m.). R4 received these medications at 15:53 (3:53 p.m.). * On 10/28/24 Carvedilol 25 mg (milligrams) two times a day and Magnesium Oxide 500 mg twice daily were scheduled at 6:00 a.m. R4 received Carvedilol 25 mg at 8:15 a.m. and Magnesium Oxide 500 mg at 8:18 a. m. On 10/28/24 Magnesium Oxide 500 mg two times a day and Carvedilol 25 mg two times a day were scheduled at 1400 (2:00 p.m.). Magnesium Oxide 500 mg was administered at 17:02 (5:02 p.m.) and Carvedilol 25 mg was administered at 17:03 (5:03 p.m.). * On 10/29/24 Magnesium Oxide 500 mg two times a day and Carvedilol 25 mg two times a day were scheduled at 1400 (2:00 p.m.). Magnesium Oxide 500 mg & Carvedilol 25 mg were administered at 18:25 (6:25 p.m.). On 10/29/24 Diclofenac Potassium 50 mg twice daily, Diazepam 2 mg three times daily, Clonazepam 1 mg three times daily, Propranolol 10 mg three times daily, and Pregabalin 100 mg three times daily were scheduled for 16:00 (4:00 p.m.). R4 received these medications at 18:24 (6:24 p.m.). * On 10/30/24 Carvedilol 25 mg (milligrams) two times a day and Magnesium Oxide 500 mg twice daily were scheduled at 6:00 a.m. R4 received Carvedilol 25 mg at 9:35 a.m. and Magnesium Oxide 500 mg at 9:36 a. m. R4 receives these medications over three hours after the scheduled time. (continued on next page)

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F 0580

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

On 10/30/24 Artificial Tears 1 drop in both eyes is scheduled four times daily. R4's schedule dose at 7:30 a.m. was administered at 10:40 a.m., 3 hours after the scheduled time.

On 10/30/24 Clonazepam 1 mg three times daily, Pregabalin 100 mg three times daily, Diazepam 2 mg three times daily, Diclofenac Potassium 50 mg two times daily, and Propranolol 10 mg three times daily were scheduled at 8:00 a.m. R4 received Clonazepam 1 mg & Pregabalin 100 mg at 9:33 a.m., Diazepam 2 mg & Diclofenac Potassium 50 mg at 9:25 a.m. and Propranolol 10 mg at 10:40 a.m.

* On 10/31/24 Carvedilol 25 mg (milligrams) two times a day and Magnesium Oxide 500 mg twice daily were scheduled at 6:00 a.m. R4 received Magnesium Oxide 500 mg at 10:13 a.m. & Carvedilol 25 mg at 10:14 a.m. This was four hours after the scheduled time.

On 10/31/24 Artificial Tears 1 drop in both eyes is scheduled four times daily. R4's schedule dose at 7:30 a.m. was administered at 10:13 a.m.

On 10/31/24 Clonazepam 1 mg three times daily, Pregabalin 100 mg three times daily, Diazepam 2 mg three times daily, Diclofenac Potassium 50 mg two times daily, and Propranolol 10 mg three times daily were scheduled at 8:00 a.m. Clonazepam 1 mg, Pregabalin 100 mg, Diazepam 2 mg, and Diclofenac Potassium 50 mg was administered at 10:13 am. Propranolol 10 mg was administered at 10:15 a.m.

On 10/31/24 Magnesium Oxide 500 mg two times a day and Carvedilol 25 mg two times a day were scheduled at 1400 (2:00 p.m.). Magnesium Oxide 500 mg & Carvedilol 25 mg were administered at 18:10 (6:10 p.m.).

On 10/31/24 Diclofenac Potassium 50 mg twice daily, Diazepam 2 mg three times daily, Clonazepam 1 mg three times daily, Propranolol 10 mg three times daily, and Pregabalin 100 mg three times daily were scheduled for 16:00 (4:00 p.m.). R4 received these medications at 18:10 (6:10 p.m.).

* On 11/1/24 Carvedilol 25 mg (milligrams) two times a day and Magnesium Oxide 500 mg twice daily were scheduled at 6:00 a.m. R4 received Carvedilol 25 mg at 9:41 a.m. & Magnesium Oxide 500 mg at 9:48 a.m.

On 11/1/24 Artificial Tears 1 drop in both eyes is scheduled four times daily. R4's schedule dose at 7:30 a.m. was administered at 9:40 a.m.

On 11/1/24 Clonazepam 1 mg three times daily, Pregabalin 100 mg three times daily, Diazepam 2 mg three times daily, Diclofenac Potassium 50 mg two times daily, and Propranolol 10 mg three times daily were scheduled at 8:00 a.m. Propranolol 10 mg was administered at 9:41 a.m., Diclofenac Potassium 50 mg was administered at 9:47 a.m., and Pregabalin 100 mg, Clonazepam 1 mg & Diazepam 2 mg was administered at 9:48 a.m.

On 11/1/24 Magnesium Oxide 500 mg two times a day and Carvedilol 25 mg two times a day were scheduled at 1400 (2:00 p.m.). Magnesium Oxide 500 mg & Carvedilol 25 mg were administered at 16:38 (4:38 p.m.).

* On 11/2/24 Carvedilol 25 mg (milligrams) two times a day and Magnesium Oxide 500 mg twice daily were scheduled at 6:00 a.m. R4 received these medications at 8:58 a.m.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	* On 11/3/24 Carvedilol 25 mg (milligrams) two times a day and Magnesium Oxide 500 mg twice daily were scheduled at 6:00 a.m. R4 received these medications at 7:56 a.m. On 11/3/24 Magnesium Oxide 500 mg twice daily and Carvedilol 25 mg twice daily were scheduled at 14:00 (2:00 p.m.). R4 received these medications at 16:10 (4:10 p.m.). * On 11/4/24 Carvedilol 25 mg (milligrams) two times a day and Magnesium Oxide 500 mg twice daily were scheduled at 6:00 a.m. R4 received these medications at 7:28 a.m. On 11/4/24 Magnesium Oxide 500 mg twice daily and Carvedilol 25 mg twice daily were scheduled at 14:00 (2:00 p.m.). R4 received these medications at 18:34 (6:34 p.m.). On 11/4/24 Diclofenac Potassium 50 mg two times a day, Diazepam 2 mg three times a day, Propranolol 10 mg three times a day, Clonazepam 1 mg three times a day, & Pregabalin 100 mg three times a day were scheduled at 16:00 (4:00 p.m.) R4 receives these medications at 18:33 (6:33 p.m.). * On 11/5/24 Carvedilol 25 mg (milligrams) two times a day and Magnesium Oxide 500 mg twice daily were scheduled at 6:00 a.m. R4 received Carvedilol 25 mg at 9:26 a.m. and Magnesium Oxide 500 mg at 9:28 a. m. On 11/5/24 Clonazepam 1 mg three times daily, Pregabalin 100 mg three times daily, Diazepam 2 mg three times daily, Diclofenac Potassium 50 mg two times daily, and Propranolol 10 mg three times daily were scheduled at 8:00 a.m. R4 was administered these medications at 9:26 a.m. On 11/5/24 Magnesium Oxide 500 mg twice daily and Carvedilol 25 mg twice daily were scheduled at 14:00 (2:00 p.m.). R4 received these medications at 17:21 (5:21 p.m.). * On 11/6/24 Carvedilol 25 mg (milligrams) two times a day and Magnesium Oxide 500 mg twice daily were scheduled at 6:00 a.m. R4 received these medications at 9:59 a.m. On 11/6/24 Clonazepam 1 mg three times daily, Pregabalin 100 mg three times daily, Diazepam 2 mg three times daily, Diclofenac Potassium 50 mg two times daily, and Propranolol 10 mg three times daily were scheduled at 8:00 a.m. Pregabalin 100 mg & Clonazepam 1 mg was administered at 9:47 a.m., Propranolol 10 mg & Diclofenac Potassium 50 mg was administered at 9:59 a.m., and & Diazepam 2 mg was administered at 10:02 a.m. * On 11/7/24 Carvedilol 25 mg (milligrams) two times a day and Magnesium Oxide 500 mg twice daily were scheduled at 6:00 a.m. Carvedilol 25 mg was administered at 7:54 a.m. and Magnesium Oxide 500 mg. was administered at 7:55 a.m. * On 11/9/24 Magnesium Oxide 500 mg twice daily and Carvedilol 25 mg twice daily were scheduled at 14:00 (2:00 p.m.). R4 received these medications at 17:46 (5:46 p.m.). On 11/9/24 Diclofenac Potassium 50 mg twice a day, Diazepam 2 mg three times a day, Clonazepam 1 mg three times a day, Pregabalin 100 mg three times a day & Propranolol 10 mg three times a day were scheduled at 16:00 (4:00 p.m.). R4 received Diclofenac Potassium 50 mg, Diazepam 2 mg, Clonazepam 1 mg, & Pregabalin 100 mg were administered at 17:45 (5:45 p.m.) and Carvedilol 25 mg & Propranolol 10 mg were administered at 17:46 (5:46 p.m.). (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	* On 11/10/24 Carvedilol 25 mg (milligrams) two times a day and Magnesium Oxide 500 mg twice daily were scheduled at 6:00 a.m. Carvedilol 25 mg & Magnesium Oxide 500 mg were administered at 7:36 a.m. On 11/10/24 Magnesium Oxide 500 mg twice daily and Carvedilol 25 mg twice daily were scheduled at 14:00 (2:00 p.m.). R4 received these medications at 18:46 (6:46 p.m.). On 11/10/24 Diclofenac Potassium 50 mg twice a day, Diazepam 2 mg three times a day, Clonazepam 1 mg three times a day, Pregabalin 100 mg three times a day & Propranolol 10 mg three times a day were scheduled at 16:00 (4:00 p.m.). R4 received Propranolol 10 mg at 18:46 (6:46 p.m.), Diclofenac Potassium 50 mg at 18:47 (6:47 p.m.), and Diazepam 2 mg, Clonazepam 1 mg, & Pregabalin 100 mg at 18:48 (6:48 p.m.). On 11/10/24 Propranolol 10 mg three times a day, Pregabalin 100 mg three times a day Clonazepam 1 mg three times a day, & Diazepam 2 mg three times were scheduled at 21:00 (9:00 p.m.). R4 received these medications at 22:42 (10:42 p.m.). * On 11/11/24 Magnesium Oxide 500 mg twice daily and Carvedilol 25 mg twice daily were scheduled at 14:00 (2:00 p.m.). R4 received these medications at 15:54 (3:54 p.m.). * On 11/12/24 Magnesium Oxide 500 mg twice daily and Carvedilol 25 mg twice daily were scheduled at 14:00 (2:00 p.m.). R4 received these medications at 19:17 (7:17 p.m.). * On 11/13/24 Carvedilol 25 mg (milligrams) two times a day and Magnesium Oxide 500 mg twice daily were scheduled at 6:00 a.m. R4 received Carvedilol 25 mg at 8:02 a.m. and Magnesium Oxide 500 mg at 8:03 a.m. On 11/13/24 Magnesium Oxide 500 mg twice daily and Carvedilol 25 mg twice daily were scheduled at 14:00 (2:00 p.m.). R4 received these medications at 21:19 (9:19 p.m.). * On 11/14/24 Carvedilol 25 mg (milligrams) two times a day and Magnesium Oxide 500 mg twice daily were scheduled at 6:00 a.m. R4 received these medications at 8:38 a.m. On 11/14/24 Magnesium Oxide 500 mg twice daily and Carvedilol 25 mg twice daily were scheduled at 14:00 (2:00 p.m.). R4 received these medications at 15:47 (3:47 p.m.). * On 11/15/24 Carvedilol 25 mg (milligrams) two times a day and Magnesium Oxide 500 mg twice daily were scheduled at 6:00 a.m. Carvedilol 25 mg was administered at 10:50 a.m. and Magnesium Oxide 500 mg was administered at 10:51 a.m. On 11/15/24 Clonazepam 1 mg three times daily, Pregabalin 100 mg three times daily, Diazepam 2 mg three times daily, Diclofenac Potassium 50 mg two times daily, and Propranolol 10 mg three times daily were scheduled at 8:00 a.m. R4 received these medications at 10:43 a.m. On 11/15/24 Magnesium Oxide 500 mg twice daily and Carvedilol 25 mg twice daily were scheduled at 14:00 (2:00 p.m.). R4 received these medications at 17:28 (5:28 p.m.). (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	* On 11/16/24 Magnesium Oxide 500 mg twice daily and Carvedilol 25 mg twice daily were scheduled at 14:00 (2:00 p.m.). R4 received Carvedilol 25 mg at 15:53 (3:53 p.m.) & Magnesium Oxide 500 mg at 15:54 (3:54 p.m.). * On 11/17/24 Carvedilol 25 mg (milligrams) two times a day and Magnesium Oxide 500 mg twice daily were scheduled at 6:00 a.m. R4 received Carvedilol 25 mg at 7:28 a.m. & Magnesium Oxide 500 mg at 7:29 a.m. On 11/17/24 Magnesium Oxide 500 mg twice daily and Carvedilol 25 mg twice daily were scheduled at 14:00 (2:00 p.m.). R4 received these medications at 15:52 (3:52 p.m.). * On 11/18/24 Carvedilol 25 mg (milligrams) two times a day and Magnesium Oxide 500 mg twice daily were scheduled at 6:00 a.m. R4 received these medications at 7:34 a.m. On 11/18/24 Magnesium Oxide 500 mg twice daily and Carvedilol 25 mg twice daily were scheduled at 14:00 (2:00 p.m.). R4 received Magnesium Oxide 500 mg at 15:53 (3:53 p.m.) & Carvedilol 25 mg at 15:55 (3:55 p.m.). * On 11/19/24 Carvedilol 25 mg (milligrams) two times a day and Magnesium Oxide 500 mg twice daily were scheduled at 6:00 a.m. R4 received these medications at 7:48 a.m. On 11/19/24 Magnesium Oxide 500 mg twice daily and Carvedilol 25 mg twice daily were scheduled at 14:00 (2:00 p.m.). R4 received Magnesium Oxide 500 mg at 16:24 (4:24 p.m.) & Carvedilol 25 mg at 16:27 (4:27 p.m.). On 11/19/24 Propranolol 10 mg three times a day, Pregabalin 100 mg three times a day Clonazepam 1 mg three times a day, & Diazepam 2 mg three times were scheduled at 21:00 (9:00 p.m.). R4 received on 11/20/24 Diazepam 2 mg at 05:10 (5:10 a.m.), Clonazepam 1 mg & Propranolol 10 mg at 05:11 (5:11 a.m.), & Pregabalin 100 mg at 05:12 (5:12 a.m.). * On 11/20/24 Carvedilol 25 mg (milligrams) two times a day and Magnesium Oxide 500 mg twice daily were scheduled at 6:00 a.m. R4 received Carvedilol 25 mg at 8:02 a.m. and Magnesium Oxide 500 mg at 8:03 a.m. Two hours after the scheduled time. On 11/20/24 Magnesium Oxide 500 mg twice daily and Carvedilol 25 mg twice daily were scheduled at 14:00 (2:00 p.m.). R4 received these medications at 18:22 (6:22 p.m.). On 11/20/24 Diclofenac Potassium 50 mg twice a day, Diazepam 2 mg three times a day, Clonazepam 1 mg three times a day, Pregabalin 100 mg three times a day & Propranolol 10 mg three times a day were scheduled at 16:00 (4:00 p.m.). R4 received Diazepam 2 mg & Clonazepam at 18:24 (6:24 p.m.), Pregabalin 100 mg at 18:25 (6:25 p.m.), Propranolol 10 mg at 18:29 (6:29 p.m.), & Diclofenac Potassium 50 mg at 18:22 (6:22 p.m.). On 11/20/24 Propranolol 10 mg three times a day, Pregabalin 100 mg three times a day Clonazepam 1 mg three times a day, & Diazepam 2 mg three times were scheduled at 21:00 (9:00 p.m.). R4 received Clonazepam 1 mg at 23:51 (11:51 p.m.) & Propranolol 10 mg, Pregabalin 100 mg, & Diazepam 2 mg at 23:52 (11:52 p.m.). (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	* On 11/21/24 Carvedilol 25 mg (milligrams) two times a day and Magnesium Oxide 500 mg twice daily were scheduled at 6:00 a.m. R4 received these medications at 8:05 a.m. On 11/21/24 Magnesium Oxide 500 mg twice daily and Carvedilol 25 mg twice daily were scheduled at 14:00 (2:00 p.m.). R4 received these medications at 15:46 (3:46 p.m.). * On 11/22/24 Carvedilol 25 mg (milligrams) two times a day and Magnesium Oxide 500 mg twice daily were scheduled at 6:00 a.m. R4 received Carvedilol 25 mg at 7:55 a.m. and Magnesium Oxide 500 mg at 7:56 a. m. On 11/22/24 Magnesium Oxide 500 mg twice daily and Carvedilol 25 mg twice daily were scheduled at 14:00 (2:00 p.m.). R4 received Carvedilol 25 mg at 16:19 (4:19 p.m.) & Magnesium Oxide 500 mg at 16:20 (4:20 p. m.). * On 11/23/24 Carvedilol 25 mg (milligrams) two times a day and Magnesium Oxide 500 mg twice daily were scheduled at 6:00 a.m. R4 receives these medications at 7:37 a.m. On 11/23/24 Magnesium Oxide 500 mg twice daily and Carvedilol 25 mg twice daily were scheduled at 14:00 (2:00 p.m.). R4 received Carvedilol 25 mg at 18:04 (6:04 p.m.) & Magnesium Oxide 500 mg at 18:05 (6:05 p. m.). On 11/23/24 Diclofenac Potassium 50 mg twice a day, Diazepam 2 mg three times a day, Clonazepam 1 mg three times a day, Pregabalin 100 mg three times a day & Propranolol 10 mg three times a day were scheduled at 16:00 (4:00 p.m.). R4 received Propranolol 10 mg & Diclofenac Potassium 50 mg at 17:58 (5:58 p.m.) and Pregabalin 100 mg, Diazepam 2 mg, & Clonazepam 1 mg at 18:11 (6:11 p.m.). * On 11/24/24 Carvedilol 25 mg (milligrams) two times a day and Magnesium Oxide 500 mg twice daily were scheduled at 6:00 a.m. R4 received these medications at 8:09 a.m. On 11/24/24 Magnesium Oxide 500 mg twice daily and Carvedilol 25 mg twice daily were scheduled at 14:00 (2:00 p.m.). R4 received these medications at 18:22 (6:22 p.m.). On 11/24/24 Diclofenac Potassium 50 mg twice a day, Diazepam 2 mg three times a day, Clonazepam 1 mg three times a day, Pregabalin 100 mg three times a day & Propranolol 10 mg three times a day were scheduled at 16:00 (4:00 p.m.). R4 received Clonazepam 1 mg, Propranolol 10 mg, Pregabalin 100 mg & Diclofenac Potassium 50 mg at 18:22 (6:22 p.m.) and Diazepam 2 mg at 18:24 (6:24 p.m.). * On 11/25/24 Carvedilol 25 mg (milligrams) two times a day and Magnesium Oxide 500 mg twice daily were scheduled at 6:00 a.m. R4 received Carvedilol 25 mg at 8:03 a.m. and Magnesium Oxide 500 mg at 8:04 a. m. On 11/25/24 Magnesium Oxide 500 mg twice daily and Carvedilol 25 mg twice daily were scheduled at 14:00 (2:00 p.m.). R4 received these medications at 21:50 (9:50 p.m.). * On 11/26/24 Magnesium Oxide 500 mg twice daily and Carvedilol 25 mg twice daily were scheduled at 14:00 (2:00 p.m.). R4 received these medications at 17:54 (5:54 p.m.). (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Fort Atkinson Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 430 Wilcox St Fort Atkinson, WI 53538	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/26/24 Diclofenac Potassium 50 mg twice a day, Diazepam 2 mg three times a day, Clonazepam 1 mg three times a day, Pregabalin 100 mg three times a day & Propranolol 10 mg three times a day were scheduled at 16:00 (4:00 p.m.). R4 received Clonazepam 1 mg, Diazepam 2 mg, & Pregabalin 100 mg at 17:53 (5:53 p.m.) and Propranolol 10 mg & Diclofenac Potassium 50 mg at 17:54 (5:54 p.m.). * On 11/27/24 Magnesium Oxide 500 mg twice daily and Carvedilol 25 mg twice daily were scheduled at 14:00 (2:00 p.m.). R4 received these medications at 17:39 (5:39 p.m.). On 11/27/24 Diclofenac Potassium 50 mg twice a day, Diazepam 2 mg three times a day, Clonazepam 1 mg three times a day, Pregabalin 100 mg three times a day & Propranolol 10 mg three times a day were scheduled at 16:00 (4:00 p.m.). R4 received Clonazepam 1 mg at 17:33 (5:33 p.m.), Diazepam 2 mg, Propranolol 10 mg, & Pregabalin 100 mg at 17:35 (5:35 p.m.), and Diclofenac Potassium 50 mg at 17:36 (5:36 p.m.). * On 11/28/24 Carvedilol 25 mg (milligrams) two times a day and Magnesium Oxide 500 mg twice daily were scheduled at 6:00 a.m. R4 received Magnesium Oxide 500 mg at 10:13 a.m. & Carvedilol 25 mg at 10:14 a. m. On 11/28/24 Clonazepam 1 mg three times daily, Pregabalin 100 mg three times daily, Diazepam 2 mg three times daily, Diclofenac Potassium 50 mg two times daily, and Propranolol 10 mg three times daily were scheduled at 8:00 a.m. R4 received Diclofenac Potassium 50 mg at 10:13 a.m., Propranolol 10 mg at 10:14 a.m. and Pregabalin 100 mg, Diazepam 2 mg, & Clonazepam 1 mg at 10:28 a.m. On 11/28/24 Magnesium Oxide 500 mg twice daily and Carvedilol 25 mg twice daily were scheduled at 14:00 (2:00 p.m.). R4 received these medications at 16:29 (4:29 p.m.). * On 11/29/24 Carvedilol 25 mg (milligrams) two times a day and Magnesium Oxide 500 mg twice daily were scheduled at 6:00 a.m. R4 received these medications at 8:28 a.m. On 11/29/24 Magnesium Oxide 500 mg twice daily and Carvedilol 25 mg twice daily were scheduled at 14:00 (2:00 p.m.). R4 received these medications at 17:18 (5:18 p.m.). * On 11/30/24 Carvedilol 25 mg (milligrams) two times a day and Magnesium Oxide 500 mg twice daily were scheduled at 6:00 a.m. R4 received these medications at 7:42 a.m. Surveyor reviewed R4's progress notes including eMAR (electronic medication administration record) notes from 10/27/24 to 11/30/24 and was unable to locate R4's physician was notified of medications being administered late regarding the above dates and times. On 1/6/25, at 7:34 a.m., Surveyor asked Med Tech-W if she administers medication late to a resident and the medication is administered multiple times during the day what would she do. Med Tech-W informed Surveyor she would tell the nurse and the nurse would call the doctor. On 1/6/25, at 9:34 a.m., Surveyor asked RN (Registered Nurse)-L if a resident receives a medication BID/TID (twice a day/three times a day) and is administered late does the resident's doctor need to be notified. RN-L replied yes. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/7/25, at 9:11 a.m. Surveyor asked LPN (Licensed Practical Nurse)-E if a residents medication is administered late and is given two or three times a day does the doctor need to be notified. LPN-E informed Surveyor have to call the doctor. On 1/7/25, at 1:21 p.m., Surveyor asked LPN/UM (Licensed Practical Nurse/Unit Manager)-F if medications are administered late should the resident's physician be notified. LPN/UM-F informed Surveyor must notify the doctor and power of attorney. Surveyor asked if the notification is documented in either an eMAR or progress note. LPN/UM-F replied yes. On 1/7/25, at 3:46 p.m. NHA (Nursing Home Administrator)-A and DON (Director of Nursing)-B were informed of the above. No information was provided to Surveyor as to why R4's physician was not notified of R4's medication being administered late. 2.) R3 was admitted to the facility on [DATE] and discharged on [DATE]. R3 was reviewed as a closed record. R3's diagnoses includes diabetes mellitus, congestive heart failure, peripheral vascular disease, anxiety disorder, depression, chronic kidney disease, and hypertension. On 9/7/24 Gentamicin Sulfate Ophthalmic solution twice daily was scheduled at 6:00 a.m. R3 received this eye drop at 8:43 a.m. On 9/7/24 Bumetanide 1 mg three times daily and Midodrine 10 mg three times daily were scheduled at 7:00 a.m. R3 received Midodrine 10 mg at 8:38 a.m. and Bumetanide 1 mg at 8:44 a.m. On 9/7/24 Insulin Aspart 8 units, Insulin Aspart sliding scale, and Lantus SoloStar 30 units were scheduled at 11:00 a.m. R3 received these insulins at 12:57 p.m. On 9/7/24 Gentamicin Sulfate Ophthalmic Solution twice daily was scheduled at 14:00 (2:00 p.m.) R3 received these eye drops at 20:21 (8:21 p.m.). On 9/7/24 Insulin Aspart 8 units and Insulin Aspart sliding scale was scheduled at 5:00 p.m. R3 received these insulins at 20:21 (8:21 p.m.). On 9/7/24 Apixaban 5 mg twice daily, Bumetanide 1 mg three times daily, and Midodrine 10 mg three times daily was scheduled at 5:00 p.m. R3 received Bumetanide 1 mg & Midodrine 10 mg at 20:20 (8:20 p.m.) and Apixaban 5 mg at 20:21 (8:21 p.m.). On 9/8/24 Gentamicin Sulfate Ophthalmic solution twice daily was scheduled at 6:00 a.m. R3 received the eye drops at 8:39 a.m. On 9/8/24 Bumetanide 1 mg three times daily and Midodrine 10 mg three times were scheduled at 7:00 a.m. R3 received these medications at 8:40 a.m. On 9/8/24 Insulin Aspart 8 units, Insulin Aspart sliding scale, and Lantus SoloStar 30 units were scheduled at 11:00 a.m. R3 received Lantus SoloStar 30 units at 12:57 p.m. and Insulin Aspart 8 units & sliding scale at 12:58 p.m. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fort Atkinson Care Center	430 Wilcox St Fort Atkinson, WI 53538

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/8/24 Gentamicin Sulfate Ophthalmic Solution twice daily was scheduled at 14:00 (2:00 p.m.) R3 received these eye drops at 18:03 (6:03 p.m.). On 9/8/24 Lantus SoloStar 30 units was scheduled at 23:00 (11:00 p.m.). R3 received this insulin at 12:41 a.m. On 11/1/24 Bumetanide 1 mg three times daily, & Midodrine 10 mg were scheduled at 7:00 a.m. R3 Bumetanide 1 mg at 8:40 a.m. & Midodrine 10 mg at 8:52 a.m. On 11/1/24 Insulin Aspart 8 units scheduled & sliding scale and Lantus SoloStar insulin 30 units are scheduled at 11:00 a.m. R3 received Insulin Aspart 8 units scheduled & sliding scale at 13:02 (1:02 p.m.) and Lantus SoloStar 30 units at 13:03 (1:03 p.m.). On 11/3/24 Insulin Aspart 8 units scheduled & sliding scale, Bumetanide 1 mg three times daily, & Midodrine 10 mg three times daily were scheduled at 7:00 a.m. R3 received Insulin Aspart 8 units, Insulin Aspart sliding scale insulin & Bumetanide 1 mg at 8:49 a.m. and Midodrine 10 mg at 8:50 a.m. On 11/4/24 Insulin Aspart 8 units scheduled & sliding scale, Bumetanide 1 mg three times daily, & Midodrine 10 three times daily mg were scheduled at 7:00 a.m. R3 received Midodrine 10 mg at 8:39 a.m. and Insulin Aspart 8 units scheduled & sliding scale & Bumetanide 1 mg at 8:40 a.m. On 11/5/24 Insulin Aspart 8 units scheduled & sliding scale and Lantus SoloStar insulin 30 units are scheduled at 11:00 a.m. R3 received Insulin Aspart 8 units scheduled & sliding scale and Lantus SoloStar insulin 30 units at 15:44 (3:44 p.m.). On 11/5/24 Midodrine 10 mg three times daily and Bumetanide 1 mg three times daily are scheduled at 12:00 p.m. R3 received Midodrine 10 mg at 15:43 (3:43 p.m.) & Bumetanide 1 mg at 15:44 (3:44 p.m.). On 11/6/24 Insulin Aspart 8 units was scheduled at 7:00 a.m. R3 received Insulin Aspart 8 units at 10:04 a.m. On 11/7/24 Insulin Aspart sliding scale, Insulin Aspart 8 units, Bumetanide 1 mg, & Midodrine 10 mg were scheduled at 7:00 a.m. R3 received Bumetanide 1 mg at 8:32 a.m., Midodrine 10 mg at 8:45 a.m. sliding scale Insulin Aspart at 8:50 a.m., and Insulin Aspart 8 units scheduled at 13:45 (1:45 p.m.). On 11/7/24 Insulin Aspart 8 units scheduled & sliding scale and Lantus SoloStar insulin 30 units are scheduled at 11:00 a.m. R3 received Insulin Aspart 8 units at 12:51 p.m., Insulin Aspart sliding scale & Lantus SoloStar 30 units at 13:51 (1:51 p.m.). On 11/7/24 Bumetanide 1 mg three times daily is scheduled at 12:00 p.m. R3 received this medication at 13:51 (1:51 p.m.). On 11/11/24 Midodrine 10 mg three times daily and Bumetanide 1 mg three times daily were scheduled at 7:00 a.m. R3 received Midodrine 10 mg at 8:57 a.m. & Bumetanide 1 mg at 8:58 a.m. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Fort Atkinson Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 430 Wilcox St Fort Atkinson, WI 53538	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/6/25, at 7:34 a.m., Surveyor asked Med Tech-W if she administers medication late to a resident and the medication is administered multiple times during the day what would she do. Med Tech-W informed Surveyor she would tell the nurse and the nurse would call the doctor. On 1/6/25, at 9:34 a.m., Surveyor asked RN (Registered Nurse)-L if a resident receives a medication BID/TID (twice a day/three times a day) and is administered late does the resident's doctor need to be notified. RN-L replied yes. On 1/7/25, at 9:11 a.m. Surveyor asked LPN (Licensed Practical Nurse)-E if a residents medication is administered late and is given two or three times a day does the doctor need to be notified. LPN-E informed Surveyor have to call the doctor. On 1/7/25, at 1:21 p.m., Surveyor asked LPN/UM (Licensed Practical Nurse/Unit Manager)-F if medications are administered late should the resident's physician be notified. LPN/UM-F informed Surveyor must notify the doctor and power of attorney. Surveyor asked if the notification is documented in either an eMAR or progress note. LPN/UM-F replied yes. On 1/7/25, at 3:46 p.m. NHA (Nursing Home Administrator)-A and DON (Director of Nursing)-B were informed of the above. No information was provided to Surveyor as to why R4's physician was not notified of R3's medication being administered late.

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F 0584

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

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.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 49435

Based on observation, interview, and record review, the facility did not ensure the residents environment was comfortable and homelike. The heating unit that supplied heat to the north side of the facility was not fully operational and did not maintain a comfortable, homelike environment with comfortable living temperatures for residents. This has the potential to affect the 14 residents who were residing in the north hallway of the facility when the heating unit went down on 11/21/24.

*Temperatures in the north hallway of the facility were below 71 degrees Fahrenheit. This affected resident rooms, hallways, and a common area on the north side of the building.

Findings include:

The facility's policy entitled, Safe and Homelike environment, dated 3/1/20, documents, in part: In accordance with residents rights, the facility will provide a safe, clean, comfortable and homelike environment . Definitions: . Comfortable and safe temperature levels means that the ambient temperature should be in a relatively narrow range that minimizes residents to loss of body heat and risk of hypothermia/hyperthermia and is comfortable for the residents . The facility will maintain comfortable and safe temperature levels. The facility should strive to keep the temperature in common resident areas between 71 and 81 degrees Fahrenheit. If and when a resident prefers his or her room temperature to be kept below 71 degrees Fahrenheit, or above 81 degrees Fahrenheit, the facility will assess the safety of this practice on the resident and the resident's roommate .

The facility's undated Emergency Operations Program and Plan Manual documents, in part, Extreme Weather-Heat or Cold. It is the policy of this facility to protect our residents, staff and others who may be in our facility from harm during emergency events . The priority of this facility to minimize the stress our residents could experience from extreme temperatures related to weather events. To mitigate this risk, we rigorously maintain our systems of heating, ventilation and air conditioning and generator .

On 1/6/25 at 8:00 AM, Surveyor toured the facility hallways. Surveyor noted a cooler air temperature starting on the corner of the east and north hallways. Surveyor observed a thermostat on the corner of the east and north hallway. The thermostat read 69 degrees Fahrenheit and was set to 78 degrees Fahrenheit.

On 1/6/25 at 10:55 AM, Surveyor interviewed Maintenance Director (MD)-I about the cooler temperature noted in the north hallway. MD-I stated that one of the furnaces on the roof went down. Surveyor asked when the issue with the heating unit started. MD-I stated MD-I could not recall the exact date but thought it was early in December. MD-I stated that MD-I had ordered parts and installed parts but could not recall the exact dates. MD-I stated that the heat was working but not all they way. MD-I stated some residents on the north hallway moved to an area of the building where the heat is functioning but the residents that are currently on the north hallway had refused to move from their rooms. Surveyor asked how often the temperatures on the north unit are checked. MD-I stated multiple times a day. Surveyor asked what the coldest recorded temperature was since the heating unit went down. MD-I stated 68- or 69-degrees Fahrenheit.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The comfortable air temperature in a facility range is 71 degrees Fahrenheit to 81 degrees Fahrenheit. Surveyor noted that the facility had a total of 7 residents residing in rooms on the north hallway. On 1/6/25 at 3:15 PM, Surveyor and MD-I took temperatures of the north hallway and resident rooms together. The temperatures were taken with MD-I's ultraviolet scanner with a laser. The laser was pointed at a surface within the resident's room or on a wall. The temperatures were: -The front of the north hallway was 68 degrees Fahrenheit. -room [ROOM NUMBER] occupied by R17 was 65 degrees Fahrenheit. -room [ROOM NUMBER] occupied by R18 was 64 degrees Fahrenheit. -room [ROOM NUMBER] occupied by R19 was 62 degrees Fahrenheit. -The activity room located in the middle of the North hallway was 61 degrees. -room [ROOM NUMBER] occupied by R1 was 62 degrees Fahrenheit. -room [ROOM NUMBER] occupied by R20 was 59 degrees Fahrenheit. -room [ROOM NUMBER] occupied by R12 was 64 degrees Fahrenheit. -room [ROOM NUMBER] occupied by R21 was 62 degrees Fahrenheit. -The end of the north hallway was 62 degrees Fahrenheit. On 1/6/25 at 12:28 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A. Surveyor asked if NHA-A was aware of the facilities heating issues that have been going on for over a month. NHA-A stated NHA-A had not heard that but will look into it and get back to Surveyor. NHA-A returned to Surveyor at 1:08 PM and handed a Performance Improvement Plan (PIP) to Surveyor. NHA-A stated that the previous Administrator had started a PIP for the issue with the heat. NHA-A indicated that a commercial heating company would be coming tomorrow to assess to try to fix the issue with the heating unit. Surveyor reviewed the PIP dated 11/21/24 which documents, in part: Project overview: .Residents have the right to safe, clean, comfortable and homelike environment . -11/21/24: The heater broke down and maintenance attempted to troubleshoot the heater. -11/22/24: Regional Director of Maintenance came to troubleshoot the heating system. -11/23/24: Relay and overload parts were ordered for the heater. -11/23/24: Extra Blankets were offered; residents are encouraged to keep their doors open. Encouraged residents to move. One resident moved. I will continue to offer to move residents every day. I will check on comfort during caring partners. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-11/26/24: Parts delivered and installed. The heater kicked on, but the rooms and common areas were still cooler. Temps averaging 68-70 degrees Fahrenheit. -12/2/24: The room was still cold; the contractor came in to assess and the module went bad. The part was ordered. The flame sensor and igniter rod were also ordered. Residents offered to move rooms and are still refusing. -12/5/24: Temperatures dropped outside causing areas to get colder . Temps averaging 62-68 degrees Fahrenheit. 6 residents moved rooms. -12/10/24: Continue to offer room moves, Blankets and daily room temps . -12/11/24: Room-to-room visits requesting the remaining residents move. They all refused. Message left for Ombudsman. Caring Partner sheets updated. -12/12/24: No suggestions from ombudsman. We can't make them move, just continue current approaches. -12/16/24: Parts were ordered and due in today. Arrival pending. Building warmer. Surveyor reviewed an invoice from [local residential heating company], dated 12/3/24, which documents: On arrival northeast Greenheck unit would not heat. Wiring for heating control not wired properly. No wiring diagrams. Referred client to a commercial HVAC contractor. Was able to get heat working temporarily. On 1/7/25 at 8:44 AM, Surveyor interviewed MD-I regarding the PIP timeline provided to Surveyor. MD-I informed Surveyor that the same heating unit has had multiple issues throughout the time from 11/21/24 to present. Surveyor asked if MD-I was taking temperatures of the north hallway while the heating unit was not fully functional. MD-I stated that he logged temps and would get a copy for Surveyor. MD-I stated MD-I and the Regional Director of Maintenance were able to get the heating somewhat functional after installing parts on 11/26/24. On 12/2/24 when the module went bad, MD-I called [local residential heating company] for help. MD-I was told he needed to get a commercial HVAC contractor. MD-I then called around to commercial HVAC contractors, but multiple contractors were not able to come out. MD-I stated that a local commercial HVAC company agreed to come out. The techs arrived on 12/11/24. MD-I stated that two techs went up to the roof, looked at the unit and returned to MD-I to tell MD-I that they would not be able to service the unit. MD-I then reached out to the regional director and the regional director found a commercial HVAC contractor to come out to service the unit. On 12/12/24, the commercial HVAC company arrived at the facility and stated that the control module was faulty. A new control module was ordered. On 12/16/24, MD-I installed new control module and MD-I stated the heating unit did kick on. MD-I stated that the building did get warmer and at one point MD-I was asked to turn the heat down because the heat was too much. MD-I stated the unit had a new issue that appeared this last weekend. MD-I stated he called the commercial HVAC company on 1/3/25 and 1/5/25 to come service the unit. MD-I was told that the HVAC company would come on 1/6/24 but then on 1/6/24 the tech got stuck in a different city and was unable to come. MD-I stated that a tech is coming out tomorrow (1/7/24). (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Surveyor reviewed the temperature logs provided by MD-I. The logs include an AM and PM temperature taken in the north hallway of the facility. The following dates are the when the temperature readings were below 71 degrees Fahrenheit: -From the AM temperature reading on 11/21/24 through AM temperature reading on 11/26/24, the temperatures ranged from 67 to 70 degrees Fahrenheit. Surveyor noted that the temperatures were below 71 degrees for five and a half days. -From the AM temperature reading on 12/2/24 through the PM temperature reading on 12/3/24, the temperatures ranged from 66 to 68 degrees Fahrenheit. Surveyor noted that the temperatures were below 71 degrees for 2 days. -From the AM temperature reading on 1/2/25 through the PM temperature reading on 1/7/25, the temperatures ranged from 65 to 70 degrees Fahrenheit. Surveyor noted that the temperatures were below 71 degrees for 6 days. Surveyor observed and interviewed residents residing in rooms on the north hallway: On 1/6/25 at 1:35 PM, Surveyor interviewed R17 who resides in room [ROOM NUMBER] on the north hallway. R17 stated that in the morning temp in the room can be chilly. R17 stated that R17 has been in other rooms in the hallway and R17's room now is better than others. R17 stated room [ROOM NUMBER] was really cold. R17 stated R17 was offered a different room but did not want to move. R17 was told by the facility that the move would be temporary, and that heat would be fixed between the 21st and 28th of December. Surveyor asked if R17 would move to another room if able. R17 stated that R17 did not want to move. Surveyor noted that R17 had a covering over R17's head and multiple blankets on bed. On 1/6/25 at 1:39 PM, R18 was observed sleeping under multiple blankets in room [ROOM NUMBER] on the north hallway. On 1/7/25 at 7:46 AM, Surveyor interviewed R18. R18 was wearing sweatpants and sweatshirt. Surveyor asked about the temperature of R18's room. R18 shrugged his shoulders. Surveyor asked R18 was comfortable. R18 shook R18's head yes. Surveyor asked if R18 would like to change rooms, R18 said R18 wanted to go to breakfast. On 1/6/25 at 1:35 PM, Surveyor observed R19, who resides in room [ROOM NUMBER] on the north hallway, being approached by the maintenance director to move to a different room. R19 indicated that R19 did not want to move rooms. Surveyor observed R19 with long sleeved shirt and pants. On 1/7/25 at 11:18 AM, R19 told Surveyor R19 was comfortable and had no complaints. On 1/7/25 at 11:19 AM, R1, who resides in room [ROOM NUMBER] on the north hallway, informed Surveyor that R1 had no complaints. R1 was observed under the bed comforter resting in bed. On 1/7/24 at 7:50 AM, Surveyor interviewed R20, who resides in room [ROOM NUMBER] on the north hallway, about R20's room temperature. R20 stated that R20 grew up in an old house and was used to cool temperatures in the house. R20 stated R20 had enough blankets. R20 stated that the facility staff have asked multiple times to move R20 to another room. R20 stated that R20 does not want to move. Surveyor noted R20 was wearing a T-shirt and had a blanket over his lap. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Fort Atkinson Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 430 Wilcox St Fort Atkinson, WI 53538	

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/7/25 at 11:22 AM, R12, who resides in room [ROOM NUMBER] on the north hallway, informed Surveyor that R12 had no complaints. R12 stated that R12 was comfortable. On 1/6/25 at 9:32 AM, Surveyor interviewed R21 who resides in room [ROOM NUMBER] on the north hallway. R21 stated that it can get cold. R21 stated R21 sleeps with mittens on at night. R21 stated that R21 likes the temp cool but not cold like it is now. Surveyor asked if R21 wanted a different room. R21 did not answer the question. Surveyor asked if R21 was offered blankets. Resident stated they are offered but R21 wears mittens instead and is fine with the gloves instead. On 1/7/25 at 8:09 AM, Surveyor noted R21 was wearing gloves and R21 stated that R21 was cold. R21 was wearing a sweater and had a blanket over R21's lap. Surveyor interviewed facility staff about the heating and residents located on the north side of the building: On 1/2/25 at 11:18 AM, Surveyor interviewed Certified Nursing Assistant (CNA)-J. CNA-J stated CNA-J couldn't remember exactly when but stated that the heat did go out in half of the building. The north side residents were given the choice to move. Seven residents decided to stay on the north side. Surveyor asked if there were enough blankets. CNA-J stated that they had enough, and staff brought out a new supply from laundry to ensure that residents had enough blankets. On 1/6/25 at 3:55 PM, Surveyor interviewed Licensed Practical Nurse (LPN)-K who works the PM and Night shift at the facility. LPN-K stated that heat stopped working around Thanksgiving time. LPN-K stated that residents that are still on the north side just won't move. Surveyor asked if extra monitoring is being completed. LPN-K stated that LPN-K checks in with residents on the north side frequently. LPN-K stated that staff offer extra blankets for all residents who are on the north side especially at the beginning of the night shift to make sure that they are comfortable. LPN-K stated that the residents on the north side are ok. On 1/2/25 at 11:01 AM, Surveyor interviewed Registered Nurse (RN)-R. RN-R stated that the north side of the building has been cooler, and the south side had heat. RN-R stated that the heat stopped working on the north side some time in November or December. RN-R stated that the facility never ran out of blankets. RN-R stated that they moved residents to the south side when the heat went out, but some residents chose to stay on the north side. On 1/6/25 at 3:40 PM Surveyor interviewed Director of Nursing (DON)-B. Surveyor asked when DON-B was made aware of the heating issue in the building. DON-B stated that DON-B was aware when she first started at this facility on December 21st or 22nd. DON-B stated that MD-I was taking temperature readings and that she expected them to be completed daily. DON-B stated that if the temperature was to go below 60 degrees Fahrenheit, the residents would have to be moved. DON-B stated that a question was added to their Caring partner sheets to address the temperature in a resident's room and ask if the resident is comfortable. Surveyor asked what Caring partners were. DON-B stated that the IDT team will do daily rounding with each resident and address any concerns. On 1/7/24 at 7:30 AM, Surveyor observed a commercial HVAC company van parked in the facility parking lot and a HVAC technician on the roof of the facility. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/7/25 at 10:35 AM, Surveyor interviewed NHA-A and DON-B. NHA-A stated that [R20] who resides in room [ROOM NUMBER] was encouraged to move last night because the temperature of the room was too low. [R20] refused. NHA-A stated that the risks were explained to [R20] and [R20] still did not want to move. NHA-A stated that in addition to the commercial HVAC company trying to fix the roof heating unit, the regional director of maintenance was going to come and try to fix the boiler system so that the wall radiator heat would function better. DON-B and NHA-A stated that the heat was functioning from 12/16/24 until this last weekend. NHA-A stated that the commercial HVAC company has ordered a part today to fix the heating unit, but they are unsure when the part will arrive. NHA-A stated that the facility had reached out to the Ombudsman to see how to handle the residents that still do not want to move. On 1/7/24 at 11:15 AM, Surveyor and MD-I took temperatures of the north hallway resident rooms together. -room [ROOM NUMBER] occupied by R17 was 63 degrees Fahrenheit. -room [ROOM NUMBER] occupied by R18 was 61 degrees Fahrenheit. -room [ROOM NUMBER] occupied by R19 was 60 degrees Fahrenheit. -room [ROOM NUMBER] occupied by R1 was 59 degrees Fahrenheit. -room [ROOM NUMBER] occupied by R20 was 57 degrees Fahrenheit. -room [ROOM NUMBER] occupied by R12 was 61 degrees Fahrenheit. -room [ROOM NUMBER] occupied by R21 was 59 degrees Fahrenheit. On 1/7/24 at 1:00 PM, DON-B informed surveyor that the facility had made the decision to shut down the north wing until the heating unit is fixed. DON-B stated that the facility is moving residents to rooms where the heat is functioning properly. On 1/8/24 at 10:42 AM, Surveyor observed NHA-A touring the north hallway with the local Fire department. Surveyor heard NHA-A tell the fire department that the part for the heater should arrive in 2 to 3 days. Surveyor observed all resident rooms to be empty on the north side of the building. On 1/8/24 at 10:50 AM, DON-B informed surveyor that after the 16th of December until 1/2/25, the heating unit was functioning and kept the temperature around 74- or 75-degrees Fahrenheit. The heat was maintained until 1/2/25 and that is when MD-I contacted the commercial HVAC company. The commercial HVAC company told the facility that a technician would come on Monday, 1/6/25. On Monday, 1/6/25, the technician who was supposed to come to the facility was unable to arrive and that is why they came to the facility on [DATE]. DON-B confirmed that the part ordered on 1/7/25 and should arrive in 2 to 3 days. DON-B stated because they do not know when the unit will be fully functional, Residents will remain out of the north side of the building until it is fixed. On 1/8/24 at 12:57 PM, NHA-A and DON-B were informed of the concerns that the heating unit that feeds the north side of the building has been intermittently functioning since 11/21/24 and temperatures were not always maintained between 71- and 81-degrees Fahrenheit. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	No additional information was provided.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49435 Based on interviews and record review, the facility did not ensure a resident-to-resident altercation was thoroughly investigated for 2 (R14 and R15) of 4 residents reviewed for an allegation of abuse. *R14 and R15's Facility Reported Incident (FRI) dated 12/24/24 documents R15 was in a wheelchair in the middle of the hallway. R14 was trying to get by R15 in his wheelchair but was unsuccessful. R15 became upset that R14 was not moving fast enough and kicked R14 in the left shin. The FRI does not contain statements from other residents to determine if other residents feel safe or if other residents have had interactions with R15. The FRI does not contain staff statements that speak to R14 and R15's pattern of behavior/agitation prior to the Resident-to-Resident altercation. Education was not provided to staff after the altercation to prevent future Resident-to-Resident altercations. Findings include: The undated facility policy entitled, Abuse/Neglect/Exploitation, documents, in part: It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property . An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur. Written procedures for investigations include: Identifying staff responsible for the investigation . Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations; Focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent and cause; and Providing complete and thorough documentation of the investigation . Taking all necessary actions as a result of the investigation, which may include, but are not limited, to the following: Analyzing the occurrence(s) to determine why abuse, neglect, misappropriation of resident property or exploitation occurred, and what changes are needed to prevent further occurrences . Training of staff on changes made and demonstration of staff competency after training is implemented . 1.) R14 was admitted to the facility on [DATE] with diagnosis that include cognitive communication deficit and muscle weakness. R14's Quarterly Minimum Data Set (MDS) assessment dated [DATE] documents a Brief Interview for Mental Status (BIMS) score of 10, indicating Moderate Cognitive Impairment. R15 was admitted to the facility on [DATE] with diagnosis that include Traumatic Brain Injury, Muscle weakness, Cognitive communication deficit, Anxiety, and Schizophrenia. R15's Quarterly MDS assessment dated [DATE] documents a BIMS score of 00, indicating Severe Cognitive Impairment. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor reviewed the Facility's FRI regarding a Resident-to-Resident altercation that occurred on 12/24/24. The FRI documents: On 12/24/24 [R15] was in the middle of the hallway. [R14] was trying to self-propel his wheelchair around [R15]. [R14] was unsuccessful. [R15] then became upset as [R14] was not moving fast enough and kicked [R14] in the left shin. The FRI included one staff statement from Certified Nursing Assistant (CNA)-H which documents: 1:20 PM, [R15] was in the middle of the hallway. R14 tried to push him out of the way and R15 yelled and kicked [R14] in the leg. Surveyor noted that CNA-H's statement did not include R14 and R15's mood or behaviors earlier in the day. The FRI included the following statement from Interim Nursing Home Administrator (iNHA)-N regarding staff interviews: Staff interviewed; however, no other staff saw the incident at the time besides the enclosed statement from [CNA-H]. They heard about the incident and are aware that both residents remain on behavior monitoring/charting. Surveyor noted that no other staff statements were collected to address R14 and R15's mood or behaviors earlier in the day. The FRI did not include any statements or interviews of other residents living in the facility to determine if other resident's felt safe or if other resident's have had negative interactions with R15. The FRI did not include any documentation of education completed to prevent further potential abuse in the facility. On 1/7/25 at 1:30 PM, Surveyor interviewed CNA-H. CNA-H confirmed that CNA-H written statement in the FRI was correct. CNA-H stated that CNA-H yelled, stop and immediately separated R14 and R15, informed Licensed Practical Nurse (LPN)-E and filled out an incident report. Surveyor asked how R15 was behaving earlier in the day. CNA-H stated that R15 has never had any issues with R14 in the past and R15 did not display any concerning behaviors prior to the incident in the hallway. On 1/7/25 at 1:40 PM, Surveyor interviewed LPN-E. LPN-E stated that LPN-E heard of the altercation between R14 and R15 from CNA-H. LPN-E stated that LPN-E interviewed both residents and concluded that R15 was frustrated with how slow R14 was moving and that is why R15 kicked R14. LPN-E stated that LPN-E made sure both residents were separated and safe. LPN-E assessed both residents. LPN-E notified the Director of Nursing, Nursing Home Administrator, the resident's doctors, the resident's families as well as the police. Surveyor asked if R14 and R15 had any previous resident-to-resident interactions. LPN-E stated that R14 and R15 had never had an altercation like this in the past. Surveyor asked if R14 or R15 were acting any different earlier in the day. LPN-E stated that LPN-E could not recall anything out of the ordinary for R14 and R15 on the day of the interaction. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/8/25 at 12:38 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A. Surveyor asked what NHA-A would include in an investigation of resident-to-resident abuse. NHA-A stated that NHA-A would make sure that the residents and staff were safe first. NHA-A would make sure appropriate medical care was given to the residents. NHA-A would make a report to the State Agency and start an investigation that would include things like: witness statements, questionnaires for residents and staff to complete, and education. Surveyor informed NHA-A of the concerns that statements from other residents were not included in the FRI about R14 and R15's resident-to-resident altercation and that no education was completed after the altercation. NHA-A indicated that NHA-A was not the acting Administrator at the time of the altercation but stated that NHA-A would look to see if there was any other information to provide to Surveyor. No other information was provided as to why, the facility did not ensure a Resident-to-Resident altercation was thoroughly investigated.

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20483 Based on interview and record review, the facility did not ensure residents received treatment and care in accordance with professional standards of practice (N6, Wisconsin Nurse Practice Act) for 4 (R5, R3, R10, and R13) of 21 sample Residents. On [DATE], R5 experienced a seizure, which was a change of condition for R5, as R5 had not a seizure previously. The facility did not ensure that R5 was assessed to determine the etiology of the seizure, did not develop a seizure care plan and did not monitor R5 closely for seizures. R5 experienced another seizure on [DATE]. Following a seizure on [DATE], Lorazepam 0.5 mg every two hours as needed for seizure activity was ordered. This order was not picked up until [DATE]. On [DATE], R5 received an order for Levetiracetam, an anti-convulsant medication. R5 did not start receiving this medication until [DATE], which was two days after it was ordered. R5 continued to have seizures on [DATE], [DATE], and [DATE]. R5 did not receive Lorazepam every two hours as needed for seizure activity as there was not a signature on the prescription from the provider and the pharmacy did not send this medication. On [DATE], R5 was transferred to the hospital due to seizure activity and medications not being available. R5 continued to have seizures in the ER (emergency room) on [DATE] and on [DATE] in the hospital R5 was comatose & did not respond to verbal or tactile stimuli. R5 expired in the hospital on [DATE]. The facility did not provide treatment and care in accordance with professional standards for R5, who had a change in condition (seizures) with new medication orders, by failing to provide the following: - The facility did not ensure R5 was assessed to determine the etiology of the change of condition (seizure) - The facility did not process the new medication orders for R5 - The facility did not ensure that R5 received the medications as ordered - The facility did not monitor R5 for seizure activity as ordered - The facility did not implement a care plan with interventions to manage seizure activities - The facility did not monitor any interventions for R5 to prevent seizures and provide safety The facility's failure to implement the above created a finding of Immediate Jeopardy (IJ) which began on [DATE]. NHA (Nursing Home Administrator)-A and DON (Director of Nursing)-B were notified of the immediate jeopardy on [DATE] at 3:36 p.m. The immediate jeopardy was removed on [DATE]. The deficient practice continues at a scope and severity of D (potential for harm/isolated) related to the examples of R3, R10, and R13 and as the facility continues to implement its action plan. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	* R3's Midodrine 10 mg physician order instructs staff to hold the medication if R3's systolic blood pressure is greater than 130. R3 received Midodrine 10 mg even though the systolic blood pressure was greater than 130 on [DATE] at 12:00 p.m., [DATE] at 7:00 a.m. and 12:00 p.m., [DATE] at 7:00 a.m., [DATE], [DATE], and [DATE] at 5:00 p.m., [DATE] at 7:00 a.m. and 5:00 p.m., [DATE] at 5:00 p.m., [DATE] at 7:00 a.m. and 12:00 p.m., and [DATE] at 7:00 a.m. * R10 had a Medical Doctor (MD) order to check R10's heart rate 3 times a day and notify the MD if R10's heart rate was lower than 45 beats per minute. The facility did not always document a heart rate 3 times a day per MD order. * R13 has an active physician order indicating that R13 had an area of Moisture Associated Skin Damage (MASD) on R13's left thigh that developed in February of 2024. Facility staff initially assessed the area as MASD and was actively treating the area with zinc two times a day. The facility did not complete weekly wound assessments of the area to determine if the area was improving or worsening. On [DATE], R13 informed Surveyor that R13's has had a skin issue off and on for months and that R13's skin had opened again. On [DATE], Director of Nursing (DON)-B informed surveyor that the open area looked more like a skin tear from R13's incontinence brief. On [DATE], the facility wound MD diagnosed a stage 2 pressure injury to R13's left thigh. * R13 had an MD order placed on [DATE] alerting staff to make an appointment for R13 to see a surgeon regarding R13's hernia. The facility did not follow through with making an appointment with a surgeon until Surveyor brought it to the facility's attention on [DATE]. Findings include: The facility policy titled, Notification of Changes Policy, and implemented [DATE] 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. Nurses and other care staff are educated to identify changes in a resident's status and define changes that require notification of the resident and/or their representative, and the resident's physician, to ensure best outcomes of care for the resident. According to the Wisconsin Nurse Practice Act, N6.03(1), An R.N. (Registered Nurse) shall utilize the nursing process in the execution of general nursing procedures in the maintenance of health, prevention of illness or care of the ill. The nursing process consists of the steps of assessment, planning, intervention, and evaluation. This standard is met through performance of each of the following steps of the nursing process: (a) Assessment. Assessment is the systematic and continual collection and analysis of data about the health status of a patient culminating in the formulation of a nursing diagnosis. (b) Planning. Planning is developing a nursing plan of care for a patient which includes goals and priorities derived from the nursing diagnosis. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	(c) Intervention. Intervention is the nursing action to implement the plan of care by directly administering care or by directing and supervising nursing acts delegated to L.P.N.s (Licensed Practical Nurse) or less skilled assistants. (d) Evaluation. Evaluation is the determination of a patient's progress or lack of progress toward goal achievement which may lead to modification of the nursing diagnosis. According to N6.04(1), In the performance of acts in basic patient situations, the L.P.N. shall, under the general supervision of an R.N. or the direction of a provider . (b) Provide basic nursing care. (c) Record nursing care given and report to the appropriate person changes in the condition of a patient . (e) Perform the following other acts when applicable: 1. Assist with the collection of data. 2. Assist with the development and revision of a nursing care plan. 3. Reinforce the teaching provided by an R.N. provider and provide basic health care instruction. 4. Participate with other health team members in meeting basic patient needs. According to [NAME] Hopkin's Medicine, Evaluation of a First-Time Seizure, The goal of treatment is to control, stop, or reduce how often seizures occur. Treatment is most often done with medicine. There are many types of medicines used to treat epilepsy. Your healthcare provider will need to identify the type of seizure you are having. Medicines are selected based on the type of seizure, age of the person, side effects, cost, and ease of use . It is important to take your medicine on time and as prescribed by your doctor. 1.) R5 was originally admitted to the facility on [DATE] with diagnoses that included osteomyelitis, diabetes mellitus, MRSA (methicillin resistant staphylococcus aureus), PVD (peripheral vascular disease), chronic kidney disease, hypertension, Atrial Fibrillation, acute embolism and thrombosis of unspecified deep veins of lower extremities and necrotizing diabetic foot infection. On [DATE], R5 was transferred to the hospital and returned to the facility on [DATE] and begun hospice services. The significant change MDS (minimum data set) with an assessment reference date of [DATE], documents a BIMS (Brief Interview for Mental Status) score of 10, indicating moderate cognitive impairment for R5. R5 is assessed as being dependent for toileting hygiene & chair/bed to chair transfer, and partial/moderate assistance for rolling left and right. R5 is assessed as frequently incontinent of urine and bowel. The cognitive loss/dementia & functional abilities (self care and mobility) CAA (care area assessment) both dated [DATE] were triggered but all the sections are blank and have not been completed. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The hospital discharge summary dated [DATE] documents under final diagnosis section: 1. Diabetic foot ulcer with osteomyelitis. 2. Necrotizing soft tissue infection. 3. Insulin requiring or dependent type II diabetes mellitus. 4. PVD (peripheral vascular disease). 5. Phalanges fracture foot. 6. Hypertension. 7. Hyperlipidemia. 8. Chronic kidney disease. 9. Gastro-esophageal reflux disease without esophagitis. 10. Depression The hospice note dated [DATE] at 11:30 a.m. documents: focused visit performed d/t (due to): unresponsive episode. Staff greeted writer and shoed writer to Pt (patient) room. Pt was in bed upon arrival and was responsive to voice. Pt collaborated with writer as well as facility RN who also came to Pt room. Pt declined breakfast this AM (morning) but did take medications and was able to drink water. Per caregiver who was with the Pt he had full body convulsions that resolved quickly. Pt was alert and talking prior to convulsions. Pt is alert and answers questions per baseline at time of writers assessment. Facility asking for comfort medications. Writer voiced that TC (telephone call) will be placed to Pt POA (power of attorney) who needs to be asked prior to getting comfort medications in place. DON (Director of Nursing) was accepting of Lorazepam, Hyoscyamine and current Oxycodone orders. She declines need/want for Haldol. TC placed to POA with no answer, detailed message left. Symptoms/needs addressed and recommendations: continue to monitor, comfort medications if needed There was no evidence that the physician was consulted that R5 had seizures for the first time. There was no evidence that the physician was consulted to evaluate R5's change in condition. The Centers for Disease Control (CDC) Epilepsy webpage documents, First Aid for Seizures: When to call for help - The seizure lasts for more than 5 minutes; It is also important to call 911 if the person having the seizure - Has never had a seizure before. The nurses note dated [DATE] at 9:04 a.m. by LPN (Licensed Practical Nurse)-X documents: 7:14 a.m. convulsing then became unresponsive, with labored breathing. 7:16 a.m. [Name of] hospice nurse called ([First name]) will be in to evaluate. 7:25 a.m. resident alert. 7:36 a.m. POA (power of attorney): [First name] called, left voicemail with detailed message regarding [R5's first name] episode of convulsing. BP (blood pressure): ,d+[DATE], p (pulse): 101, T (temperature): 96.4, O2 (oxygen): 98% /RA (room air) R (respirations) 24, labored. On [DATE] at 2:04 p.m., Surveyor spoke with LPN-X on the telephone. Surveyor read LPN-X her nurses note dated [DATE] and asked if she remembered R5. LPN-X replied that LPN-X did not honestly remember and stated that so much goes on at that place (the facility). LPN-X informed Surveyor she didn't think R5 was her resident. Surveyor asked LPN-X if prior to [DATE] did R5 have any seizures. LPN-X replied that LPN-X was not sure if R5 had history of seizures. There was no evidence that the physician was consulted that R5 had seizures for a second time. There was no evidence that the physician was consulted to evaluate R5's change in condition. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Fort Atkinson Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 430 Wilcox St Fort Atkinson, WI 53538	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The hospice note dated [DATE] at 9:50 a.m. documents: focused visit performed d/t: seizure like behavior. Symptoms/needs addressed and recommendations: Please see previous report of seizure like behavior. Requested nurse assessment. Arrived no staff available to check in with. Went to patient room and CNA (Certified Nursing Assistant) [first name] was giving [R5's first name] a bath. She was with him at the time of the seizure. She stated she was getting him ready for a shower when he started to seize. She described it as a whole body shaking that lasted for ,d+[DATE] seconds. He was unresponsive afterwards and incontinent of bowel and urine. Per [Name], the med tech had given him his morning medications but no insulin. This was confirmed by nurse [first name]. Assessed [R5's first name]. Pupil in left eye responsive to light, alert and oriented to al but day-- thought it was Tuesday. VSS (vital signs stable). He is sleepy. Blood glucose at 9 am was 263. There is no earlier blood glucose. He is currently sleeping and comfortable. Reassessment plan: resolved during visit. Discussed goals of care? Yes. Discussion included the following domains symptom management, medical interventions, and routine tasks .Training provided: Check blood glucose during seizure or unresponsive episodes, call [Hospice name] for any further questions or concerns. Surveyor noted that there was no evidence that the physician was consulted that R5 experienced a seizure, which was not R5's baseline. There was no evidence that the physician was consulted about a change in R5's condition. The medication order with an order date & start date of [DATE] documents Lorazepam (Ativan) 0.5 mg tab Dose: 0.5 mg/Route: Oral/Freq (frequency): EVERY 2 HOURS PRN (as needed)/Admin Inst (administration instruction): Every 2 hours as needed for seizure activity. The facility did not note this order until [DATE]. The facility did not develop a seizure care plan after R5 experienced a seizure on [DATE] and [DATE]. The facility did not have any evidence that R5's seizures were being monitored or that the physician was consulted about R5's seizure activity. The nurses note dated [DATE], at 7:00 a.m., by LPN-Y documents: Resident noted with ,d+[DATE] minutes of unresponsiveness and fixated stair [sic] (stare). Resident noted drooling. BP ,d+[DATE], HR 133, BS (blood sugar) 188 mg/dl, Spo2 99%. Per RN took resident about 12 minutes to come out of seizure. Hospice updated. Surveyor noted that there was no evidence that the facility called emergency services to manage R5's seizures, as R5 had a seizure lasting ,d+[DATE] minutes and took approximately 12 minutes to come out of the seizure. On [DATE] at 1:53 p.m., Surveyor interviewed LPN-Y on the telephone regarding the nurses note dated [DATE] which LPN-Y wrote. LPN-Y informed Surveyor she doesn't really remember too much about R5 and doesn't remember R5 on this date ([DATE]). Surveyor asked LPN-Y if she recalls R5 having seizures. LPN-Y replied yes, seizure like activity, can't diagnose seizures. Surveyor inquired if she knew how often R5 would have seizures. LPN-Y replied no. R5 did not receive Lorazepam 0.5 mg every two hours as needed for seizure activity as the facility had not processed this medication order. Lorazepam is a benzodiazepine, and its primary use in seizure management is to stop ongoing seizures. The use of Lorazepam is critical in the management of R5's change in condition due to seizures as it helps prevent or stop seizures. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility had no evidence that a physician was consulted about R5's change in condition due to seizure activity. There was no evidence that the facility called emergency services to manage R5's seizures, despite R5 having a seizure lasting ,d+[DATE] minutes and taking approximately 12 minutes to come out of the seizure. The nurses note dated [DATE], at 9:26 a.m., documents: Writer spoke with [first name] RN (Registered Nurse) from [Name] team and updated her on the continuous seizure activity. Resident was to have an appt (appointment) today for wound care. When up in w/c (wheelchair) resident had 2 active seizures hospice updated and agreed to not send resident to appt. Writer tried to reach out to resident mom with no answer, when speaking to [first name] she stated that she is working on trying to get a new facility for resident closer to home. Hospice is updated on current medication for pain and that resident needs to have schedule pain meds (medication). Writer is waiting on hospice nurse to arrive. This note is written by LPN-Z who is no longer employed at the facility. Surveyor noted that the facility did not have any evidence that R5's seizures were being monitored or that the physician was notified of R5's seizure activity or lack of medication used to manage seizure activity for R5. The hospice note for date of service [DATE] 9:30 a.m. documents: Focused visit performed d/t seizures. Symptoms/needs addressed and recommendations: Writer arrived to facility and spoke with [Name] (facility LPN) and [Name] (facility RN). Staff reports pt had 2 seizures this morning. He had wound appt. scheduled offsite but facility canceled out of concern for seizure activity during transport. Staff stated pt had first seizure around 6:50 am that lasted ,d+[DATE] minutes and it took him ,d+[DATE] minutes to recover. Blood glucose checked and was 188. Staff gave him apple juice and around 7:30 am pt had 2nd seizure that also lasted about ,d+[DATE] minutes. Staff reports pt has been sleepy since. Writer arrived to pt room and found pt resting comfortably in bed. Pt was easily woken and answered questions sleepily but appropriately. Pt denies pain, SOB (shortness of breath), N/V (nausea/vomiting) or discomfort of any kind. BP ,d+[DATE], HR 96, RR 18. Wound dressing not saturated and [Name] RNCM (Registered Nurse Case Manager) has scheduled visit tomorrow for wound care and f/u so writer did not remove dressing to assess wound. Writer in communication with RNCM and discussed asking for orders to increase scheduled Oxycodone for pain and scheduling Lorazepam for seizures. The order date [DATE] documents: Levetiracetam oral tablet 500 mg (Levetiracetam) Give 1 tablet by mouth two times a day for seizures. R5 did not start receiving this medication until [DATE], which was two days after it was ordered. R5 received Levetiracetam 500 mg BID from [DATE] to [DATE]. According to MedlinePlus, Levetiracetam is used alone and along with other medications to control partial-onset seizures (seizures that involve only one part of the brain) in adults, children, and infants 1 month of age or older. Levetiracetam is also used in combination with other medications to treat seizure in adults and children [AGE] years of age or older with juvenile myoclonic epilepsy. Levetiracetam is also used in combination with other medications to treat primary generalized tonic-clonic seizures (formerly known as a grand mal seizure; seizure that involves the entire body) in adults and children 6 years of age or older with epilepsy. Levetiracetam is in a class of medications called anticonvulsants. It works by decreasing abnormal excitement in the brain. https://medlineplus.gov/druginfo/meds/a699059.html (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The APNP (Advanced Practice Nurse Prescriber) history and physical note dated [DATE] under subjective documents In the last few days, the patient has been experiencing seizures. Ativan 0.5 mg every six hours was initially prescribed, but it didn't seem to help as he still had a seizure. Keppra 500 mg twice a day has been scheduled for seizure activity, the patient will continue to be monitored for comfort. The patient is alert, oriented, and responsive. He complains of pain and has some extremity edema. Under Assessment & plan includes documentation of 2. Seizure activity: Discontinue Ativan 0.5 mg every 6 hours. Initiate Keppra 500 mg twice daily. Monitor seizure frequency and effectiveness of medication. Keppra (Levetiracetam) 500 mg twice daily was not started until [DATE] and there was not an order for Ativan 0.5 mg every 6 hours as documented in APNP note dated [DATE]. The nurses note dated [DATE] at 15:13 (3:13 p.m.) documents: RN received call from lab; critical C reactive level @ (at) 7.03. (Protein produced by the liver in response to inflammation). RN notified [APNP-BB], she received. Awaiting any new orders. This nurses note was written by RN-CC. Hospice note dated [DATE] under reason for call documents seizure. Under call documentation documents Telephone call time: 0854 (8:54 a.m.) Who called: [First name], Relationship to patient: RN at facility, Call back # [phone number], Reason for call Seizure Patient having seizures this morning. He is conscious and taking, all vitals WNL (within normal limits). Is at baseline. [First name] said they don't have any orders for seizure activity. Writer looked on the MAR and he has an order for Lorazepam PRN for seizure activity, and another PRN Lorazepam order for anxiety, nausea etc. She said they do not have those orders. Writer offered to fax those over to her today. She was very thankful. Writer faxed those over to her at [number] with success. She did not feel like pt needed an RN visit and will call with any further needs. Updated team on this today and they can f/u if needed. Surveyor noted there is no documentation of R5 having a seizure on [DATE] in R5's medical record. Surveyor received this information on [DATE] from [name] hospice. R5 did not receive Lorazepam 0.5 mg every two hours as needed for seizure activity and there was no monitoring for seizures. The facility did not have any evidence that R5's seizures were being monitored or that a physician was notified of R5's seizure activity. This note provided to Surveyor was provided by hospice services and was not part of R5's medical record. Depite R5 having a change in condition due to seizures, this was not documented accurately in R5's medical record. The nurses note dated [DATE] at 22:13 (10:13 p.m.) documents: 1600 (4:00 p.m.) [Name] Hospice arrived to assess pt after his transfer wasn't completed earlier today d/t (due to) seizure activity. Meds reviewed and oxy (Oxycodone) needs to be sched (scheduled) and Lorazepam for seizures. Res started continually seizing while nurse was here sent to ER (emergency room) via 911. Pt sister came in around 2030 (8:30 p. m.) to pick up his belongings per family he was being directly admitted to the Hospice inpatient unit and would not be returning to us. This note was written by RN-L. On [DATE] at 11:11 a.m., Surveyor interviewed RN-L regarding the nurses note she wrote on [DATE] at 10:13 p.m. RN-L explained to Surveyor this was her first day back to work. RN-L informed Surveyor she thinks they came to her because she was the RN in the building. RN-L informed Surveyor she doesn't know anything about prior seizures and was putting a medication list together but by the time she came back with the eMAR EMS was taking R5 out the front door. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The hospice note for date of service [DATE] documents: Focused visit performed d/t: Assess comfort after reported seizure activity before planned transfer to another facility. Symptoms/needs addressed and recommendations: TC (telephone call) to facility with ETA (estimated time arrival), no answer. TC collab with [hospice name] SW (social worker) [first name], update received on [hospice name] receiving update from [Name] case manager [first name] on pt having seizure before planned transport to [Name] SNF (skilled nursing facility) in [NAME]. Transport arranged was non-medical and unable to transport pt until stable. No update received today from [Hospice name] from facility. On arrive to facility spoke with [Name] Administrator on purpose of visit. [First name] states I heard pt had another seizure. Collab (collaboration) with [Name] RN and med tech [Name]. Writer asking if pt received PRN Lorazepam after reported seizure. [Name] RN reports that they have not yet received Lorazepam order from pharmacy confirms facility has orders, but no Lorazepam. Writer notes that pt has 2 orders for Lorazepam. The initial comfort pack order from ,d+[DATE], Lorazepam 0.5 mg Q4 PRN and an order placed by facility provider on , d+[DATE] Lorazepam 0.5 q2 for seizure activity. [Name] looks at pts facility chart and reports that the medication is listed as arrived today, searched several med carts and other area of facility and could not find the medication. Writer asked about scheduled and PRN Oxycodone. Facility reports they only have an order for PRN Oxycodone, pt last received on ,d+[DATE]. [Name] RN and [Name] med tech confirm that patient has not been receiving scheduled Oxycodone 5 mg Q6 ordered on ,d+[DATE]. TC collab with [Name]Pharmacy staff [Name]. Reports order for Lorazepam 0.5 mg Q2 for seizures was not sent due to pending provider signature. Reports that pharmacy sent an update to provider and they have not received a signed order. Reports facility can't request Lorazepam from contingency until pharmacy receives a signed order. [Name] confirms that scheduled order Oxycodone 5 mg Q6 was sent on ,d+[DATE] and received by facility. Writer updated that scheduled Oxycodone is not at facility and pt has not been receiving it as prescribed. [Name] med tech confirms that pt has been receiving scheduled Keppra 500 mg BID .No wipes in pts room. Writer went to care to grab incontinence supplies. Once back in pts room, [Name] and CNA (Certified Nursing Assistant) present and starting to complete incontinence cares. Writer assisting, noted pt to not be responding to questions, staring off and eyes rolling back, stiffened movements and jerking began, followed by abnormal respiratory pattern, gagging and active seizure noted at 1755 (5:55 p.m.), pt turned to right side, seizure lasted ,d+[DATE] minutes, pt unresponsive after, P 116, RR 22 and uneven. TC update to guardian/[Name] with update, confirms she would like writer to call 911 and send pt out to ER The hospital ED (emergency department) Clinical Summary dated [DATE] at 20:00 (8:00 p.m.) documents arrival as [DATE] 18:32:44 (6:32 p.m. and 44 seconds). Under Chief Complaint documents pt BIBA (brought in by ambulance) for seizures. Reports has had 3 seizures today, one witnessed by EMS (emergency medical services) that lasted aprx. (approximately) 30 secs (seconds) and described as tonic clonic. Pt is actively on Keppra, facility had no medications to give patient. Pt. is on hospice. Under History of Present Illness documents [R5's last & first name] is a male patient age [AGE] years. 62 yom (year old male) on hospice for PAD (peripheral artery disease) and necrotizing left foot wound, inpatient hospice does not have meds, hx (history) of seizure off antiepileptics x (times) 2 weeks but hospice center did not have any meds (medication) for treatment so came to ED. Pt non verbal cannot provide history, here with hospice nurse and mother. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The hospital history and physical dated [DATE] at 22:07 (10:07 p.m.) under chief complaint documents Intractable seizures in the hospice patient. Under history of present illness documents [AGE] year-old male wit history of mild cognitive impairment, hypertension, diabetes mellitus type 2, peripheral vascular disease and who has had gangrene and necrotizing infection of the left foot and who is currently and nursing home resident on hospice care is brought in to be evaluated for intractable seizures. Patient is obtunded and unable to give any history. History was provided by hospice nurse. The patient was being moved from the current nursing home to another facility to continue with inpatient hospice today. When the nurse visited, the patient was found to be having seizures and apparently the seizures had been going on for 2 weeks. Apparently the medications that had been prescribed for the treatment of the patient's seizures had not been made available since this prescription about 2 weeks ago a such the patient had not been receiving any treatments. Prior to coming, the patient had had 3 seizures already and so the patient was brought to the ER for treatment of that. The hospice nurse had made an arrangement for the patient to be transferred to a different nursing home but did not have beds available right now and therefore the patient will be admitted here as GIP hospice while keeping the patient comfortable and controlling the seizures. The hospice emergent care note dated [DATE] under additional comments documents Patient is being admitted GIP (general inpatient care) to [Name] hospital after uncontrolled seizure activity, EOL (end of life) status and unable to return to current facility due to ordered comfort medications not available and Guardian [Name] not agreeable to pt returning to facility. Collab with ER staff [Physician name] and [Name] RN during visit. Pt received IV (intravenous) fluids, Zofran and Keppra after several seizures/emesis in ER, MD declined administering PRN Lorazepam for seizures/comfort due to reported low BPs and prevention of possible cardiac arrest The hospice note dated [DATE] documents RN performed comprehensive assessment, medication reconciliation, and plan of care review. Symptoms addressed and recommendations: Joint visit with [Name] RN precepting. Collaborated with [Name] hospital SW (social worker). Confirmed pt admitted for GIP (general inpatient care) stay. Upon arrive to pt room, pt comatose, does not respond to verbal or tactile stimuli . R5 expired in the hospital on [DATE]. On [DATE] at 12:00 p.m., Surveyor interviewed CNA (Certified Nursing Assistant)-M regarding R5's seizures on [DATE]. CNA-M informed Surveyor R5 didn't like to take showers but he agreed to take a shower. CNA-M informed Surveyor she believes when back in the room, she was getting R5 dressed and back to bed R5 wasn't responding. R5 indicated she went to get the nurse, LPN-Z who is not at the facility anymore and another nurse who is not here anymore. CNA-M informed Surveyor the nurses took vital signs and asked her to get fresh water. Surveyor asked CNA-M if R5 seizures started in R5's room. CNA-M informed Surveyor they kind of started when going back to his room. CNA-M informed Surveyor the nurse said R5 was having a seizure. Surveyor asked CNA-M if R5 had seizures before. CNA-M informed Surveyor R5 had seizures several times. CNA-M explained she didn't have R5 too often but couple times CNA-J would ask her to help her as R5 was having mild seizures. CNA-M informed Surveyor she can't say how often R5 had seizures. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 12:08 p.m., Surveyor asked CNA-J if she remembers R5 having any seizures. CNA-J replied no. Surveyor asked CNA-J if she remembers asking CNA-M for help because R5 was having a seizure as this is what CNA-M had told Surveyor. CNA-J informed Surveyor she doesn't recall as it has been awhile. CNA-J informed Surveyor if [name of CNA-M] said that it was probably true but she doesn't recall. On [DATE] at 2:21 p.m., Surveyor informed NHA-A and DON-B of the above findings. Surveyor asked NHA-A and DON-B if there was any additional information as to why the facility had not obtained R5's seizure medication that was critical to managing R5's change in condition. DON-B stated that DON-B was not at the facility at the time and could not speak to the events regarding R5's seizure activity. Surveyor asked DON-B if the physician was consulted of R5's change in condition and DON-B stated she could not speak to the events regarding R5's seizure activity as DON-B was not at the facility at the time of R5's seizures. The facility's failure to ensure R5 received appropriate care and treatment when R5 experienced a change in condition created a reasonable likelihood for serious harm, thus leading to a finding of immediate jeopardy. The immediate jeopardy was removed on [DATE] when the facility implemented the following action plan: * Education has to be completed the next tour of duty for all licensed nursing staff on change of condition and responsibilities that include collaboration with the physician, identification of necessary interventions, and the effectiveness of those interventions and implementing new interve [TRUNCATED]

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16584 Based on record review and staff interviews, the facility did not always ensure that they provided adequate supervision and assistance to prevent accidents for 1 out of 1 residents (R6) reviewed for falls. During a bed bath, R6 was rolled in bed from one side to another when the bed moved away from the wall and R6 fell to the floor. R6 immediately complained of pain and was sent to the emergency room for further evaluation. R6 was to have had all his cares done with 2 staff members present and R6 should have been rolled towards the staff member, not away from them to provide adequate assistance to prevent a fall from bed. Findings include: R6 was originally admitted to the facility on [DATE] with diagnosis that included major depressive disorder, anxiety disorder, schizoaffective disorder, and morbid obesity. The admission MDS (minimum data set), dated 6/19/24 indicates that R6 has a BIMS (brief interview for mental status) of 13, indicating that R6 is cognitively intact. R6 is assessed to have no limits to his range of motion for the upper and lower extremities. Under section GG0170 Mobility documents that R6 needs partial/ moderate assistance to roll left and right, the ability to roll from lying on back to left and right side and return to lying on back on bed. Surveyor conducted a review of the individual plan of care for R6 and noted that R6 sometimes have behaviors which include cursing, hitting during cares, screaming, yelling during cares, and accusing staff of abuse. Interventions included cares in pairs for all needs which was initiated on 8/8/24. The individual plan of care also states that R6 has physical functioning deficit related to mobility impairments, selfcare impairment due to prolonged hospital stay with weakness, physical limitations and need for staff assistance. Interventions include Rehab therapy services as ordered, dressing and personal hygiene assistance of 1. Surveyor reviewed the CNA (Certified Nursing Assistant) which indicates that R6 is to receive cares in pairs for all needs. Under the safety section, the Kardex documents to keep the bed locked. Transferring is to be done with the assistance of 2 with full body lift. R6 was evaluated by Physical Therapy on 6/19/24 with the goal to improve strength and mobility. R6 was approved to receive physical therapy for a duration of 30 days (6/19/24- 7/18/24). The physical therapy plan of treatment documented that R6 has a goal to improve ability to roll from lying on back to left and right side and return to lying on back partial/moderate assistance. Physical Therapy assessed R6 to currently needing substantial/ maximal assistance. R6 was discharged from Physical Therapy services on 6/25/24 due to being hospitalized . Physical Therapy services resumed on 7/8/24 until 7/17/24. The functional mobility assessment indicates that R6 is dependent on staff for rolling left and right during bed mobility. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The quarterly MDS, dated [DATE] documents that R6 has impairments to his range of motion on both sides of his lower extremities. R6 has impairments to his range of motion to one side of his upper extremities. Section GG170 mobility indicates that R6 is dependent(bed mobility definition- resident does none of the effort assistance requires 2 or more to complete activity) to roll left and right the ability to roll from lying on back to left and right side and return to lying on back on bed. The MDS also documents that R6 is 5 foot 9 inches tall and weighs 286 pounds. R6's medical record contained a post fall evaluation, dated 10/26/24 at 10:25 a.m. The fall details documented that on 10/26/24 at 10:15 a.m., R6 experienced a witnessed fall , by CNA- C in his room. At the time of the fall, CNA - C was providing ADL's (activities of daily living) and was trying to turn R6 on his right side (in bed) and R6 fell from the bed to the floor in the process. There were no additional nursing notes regarding the fall. Surveyor conducted a review of the facility's falls investigation, dated 10/26/24 at 10:15 a.m., documents that writer called to room by staff nurse stating that R6 had a fall , upon arrival writer noted R6 lying in supine position. CNA interviewed stated R6 rolled off the bed when I rolled him onto his side to wash him up. Also stated that wheels on bed were locked. When asked if R6 hit his head, CNA stated the no, R6 fell on to his entire right side (hip ,arm, knee). R6 stated he rolled out of bed. Immediate action taken was that RN assessed R6 and 911 was called due to increasing pain . R6 was taken to hospital. The falls investigation documented that predisposing environmental factors are bed position. Under the notes section the facility documents that when R6 returns, will change plan to 2 assist with bed mobility. It was noted that the falls investigation did not address that there was to be 2 staff, providing cares in pairs, when R6 was being washed up on the morning of 10/26/24. On 1/6/25 at 9:52 a.m., Surveyor interviewed CNA- C who was providing the morning cares to R6 on 10/26/24. CNA-C stated that she had gotten the front half of R6 all cleaned up while giving a bed bath. R6 was laying in bariatric bed that had 1 side of the bed up against the wall. CNA-C stated that the bed was in the lock position. CNA-C stated that R6 assisted her to roll to his opposite side so she could clean his backside. R6 helped by grabbing the headboard and then he began pushing against the wall which then moved the bed away from the wall and he just went over, falling to the floor. CNA- C stated that she quickly unlocked the bed and moved it to make sure R6 was alright. R6 was not observed to have hit his head or to be bleeding. CNA- C immediately called out for help from the nurse. CNA- A stated that R6 accused her of pushing him out of bed. CNA- C stated that she just had her hand on R6's hip the whole time while turning him away from her towards the wall so she could clean his backside. R6 did complain of pain to his right shoulder and hip immediately after the fall. CNA-C stated that she was not aware that R6 was to have cares in pairs for all needs and stated that R6 did not like a lot of the staff. On 1/6/25 at 1:15 p.m., Surveyor interviewed Director of Therapy- D regarding R6 and therapy recommendations for his bed mobility. Director of Therapy- D stated that R6 would be assessed to need maximum assistance with bed mobility because he could only help a little to turn himself and the Certified Nursing Assistant would have to do most of the work. Director of Therapy- D stated that staff would ask him to help roll from one side to the other and he would kind of be able to grab onto the bedframe or the mattress to assist. Director of Therapy- D stated that R6 was very unaware of his limitations. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/6/25 at 3:40 p.m., Surveyor interviewed DON (Director of Nursing)- B regarding R6's fall from the bed during cares on 10/26/24. DON- B stated that although she was not the DON at the time of this incident, she did speak with CNA-C who stated she was able to move R6 in bed with ease but R6 had pushed up against the wall, causing the bed to move. Surveyor asked DON- B why there was not 2 staff in providing cares in pairs per the plan of care. DON- B stated she was not sure and would follow-up. DON- B stated that she would expect staff, when rolling a resident side to side in bed, to roll the resident towards them, not away from them. This is for the safety of the resident. R6 did not return to the facility after being transferred to the hospital. Further review of the hospital record documented that at first it was thought that R6 had a C1 and C7 (spinal column fracture), but further review of the imaging stated that there were no fractures noted. As of the time of exit on 1/8/25, the facility did not provide any additional information as to why the CNA had rolled R6 away from her during cares which did not allow her to safely move R6 in the bed. Also, there was no additional information provided as to why cares in pairs for all care needs was not followed per the plan of care during the bed bath for R6 10/26/24.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 20483 Based on interview and review of HR (human resource) records, the facility did not ensure 1 of 3 nursing staff competencies were completed after being hired. LPN (Licensed Practical Nurse)-K was hired on 9/15/24. A Licensed Nurse Competency was not completed for LPN-K. Findings include: 1.) On 1/6/25, at 10:38 a.m., Surveyor spoke with an anonymous complainant who informed Surveyor after being hired no one trains the new employees. The anonymous complainant informed Surveyor the nurses are suppose to follow a nurse for four weeks before going on their own so they are oriented to the building and are competent but this does not happen. Surveyor asked who is responsible for training. The anonymous complainant replied no one, no training system. On 1/6/25, at 1:28 p.m., Surveyor met with BOM/HR (Business Office Manager/Human Resource)-G to discuss the training provided to new employees. BOM/HR-G informed Surveyor she does the on boarding, depending on their title they are credentialed and trained. Surveyor inquired about competencies. BOM/HR-G informed Surveyor they have Nurse Aide Competency and Licensed Nurse Competency which has to be completed prior to the new hire going on the floor by themselves. BOM/HR-G also informed Surveyor they have [name of] for in-services. On 1/6/25, at 1:35 p.m., Surveyor asked for competencies for CNA (Certified Nursing Assistant)-O with a hire date of 10/31/24, CNA-P with a hire date of 10/31/24 and LPN-K with a hire date of 9/15/24. BOM/HR-G looked at her files, then stated not seeing it, sometimes it takes a while. Surveyor informed BOM/HR-G staff was hired in September & October 2024. BOM/HR-G informed Surveyor the person they are training with would fill out the competency and didn't know why she didn't have them back. Surveyor asked if there is a specific staff member who trains new employees. BOM/HR-G replied that is what I would like, I want them to train with our own staff. BOM/HR-G informed Surveyor she will have to follow up with them (referring to CNA-O, CNA-P & LPN-K) to see if they have them. BOM/HR-G explained competencies are given to the employees, they need to be completed before they go on the floor by themselves, and the competencies are returned to her after they are signed. BOM/HR-G informed Surveyor they need a better orientation process. BOM/HR-G then showed Surveyor a rough draft on what they are going to be setting up for orientation. Surveyor asked BOM/HR-G to see if she can locate competencies for the staff requested and get back to Surveyor tomorrow. On 1/7/25, at 8:20 a.m., BOM/HR-G informed Surveyor she was able to locate competencies for CNA-O & CNA-P but was unable to locate the Licensed Nurse Competency for LPN-K. Surveyor was provided with CNA-O & CNA-P's nurse aide competency. On 1/7/25, at 3:46 p.m., NHA (Nursing Home Administrator)-A and DON (Director of Nursing)-B were informed LPN-K did not have a competency completed. No information was provided to Surveyor as to why this competency was not completed after LPN-K was hired on 9/15/24.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observe each nurse aide's job performance and give regular training. 22692 Based on interview and record review, the facility did not complete a performance review of 4 of 5 Certified Nursing Assistants (CNA's) reviewed. This had the potential to affect all 35 residents who reside in the facility. Findings include: On 1/15/24 at 9:00 AM, Surveyor asked for the performance reviews for CNA-H who was hired by the facility on 1/28/21, CNA-DD who was hired by the facility on 3/1/23, CNA-EE who was hired by the facility on 9/6/01, and CNA-FF who was hired by the facility on 4/28/23. On 1/15/24 at 12:15 PM, DON-B was interviewed and indicated no performance evaluations could be found for CNA-H for the timeframe of 1/28/23 to 1/28/24, CNA-DD for the timeframe of 3/1/23 to 3/124, CNA-EE for the timeframe of 9/6/23 to 9/6/24, and CNA-FF for the timeframe of 4/28/23 to 4/28/24. DON-B indicated performance evaluations should be completed yearly and could not be found for these 4 CNA's. On 1/15/25 at 12:20 PM, Nursing Home Administrator-A and DON-B were informed of the of the above findings. Additional information was requested, if available. None was provided as to why CNA performance evaluations were not done on at least a yearly basis.

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20483 Based on interview and record review, the facility did not provide pharmaceutical services to meet the needs of each resident for 3 (R5, R4, and R3) of 6 residents. On [DATE], R5 experienced a seizure, which was a change of condition for R5. On [DATE], R5 received a physician order for Lorazepam 0.5 mg (milligrams) every 4 hours as needed for comfort medication. This order was not picked up by the facility until [DATE]. R5 experienced another seizure on [DATE]. Following the seizure on [DATE], Lorazepam 0.5 mg every two hours as needed for seizure activity was ordered. This order was not picked up until [DATE]. On [DATE], R5 received an order for Levetiracetam 500 mg (an anti-seizure medication): Give 1 tablet by mouth two times a day for seizures. R5 did not start receiving this medication until [DATE]. R5 continued to have seizures on [DATE], [DATE], and [DATE]. R5 did not receive Lorazepam every two hours as needed for seizure activity as there was not a signature on the prescription from the provider and the pharmacy did not send this medication. On [DATE], R5 was transferred to the hospital due to seizure activity and medications not being available. R5 continued to have seizures in the ER (emergency room) on [DATE] and on [DATE] while in the hospital, R5 was comatose and did not respond to verbal or tactile stimuli. R5 expired in the hospital on [DATE]. The facility's failure to ensure medication orders were reconciled correctly, required medication orders contained the required signature, and to ensure there was collaboration and communication between the facility, pharmacy, and hospice created a finding of Immediate Jeopardy (IJ) which began on [DATE]. NHA (Nursing Home Administrator)-A and DON (Director of Nursing)-B were notified of the immediate jeopardy on [DATE] at 3:36 p.m. The immediate jeopardy was removed on [DATE] however, the deficient practice continues at a scope/severity level of D (potential for harm/isolated) related to the examples of R4 and R3 and as the facility continues to implement its action plan. * R4 did not receive scheduled medications one hour before or one hour after the scheduled time 88 times between [DATE] and [DATE]. * R3 did not receive scheduled medication one hour before or on hour after the scheduled time 11 times on [DATE] to [DATE] and 21 times [DATE] to [DATE]. Findings include: 1.) R5 was originally admitted to the facility on [DATE] with diagnoses that included osteomyelitis, diabetes mellitus, MRSA (methicillin resistant staphylococcus aureus), PVD (peripheral vascular disease), chronic kidney disease, hypertension, Atrial Fibrillation, acute embolism and thrombosis of unspecified deep veins of lower extremities, and necrotizing diabetic foot infection. On [DATE], R5 was transferred to the hospital and returned to the facility on [DATE] with hospice services. (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The hospital discharge summary dated [DATE] documents under final diagnosis: 1. Diabetic foot ulcer with osteomyelitis. 2. Necrotizing soft tissue infection. 3. Insulin requiring or dependent type II diabetes mellitus. 4. PVD (peripheral vascular disease). 5. Phalanges fracture foot. 6. Hypertension. 7. Hyperlipidemia. 8. Chronic kidney disease. 9. Gastro-esophageal reflux disease without esophagitis. 10. Depression. On [DATE], hospice ordered Lorazepam (Ativan) 0.5 mg. Route: Take 1 tab (tablet) by mouth every 4 hours as needed Comfort Med, call [hospice name] prior to first dose. May crush or dissolve. Purpose: Anxiety, Hospice Related, Nausea, Restlessness. The facility did not pick up this order until [DATE]. On [DATE], hospice ordered Hyoscyamine Sulfate 0.125 mg disintegrating tab. Route Take 1 tab by mouth every 2 hours as needed comfort med. Call [Hospice Name] prior to 1st dose. May crush or dissolve. Purpose: Bladder spasm, Hospice related respiratory congestion. The facility did not pick up this order. The nurses note dated [DATE] at 9:04 a.m. by LPN (Licensed Practical Nurse)-X documents: 7:14 a.m. convulsing then became unresponsive, with labored breathing. 7:16 a.m. [Name of] hospice nurse called ([First name]) will be in to evaluate. 7:25 a.m. resident alert. 7:36 a.m. POA (power of attorney): [First name] called, left voicemail with detailed message regarding [R5's first name] episode of convulsing. BP (blood pressure): ,d+[DATE], p (pulse): 101, T (temperature): 96.4, O2 (oxygen): 98% /RA (room air) R (respirations) 24, labored. The medication order with an order date and start date of [DATE] documents Lorazepam (Ativan) 0.5 mg tab Dose: 0.5 mg/Route: Oral/Freq (frequency): EVERY 2 HOURS PRN (as needed)/Admin Inst (administration instruction): Every 2 hours as needed for seizure activity. The facility did not note this order until [DATE]. The nurses note dated [DATE] at 7:00 a.m., by LPN-Y documents: Resident noted with ,d+[DATE] minutes of unresponsiveness and fixated stair [sic] (stare). Resident noted drooling. BP ,d+[DATE], HR 133, BS (blood sugar) 188 mg/dl, Spo2 99%. Per RN took resident about 12 minutes to come out of seizure. Hospice updated. R5 did not receive Lorazepam 0.5 mg every two hours as needed for seizure activity as the facility had not noted this order. The nurses note dated [DATE] at 9:26 a.m., documents: Writer spoke with [first name] RN (Registered Nurse) from [Name] team and updated her on the continuous seizure activity. Resident was to have an appt (appointment) today for wound care. When up in w/c (wheelchair) resident had 2 active seizures hospice updated and agreed to not send resident to appt. Writer tried to reach out to resident mom with no answer, when speaking to [first name] she stated that she is working on trying to get a new facility for resident closer to home. Hospice is updated on current medication for pain and that resident needs to have schedule pain meds (medication). Writer is waiting on hospice nurse to arrive. This note is written by LPN-Z who is no longer employed at the facility. (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The order dated [DATE] documents: Levetiracetam oral tablet 500 mg (Levetiracetam) Give 1 tablet by mouth two times a day for seizures. R5 did not start receiving this medication until [DATE]. R5 received Levetiracetam 500 mg BID from [DATE] to [DATE]. Levetiracetam (also known as Keppra) treats seizures by slowing electrical activity in the brain. The APNP (Advanced Practice Nurse Prescriber) history and physical note dated [DATE] under subjective documents: .In the last few days, the patient has been experiencing seizures. Ativan 0.5 mg every six hours was initially prescribed, but it didn't seem to help as he still had a seizure. Keppra 500 mg twice a day has been scheduled for seizure activity, the patient will continue to be monitored for comfort. The patient is alert, oriented, and responsive. He complains of pain and has some extremity edema. Under Assessment and plan includes documentation of 2. Seizure activity: Discontinue Ativan 0.5 mg every 6 hours. Initiate Keppra 500 mg twice daily. Monitor seizure frequency and effectiveness of medication. Keppra 500 mg twice daily was not started until [DATE] and there was not an order for Ativan 0.5 mg every 6 hours as documented in APNP note dated [DATE]. Hospice note dated [DATE] under reason for call documents: seizure. Under call documentation documents: Telephone call time: 0854 (8:54 a.m.) Who called: [First name], Relationship to patient: RN at facility, Call back # [phone number], Reason for call Seizure Patient having seizures this morning. He is conscious and taking, all vitals WNL (within normal limits). Is at baseline. [First name] said they don't have any orders for seizure activity. Writer looked on the MAR and he has an order for Lorazepam PRN for seizure activity, and another PRN Lorazepam order for anxiety, nausea etc. She said they do not have those orders. Writer offered to fax those over to her today. She was very thankful. Writer faxed those over to her at [number] with success. She did not feel like pt needed an RN visit and will call with any further needs. Updated team on this today and they can f/u if needed. Surveyor noted there is no documentation of R5 having a seizure on [DATE] in R5's medical record. Surveyor received this information on [DATE] from [name] hospice. R5 did not receive Lorazepam 0.5 mg every two hours as needed for seizure activity. The nurses note dated [DATE] at 22:13 (10:13 p.m.) documents: 1600 (4:00 p.m.) [Name] Hospice arrived to assess pt after his transfer wasn't completed earlier today d/t (due to) seizure activity. Meds reviewed and oxy (Oxycodone) needs to be sched (scheduled) and Lorazepam for seizures. Res started continually seizing while nurse was here sent to ER (emergency room) via 911. Pt sister came in around 2030 (8:30 p. m.) to pick up his belongings per family he was being directly admitted to the Hospice inpatient unit and would not be returning to us. This note was written by RN-L. The hospice note for date of service [DATE] documents: Focused visit performed d/t: Assess comfort after reported seizure activity before planned transfer to another facility. (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Symptoms/needs addressed and recommendations: TC (telephone call) to facility with ETA (estimated time arrival), no answer. TC collab with [hospice name] SW (social worker) [first name], update received on [hospice name] receiving update from [Name] case manager [first name] on pt having seizure before planned transport to [Name] SNF (skilled nursing facility) in [NAME]. Transport arranged was non-medical and unable to transport pt until stable. No update received today from [Hospice name] from facility. On arrive to facility spoke with [Name] Administrator on purpose of visit. [First name] states I heard pt had another seizure. Collab (collaboration) with [Name] RN and med tech [Name]. Writer asking if pt received PRN Lorazepam after reported seizure. [Name] RN reports that they have not yet received Lorazepam order from pharmacy confirms facility has orders, but no Lorazepam. Writer notes that pt has 2 orders for Lorazepam. The initial comfort pack order from ,d+[DATE], Lorazepam 0.5 mg Q4 PRN and an order placed by facility provider on , d+[DATE] Lorazepam 0.5 q2 for seizure activity. [Name] looks at pts facility chart and reports that the medication is listed as arrived today, searched several med carts and other areas of facility and could not find the medication. Writer asked about scheduled and PRN Oxycodone. Facility reports they only have an order for PRN Oxycodone, pt last received on ,d+[DATE]. [Name] RN and [Name] med tech confirm that patient has not been receiving scheduled Oxycodone 5 mg Q6 ordered on ,d+[DATE]. TC collab with [Name]Pharmacy staff [Name]. Reports order for Lorazepam 0.5 mg Q2 for seizures was not sent due to pending provider signature. Reports that pharmacy sent an update to provider and they have not received a signed order. Reports facility can't request Lorazepam from contingency until pharmacy receives a signed order. [Name] confirms that scheduled order Oxycodone 5 mg Q6 was sent on ,d+[DATE] and received by facility. Writer updated that scheduled Oxycodone is not at facility and pt has not been receiving it as prescribed. [Name] med tech confirms that pt has been receiving scheduled Keppra 500 mg BID. Writer asking if pt is receiving scheduled Tylenol prior to wound care as ordered. [Name] reports that the PRN Tylenol order and scheduled Tylenol order were entered incorrectly, so the Tylenol would not come up as scheduled and pt has not been receiving scheduled Tylenol prior to daily wound care or any pain regimen routinely .No wipes in pts room. Writer went to care to grab incontinence supplies. Once back in pts room, [Name] and CNA (Certified Nursing Assistant) present and starting to complete incontinence cares. Writer assisting, noted pt to not be responding to questions, staring off and eyes rolling back, stiffened movements and jerking began, followed by abnormal respiratory pattern, gagging and active seizure noted at 1755 (5:55 p.m.), pt turned to right side, seizure lasted ,d+[DATE] minutes, pt unresponsive after, P 116, RR 22 and uneven. TC update to guardian/[Name] with update, confirms she would like writer to call 911 and send pt out to ER The hospital ED (emergency department) Clinical Summary dated [DATE] at 20:00 (8:00 p.m.) documents: arrival as [DATE] 18:32:44 (6:32 p.m. and 44 seconds). Under Chief Complaint documents pt BIBA (brought in by ambulance) for seizures. Reports has had 3 seizures today, one witnessed by EMS (emergency medical services) that lasted aprx. (approximately) 30 secs (seconds) and described as tonic clonic. Pt is actively on Keppra, facility had no medications to give patient. Pt. is on hospice. Under History of Present Illness documents [R5's last and first name] is a male patient age [AGE] years. 62 yom (year old male) on hospice for PAD (peripheral artery disease) and necrotizing left foot wound, inpatient hospice does not have meds, hx (history) of seizure off antiepileptics x (times) 2 weeks but hospice center did not have any meds (medication) for treatment so came to ED. Pt nonverbal cannot provide history, here with hospice nurse and mother. (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The hospital history and physical dated [DATE] at 22:07 (10:07 p.m.) under chief complaint documents: Intractable seizures in the hospice patient. Under history of present illness documents [AGE] year-old male with history of mild cognitive impairment, hypertension, diabetes mellitus type 2, peripheral vascular disease and who has had gangrene and necrotizing infection of the left foot and who is currently and nursing home resident on hospice care is brought in to be evaluated for intractable seizures. Patient is obtunded and unable to give any history. History was provided by hospice nurse. The patient was being moved from the current nursing home to another facility to continue with inpatient hospice today. When the nurse visited, the patient was found to be having seizures and apparently the seizures had been going on for 2 weeks. Apparently the medications that had been prescribed for the treatment of the patient's seizures had not been made available since this prescription about 2 weeks ago as such the patient had not been receiving any treatments. Prior to coming, the patient had had 3 seizures already and so the patient was brought to the ER for treatment of that. The hospice nurse had made an arrangement for the patient to be transferred to a different nursing home but did not have beds available right now and therefore the patient will be admitted here as GIP hospice while keeping the patient comfortable and controlling the seizures. The hospice emergent care note dated [DATE] under additional comments documents: Patient is being admitted GIP (general inpatient care) to [Name] hospital after uncontrolled seizure activity, EOL (end of life) status and unable to return to current facility due to ordered comfort medications not available and Guardian [Name] not agreeable to pt returning to facility. Collab with ER staff [Physician name] and [Name] RN during visit. Pt received IV (intravenous) fluids, Zofran and Keppra after several seizures/emesis in ER, MD declined administering PRN Lorazepam for seizures/comfort due to reported low BPs and prevention of possible cardiac arrest. R5 expired at the hospital on [DATE]. On [DATE] at 3:28 p.m., Surveyor asked LPN-S who is responsible for picking up new medication orders. LPN-S informed Surveyor the nurse that's on. On [DATE] at 9:24 a.m., Surveyor asked RN-L who is responsible for picking up new medication orders. RN-L informed Surveyor the nurse on duty and she heard the ADON (Assistant Director of Nursing) when she starts is going to be. On [DATE] at 11:59 a.m., Surveyor spoke with Hospice RN/CM (Registered Nurse/Case Manager)-AA to inquire if there were any concerns regarding R5's medications. Hospice RN/CM-AA informed Surveyor there were scheduled comfort medications that were never processed and PRN Lorazepam for seizure activity was not received. Hospice RN/CM-AA stated on [DATE], R5 had a seizure during incontinence cares and R5 was sent to the hospital due to medication not being available on [DATE]. RN/CM-AA informed Surveyor R5 did not have a previous diagnosis of seizures. RN/CM-AA informed Surveyor it might be worthwhile to request R5's records from [hospice name]. On [DATE] at 1:29 p.m., Surveyor asked LPN/UM (Licensed Practical Nurse/Unit Manager)-F who is responsible for picking up hospice orders or when a resident is readmitted to the hospital. LPN/UM-F informed Surveyor the admitting nurse. Surveyor informed LPN/UM-F that on [DATE], Lorazepam 0.5 mg q 4 hours PRN was ordered for comfort and on [DATE], Lorazepam 0.5 mg q 2 hours PRN for seizure activity was not picked up until [DATE]. LPN/UM-F replied, Honestly I don't know what to say. (continued on next page)

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 01/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fort Atkinson Care Center	430 Wilcox St Fort Atkinson, WI 53538

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 11:45 p.m., Surveyor asked DON-B to review R5's Lorazepam (Ativan) narcotic sheets. DON-B informed Surveyor she would look for them. On [DATE] at 2:21 p.m., Surveyor interviewed DON-B regarding R5's Lorazepam (Ativan) narcotic sheet. DON-B stated there is no narcotic sheet for Ativan due to nurse practitioner sending order for medication to pharmacy directly without a signature. DON-B stated the form was sent back requesting a signature by pharmacy. States medication was never delivered. DON-B stated there is no narcotic sheet for a medication that was not delivered or given to resident. The facility's failure to ensure the accurate acquiring and administration of medications created a reasonable likelihood for serious harm, thus leading to a finding of immediate jeopardy. The immediate jeopardy was removed on [DATE] when the facility implemented the following action plan: * Education has to be completed the next tour of duty for all licensed nursing staff on steps to take when receiving new orders, education provided on ensuring medication is monitored for effectiveness by shift to shift report, use of the 24 hour board, effective documentation. * Licensed nursing staff education on using the SBAR when communicating with providers to ensure the information is the most up to date and factual based on current observations by the licensed nurse. * All licensed nurses will be educated on the use of PRN medications when appropriate. * Nurses will be educated on the process to follow when orders cannot be carried out as written by the provider. * All licensed nurses educated on steps to take when medications do not arrive timely that include provider, pharmacy, and Director of Nurses. * The facility has reviewed and education has to be completed the next tour of duty for all licensed nursing staff on the following policies: medication administration. * System implemented will review 24 hour charting, review all appointments and all incoming medical records in clinical stand up meeting to ensure all new orders are reviewed from all sources: new and readmissions, telephone orders, provider visits including hospice. * Nurse managers and DON will conduct random audits weekly x 4 to ensure all orders from all sources are checked for accuracy, timeliness, and availability. Root cause analysis will be conducted. * All audits will be reviewed at QAPI (quality assurance performance improvement) for further recommendations. Medical Director will be included in QAPI and reviewing the root cause analysis. The deficient practice continues at a scope/severity level of D (potential for no more than minimal harm/isolated) as evidenced by: (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Fort Atkinson Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 430 Wilcox St Fort Atkinson, WI 53538	

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	2.) The facility's policy titled, Medication Administration with an effective date of [DATE] under procedures section B Administration documents 12) Medications are administered within 60 minutes of scheduled time, except before, with or after meal orders, which are administered based on mealtimes. Unless otherwise specified by the Prescriber, routine medications are administered according to the established medication administration schedule for the facility. R4 was admitted to the facility on [DATE] and discharged on [DATE]. R4 was reviewed as a closed record. R4's diagnoses includes non-traumatic intracerebral hemorrhage, hemiplegia, hypertension, anxiety disorder, depressive disorder, and polyneuropathy. On [DATE], Surveyor reviewed R4's medication administration audit report for the time period [DATE] to [DATE] provided to Surveyor by DON (Director of Nursing)-B. This audit report shows the scheduled time and administration time for R4's medication. This report revealed the following: * On [DATE], Carvedilol 25 mg (milligrams) two times a day, Losartan Potassium 100 mg once daily, Fluticasone Propionate Nasal suspension 50 mcg/act (micrograms/actuation) once daily, Multivitamin with minerals once daily, and Magnesium Oxide 500 mg twice daily were scheduled at 6:00 a.m. R4 received these medications at 7:37 a.m., 1 hour and 37 minutes after the scheduled time. On [DATE], Magnesium Oxide 500 mg two times a day and Carvedilol 25 mg two times a day were scheduled at 1400 (2:00 p.m.). R4 received these medications at 15:53 (3:53 p.m.). * On [DATE], R4 received Carvedilol 25 mg at 8:15 a.m., Losartan Potassium 100 mg at 8:16 a.m., Fluticasone Propionate Nasal suspension 50 mcg/act at 8:26 a.m., Multivitamin with minerals at 8:18 a.m., and Magnesium Oxide 500 mg at 8:18 a.m. R4's medication were administered over two hours after the scheduled time of 6:00 a.m. On [DATE], Magnesium Oxide 500 mg two times a day and Carvedilol 25 mg two times a day were scheduled at 1400 (2:00 p.m.). Magnesium Oxide 500 mg was administered at 17:02 (5:02 p.m.) and Carvedilol 25 mg was administered at 17:03 (5:03 p.m.). * On [DATE], Carvedilol 25 mg (milligrams) two times a day, Losartan Potassium 100 mg once daily, Fluticasone Propionate Nasal suspension 50 mcg/act (micrograms/actuation) once daily, Multivitamin with minerals once daily, and Magnesium Oxide 500 mg twice daily were scheduled at 6:00 a.m. R4 received these medications at 7:15 a.m., 1 hour and 15 minutes after the scheduled time. On [DATE], Magnesium Oxide 500 mg two times a day and Carvedilol 25 mg two times a day were scheduled at 1400 (2:00 p.m.). Magnesium Oxide 500 mg and Carvedilol 25 mg were administered at 18:25 (6:25 p.m.). On [DATE], Diclofenac Potassium 50 mg twice daily, Diazepam 2 mg three times daily, Clonazepam 1 mg three times daily, Propranolol 10 mg three times daily, and Pregabalin 100 mg three times daily were scheduled for 16:00 (4:00 p.m.). R4 received these medications at 18:24 (6:24 p.m.). (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Fort Atkinson Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 430 Wilcox St Fort Atkinson, WI 53538	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	* On [DATE], R4 received Carvedilol 25 mg at 9:35 a.m., Losartan Potassium 100 mg at 9:36 a.m., Fluticasone Propionate Nasal suspension 50 mcg/act at 10:40 a.m., Multivitamin with minerals at 9:36 a.m., and Magnesium Oxide 500 mg at 9:36 a.m., over three hours after the scheduled time of 6:00 a.m. On [DATE], Artificial Tears 1 drop in both eyes is scheduled four times daily. R4's schedule dose at 7:30 a.m. was administered at 10:40 a.m., 3 hours after the scheduled time. On [DATE], R4 received 8:00 a.m. medications as follows: Clonazepam 1 mg and Pregabalin 100 mg at 9:33 a.m., Diazepam 2 mg and Diclofenac Potassium 50 mg at 9:25 a.m., and Propranolol 10 mg at 10:40 a.m. * On [DATE], R4 received Multivitamin with minerals and Magnesium Oxide 500 mg at 10:13 a.m., Fluticasone Propionate Nasal suspension 50 mcg/act, Losartan Potassium 100 mg, and Carvedilol 25 mg at 10:14 a.m. This was four hours after the scheduled time of 6:00 a.m. On [DATE], Artificial Tears 1 drop in both eyes is scheduled four times daily. R4's schedule dose at 7:30 a.m. was administered at 10:13 a.m. On [DATE], Clonazepam 1 mg, Pregabalin 100 mg, Diazepam 2 mg, and Diclofenac Potassium 50 mg were administered at 10:13 am. Propranolol 10 mg was administered at 10:15 a.m. Scheduled time was 8:00 a.m. On [DATE], Magnesium Oxide 500 mg two times a day and Carvedilol 25 mg two times a day were scheduled at 1400 (2:00 p.m.). Magnesium Oxide 500 mg and Carvedilol 25 mg were administered at 18:10 (6:10 p.m.). On [DATE], Diclofenac Potassium 50 mg twice daily, Diazepam 2 mg three times daily, Clonazepam 1 mg three times daily, Propranolol 10 mg three times daily, and Pregabalin 100 mg three times daily were scheduled for 16:00 (4:00 p.m.). R4 received these medications at 18:10 (6:10 p.m.). * On [DATE], Carvedilol 25 mg (milligrams) two times a day, Losartan Potassium 100 mg once daily, Fluticasone Propionate Nasal suspension 50 mcg/act (micrograms/actuation) once daily, Multivitamin with minerals once daily, and Magnesium Oxide 500 mg twice daily were scheduled at 6:00 a.m. R4 received these medications at 9:50 a.m. On [DATE], Artificial Tears 1 drop in both eyes is scheduled four times daily. R4's schedule dose at 7:30 a.m. was administered at 9:40 a.m. On [DATE], Propranolol 10 mg was administered at 9:41 a.m., Diclofenac Potassium 50 mg was administered at 9:47 a.m., and Pregabalin 100 mg, Clonazepam 1 mg, and Diazepam 2 mg were administered at 9:48 a.m. These medications were scheduled at 8:00 a.m. On [DATE], Magnesium Oxide 500 mg two times a day and Carvedilol 25 mg two times a day were scheduled at 1400 (2:00 p.m.). Magnesium Oxide 500 mg and Carvedilol 25 mg were administered at 16:38 (4:38 p.m.). On [DATE], Surveyor reviewed R4's medication administration audit report for the time period [DATE] to [DATE], R4's date of discharge, provided to Surveyor by DON-B. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Fort Atkinson Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 430 Wilcox St, Fort Atkinson, WI 53538	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	* On [DATE], Carvedilol 25 mg (milligrams) two times a day, Losartan Potassium 100 mg once daily, Fluticasone Propionate Nasal suspension 50 mcg/act (micrograms/actuation) once daily, Multivitamin with minerals once daily, and Magnesium Oxide 500 mg twice daily were scheduled at 6:00 a.m. R4 received these medications at 8:58 a.m. On [DATE], Artificial Tears 1 drop in both eyes is scheduled four times daily. R4's schedule dose at 7:30 a.m. was administered at 8:59 a.m. * On [DATE], Carvedilol 25 mg (milligrams) two times a day, Losartan Potassium 100 mg once daily, Fluticasone Propionate Nasal suspension 50 mcg/act (micrograms/actuation) once daily, Multivitamin with minerals once daily, and Magnesium Oxide 500 mg twice daily were scheduled at 6:00 a.m. R4 received these medications at 7:56 a.m. On [DATE], Magnesium Oxide 500 mg twice daily and Carvedilol 25 mg twice daily were scheduled at 14:00 (2:00 p.m.). R4 received these medications at 16:10 (4:10 p.m.). * On [DATE], Carvedilol 25 mg (milligrams) two times a day, Losartan Potassium 100 mg once daily, Fluticasone Propionate Nasal suspension 50 mcg/act (micrograms/actuation) once daily, Multivitamin with minerals once daily, and Magnesium Oxide 500 mg twice daily were scheduled at 6:00 a.m. R4 received these medications at 7:28 a.m. On [DATE], Magnesium Oxide 500 mg twice daily and Carvedilol 25 mg twice daily were scheduled at 14:00 (2:00 p.m.). R4 received these medications at 18:34 (6:34 p.m.). * On [DATE], Diclofenac Potassium 50 mg two times a day, Diazepam 2 mg three times a day, Propranolol 10 mg three times a day, Clonazepam 1 mg three times a day, and Pregabalin 100 mg three times a day were scheduled at 16:00 (4:00 p.m.) R4 received these medications at 18:33 (6:33 p.m.) * On [DATE], R4 received Fluticasone Propionate Nasal suspension 50 mcg/act, Losartan Potassium 100 mg, Carvedilol 25 mg at 9:26 a.m., and Multivitamin with minerals and Magnesium Oxide 500 mg at 9:28 a.m. These medications were scheduled for 6:00 a.m. On [DATE], Artificial Tears 1 drop in both eyes is scheduled four times daily. R4's schedule dose at 7:30 a.m. was administered at 9:26 a.m. On [DATE], Clonazepam 1 mg three times daily, Pregabalin 100 mg three times daily, Diazepam 2 mg three times daily, Diclofenac Potassium 50 mg two times daily, and Propranolol 10 mg three times daily were scheduled at 8:00 a.m. R4 was administered these medications at 9:26 a.m. On [DATE], Magnesium Oxide 500 mg twice daily and Carvedilol 25 mg twice daily were scheduled at 14:00 (2:00 p.m.). R4 received these medications at 17:21 (5:21 p.m.). * On [DATE], Carvedilol 25 mg (milligrams) two times a day, Losartan Potassium 100 mg once daily, Fluticasone Propionate Nasal suspension 50 mcg/act (micrograms/actuation) once daily, Multivitamin with minerals once daily, and Magnesium Oxide 500 mg twice daily were scheduled at 6:00 a.m. R4 received these medications at 9:59 a.m. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE], Artificial Tears 1 drop in both eyes is scheduled four times daily. R4's schedule dose at 7:30 a.m. was administered at 10:02 a.m. On [DATE], Pregabalin 100 mg and Clonazepam 1 mg were administered at 9:47 a.m., Propranolol 10 mg and Diclofenac Potassium 50 mg were administered at 9:59 a.m., and Diazepam 2 mg was administered at 10:02 a.m. These medications were scheduled for 8:00 a.m. * On [DATE], Carvedilol 25 mg was administered at 7:54 a.m. and Multivitamin with minerals, Fluticasone Propionate Nasal suspension 50 mcg/act, Losartan Potassium 100 mg, and Magnesium Oxide 500 mg were administered at 7:55 a.m. These medications were scheduled for 6:00 a.m. * On [DATE], Magnesium Oxide 500 mg twice daily and Carvedilol 25 mg twice daily were scheduled at 14:00 (2:00 p.m.). R4 received these medications at 17:46 (5:46 p.m.). On [DATE], R4 received Diclofenac Potassium 50 mg, Diazepam 2 mg, Clonazepam 1 mg, and Pregabalin 100 mg at 17:45 (5:45 p.m.) and Carvedilol 25 mg and Propranolol 10 mg were administered at 17:46 (5:46 p.m.) These medications were scheduled for 4:00 p.m. On [DATE], Artificial Tears four times a day was scheduled at 20:00 (8:00 p.m.). R4 received the eye drops at 17:46 (5:46 p.m.). * On [DATE], Carvedilol 25 mg, Losartan Potassium 100 mg, Multivitamin with minerals, and Magnesium Oxide 500 mg were administered at 7:36 a.m. and Fluticasone Propionate Nasal suspension 50 mcg/act was administered at 7:37 a.m. These were scheduled for 6:00 a.m. On [DATE], Magnesium Oxide 500 mg twice daily and Carvedilol 25 mg twice daily were scheduled at 14:00 (2:00 p.m.). R4 received these medications at 18:46 (6:46 p.m.). On [DATE], R4 received Propranolol 10 mg at 18:46 (6:46 p.m.), Diclofenac Potassium 50 mg at 18:47 (6:47 p.m.), and Diazepam 2 mg, Clonazepam 1 mg, and Pregabalin 100 mg at 18:48 (6:48 p.m.) These medications were scheduled for 4:00 p.m. On [DATE], Artificial Tears four times a day was scheduled at 20:00 (8:00 p.m.). R4 received the eye drops at 22:42 (10:42 p.m.). On [DATE], Propranolol 10 mg three times a day, Pregabalin 100 mg three times a day Clonazepam 1 mg three times a day, and Diazepam 2 mg three times were scheduled at 21:00 (9:00 p.m.). R4 received these medications at 22:42 (10:42 p.m.). * On [DATE], Magnesium Oxide 500 mg twice daily and Carvedilol 25 mg twice daily were scheduled at 14:00 (2:00 p.m.). R4 received these medications at 15:54 (3:54 p.m.). * On [DATE], Magnesium Oxide 500 mg twice daily and Carvedilol 25 mg twice daily were scheduled at 14:00 (2:00 p.m.). R4 received these medications at 19:17 (7:17 p.m.). * On [DATE], Losartan Potassium 100 mg, Carvedilol 25 mg, and Fluticasone Propionate Nasal suspension 50 mcg/act were administered at 8:02 a.m. and Multivitamin with minerals and Magnesium Oxide 500 mg were administered at 8:03 a.m. These medications were scheduled for 6:00 a.m. (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE], Magnesium Oxide 500 mg twice daily and Carvedilol 25 mg twice daily were scheduled at 14:00 (2:00 p.m.). R4 received these medications at 21:19 (9:19 p.m.). * On [DATE], Multivitamin with minerals, Fluticasone Propionate Nasal suspension 50 mcg/act, Carvedilol 25 mg, and Magnesium Oxide 500 mg were administered at 8:38 a.m. and Losartan Potassium 100 mg at 8:39 a.m. These medications were scheduled for 6:00 a.m. On [DATE], Magnesium Oxide 500 mg twice daily and Carvedilol 25 mg twice daily we [TRUNCATED]

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20483 Based on observation, interview, and record review, the Facility did not ensure there was a medication error rate below 5 percent. There were 2 medication errors in 34 opportunities which resulted in a medication error rate of 5.88%. Medication errors were identified for R2 & R16. * R2's Lispro insulin bottle was not dated. * R16's blood pressure & heart rate was not checked prior to receiving Metoprolol Succinate ER 25 mg (milligrams) on [DATE]. Findings include: The facility's policy titled Administration Procedures For All Medications with an effective date [DATE] under procedures I. documents Obtain and record any vital signs or other monitoring parameters ordered or deemed necessary prior to medication administration. 1.) On [DATE], at 12:09 p.m., Surveyor observed LPN (Licensed Practical Nurse)-E check R2's blood sugar which was 271. LPN-E informed Surveyor R2 will receive 6 units and the scheduled insulin. On [DATE], at 12:14 p.m., Surveyor observed LPN-E cleanse the top of the Lispro insulin vial with an alcohol pad and stated gets 10 units so will get a total of 16 units. LPN-E instilled air into the Lispro insulin vial and withdrew 16 units of insulin. Surveyor observed the Lispro insulin vial was not dated when opened. LPN-E placed R2's insulin vial in a plastic container and placed the insulin container in the medication cart. After LPN-E placed the insulin in the medication cart, Surveyor asked LPN-E if there was anything else she needed to do prior to administering the insulin. LPN-E replied no. Surveyor asked LPN-E if she could take out R2's insulin vial. LPN-E stated I know what you are going to ask. LPN-E removed R2's Lispro insulin vial for Surveyor. Surveyor asked LPN-E if the insulin vial was dated. LPN-E replied no its not I looked too. Surveyor asked LPN-E how she knows R2's Lispro insulin is not expired as there isn't a date. LPN-E replied because no date we don't. LPN-E informed Surveyor she had dated the insulin and showed Surveyor where someone had removed the portion of the label with the date. LPN-E disposed the syringe with the insulin and insulin vial stating to Surveyor I'm going to get a new vial. This observation resulted in a medication error for R2. On [DATE], at 1:21 p.m., Surveyor asked LPN/UM (Licensed Practical Nurse/Unit Manager)-F if insulin bottles should be dated when opened. LPN/UM-F replied yes. 2.) On [DATE], at 8:27 a.m., Surveyor observed LPN/UM-F cleanse her hands. LPN/UM-F removed R16's medication from medication cart and informed Surveyor she doesn't have one of R16's medications, Apixaban. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE], at 8:24 a.m., Surveyor observed LPN/UM-F prepare R16's medication which consisted of one tablet of Metoprolol Succinate ER (extended release) 25 mg (milligrams), one tablet of Jardiance 10 mg, one tablet of Prenatal multivitamin with minerals, one table Lisinopril 5 mg, and one tablet of Vitamin B1. On [DATE], at 8:37 a.m., Surveyor verified with LPN/UM-F there are 5 tablets in the medication cup and at 8:38 a.m. LPN/UM-F administered R16's medication whole with water. On [DATE], at 8:40 a.m., LPN/UM-F and LPN-E went to the Facility's contingency and two tablets of Eliquis 2. 5 mg was removed. At 8:45 a.m. R16 received Eliquis. On [DATE], at 8:46 a.m., Surveyor asked LPN/UM-F if any of the medication she administered to R16 required vital signs being taken prior. LPN/UM-F informed Surveyor she should have taken vital signs for R16's Metoprolol. LPN/UM-F informed Surveyor she will take R16 back to his room and check. On [DATE], at 9:21 a.m., Surveyor reviewed R16's physician orders and noted an order dated [DATE] which documents Metoprolol Succinate ER oral tablet Extended Release 24 hour 25 mg (Metoprolol Succinate). Give 1 tablet by mouth one time a day for HTN (hypertension). Hold for SBP (systolic blood pressure) under 110 or HR (heart rate) below 60. Not checking R16's blood pressure or heart rate prior to administering Metoprolol Succinate ER 25 mg resulted in a medication error for R16. No additional information was provided.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Establish a governing body that is legally responsible for establishing and implementing policies for managing and operating the facility and appoints a properly licensed administrator responsible for managing the facility. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36161 Based upon interview and record review, the facility's governing body failed to fulfill the responsibilities of the governing body to include establishing and implementing policies and procedures regarding the operations of the facility. The facility's governing body did not ensure that proper resources were allocated to ensure that the HVAC (Heating, Ventilation, and Air Conditioning) system providing heat to the entire facility was maintained in a functioning manner. This created the likelihood where services necessary to maintain operations of the facility along with the care and treatment of all residents may be impacted by the failures of the governing body. This deficient practice has the potential to affect all residents present in the facility at the time of the survey that were affected by not having heat. Findings include: The facility Governing Body policy Implemented 3/1/23 documents: The facility will have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility. Policy Explanation and Compliance Guidelines: 1. The governing body will appoint an administrator who is: a. Licensed by the state where required. b. Responsible for management of the facility. c. Reports to and is accountable to the governing body. 2. The governing body is responsible and accountable for the QAPI program. 3. The governing body refers to individuals such as facility owner(s), Chief Executive Officer(s), or other individuals who are legally responsible to establish and implement policies regarding the management and operations of the facility. 4. The governing body will have a process in place by which the administrator: a. Reports to the governing body. b. Method of communication between administrator and governing body. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525262	A. Building B. Wing	01/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fort Atkinson Care Center	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)
F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	c. How the governing body responds back to the administrator. d. What specific types of problems and information (i.e., survey results, allegations of abuse or neglect, complaints, etc.) are reported or not reported. e. How the administrator is held accountable and reports information about the facility's management and operation (i.e., audits, budgets, staffing supplies, etc.) f. How the administrator and the governing body are involved with the facility wide assessment. Surveyors entered the facility on 12/30/24 to investigate alleged concerns that half the building did not have heat. On 1/6/25 at 8:00 AM, Surveyor toured the facility hallways. Surveyor noted a cooler air temperature starting on the corner of the east and north hallways. Surveyor observed a thermostat on the corner of the east and north hallway. The thermostat read 69 degrees Fahrenheit and was set to 78 degrees Fahrenheit. On 1/6/25 at 10:55 AM, Surveyor interviewed Maintenance Director (MD)-I about the cooler temperature noted in the north hallway. MD-I stated that one of the furnaces on the roof went down. Surveyor asked when the issue with the heating unit started. MD-I stated MD-I could not recall the exact date but thought it was early in December. MD-I stated that MD-I had ordered parts and installed parts but could not recall the exact dates. MD-I stated that the heat was working but not all they way. MD-I stated some residents on the north hallway moved to an area of the building where the heat is functioning but the residents that are currently on the north hallway had refused to move from their rooms. Surveyor asked how often the temperatures on the north unit are checked. MD-I stated multiple times a day. Surveyor asked what the coldest recorded temperature was since the heating unit went down. MD-I stated 68- or 69-degrees Fahrenheit. The comfortable air temperature range in a facility is 71 degrees Fahrenheit to 81 degrees Fahrenheit. Surveyor noted that the facility had a total of 7 residents residing in rooms on the north hallway. On 1/6/25 at 3:15 PM, Surveyor and MD-I took temperatures of the north hallway and resident rooms together. The temperatures were taken with MD-I's ultraviolet scanner with a laser. The laser was pointed at a surface within the resident's room or on a wall. The temperatures were: -The front of the north hallway was 68 degrees Fahrenheit. -room [ROOM NUMBER] occupied by R17 was 65 degrees Fahrenheit. -room [ROOM NUMBER] occupied by R18 was 64 degrees Fahrenheit. -room [ROOM NUMBER] occupied by R19 was 62 degrees Fahrenheit. -The activity room located in the middle of the North hallway was 61 degrees. (continued on next page)

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 01/15/2025
NAME OF PROVIDER OR SUPPLIER Fort Atkinson Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 430 Wilcox St Fort Atkinson, WI 53538	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-room [ROOM NUMBER] occupied by R1 was 62 degrees Fahrenheit. -room [ROOM NUMBER] occupied by R20 was 59 degrees Fahrenheit. -room [ROOM NUMBER] occupied by R12 was 64 degrees Fahrenheit. -room [ROOM NUMBER] occupied by R21 was 62 degrees Fahrenheit. -The end of the north hallway was 62 degrees Fahrenheit. On 1/6/25 at 12:28 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A. Surveyor asked if NHA-A was aware of the facility's heating issues that have been going on for over a month. NHA-A stated NHA-A had not heard that but will look into it and get back to Surveyor. NHA-A returned to Surveyor at 1:08 PM and handed a Performance Improvement Plan (PIP) to Surveyor. NHA-A stated that the previous Administrator had started a PIP for the issue with the heat. NHA-A indicated that a commercial heating company would be coming tomorrow to assess to try to fix the issue with the heating unit. Surveyor reviewed the PIP dated 11/21/24 which documents in part: Project overview: .Residents have the right to safe, clean, comfortable and homelike environment . -11/21/24: The heater broke down and maintenance attempted to troubleshoot the heater. -11/22/24: Regional Director of Maintenance came to troubleshoot the heating system. -11/23/24: Relay and overload parts were ordered for the heater. -11/23/24: Extra Blankets were offered; residents are encouraged to keep their doors open. Encouraged residents to move. One resident moved. I will continue to offer to move residents every day. I will check on comfort during caring partners. -11/26/24: Parts delivered and installed. The heater kicked on, but the rooms and common areas were still cooler. Temps averaging 68-70 degrees Fahrenheit. -12/2/24: The room was still cold; the contractor came in to assess and the module went bad. The part was ordered. The flame sensor and igniter rod were also ordered. Residents offered to move rooms and are still refusing. -12/5/24: Temperatures dropped outside causing areas to get colder . Temps averaging 62-68 degrees Fahrenheit. 6 residents moved rooms. -12/10/24: Continue to offer room moves, blankets and daily room temps . -12/11/24: Room-to-room visits requesting the remaining residents move. They all refused. Message left for Ombudsman. Caring Partner sheets updated. -12/12/24: No suggestions from ombudsman. We can't make them move, just continue current approaches. (continued on next page)

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 01/15/2025
NAME OF PROVIDER OR SUPPLIER Fort Atkinson Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 430 Wilcox St Fort Atkinson, WI 53538	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-12/16/24: Parts were ordered and due in today. Arrival pending. Building warmer. Surveyor reviewed an invoice from [local residential heating company], dated 12/3/24, which documents: On arrival northeast Greenheck unit would not heat. Wiring for heating control not wired properly. No wiring diagrams. Referred client to a commercial HVAC contractor. Was able to get heat working temporarily. On 1/7/25 at 8:44 AM, Surveyor interviewed MD-I regarding the PIP timeline provided to Surveyor. MD-I informed Surveyor that the same heating unit has had multiple issues throughout the time from 11/21/24 to present. Surveyor asked if MD-I was taking temperatures of the north hallway while the heating unit was not fully functional. MD-I stated that he logged temps and would get a copy for Surveyor. MD-I stated MD-I and the Regional Director of Maintenance were able to get the heating somewhat functional after installing parts on 11/26/24. On 12/2/24 when the module went bad, MD-I called [local residential heating company] for help. MD-I was told he needed to get a commercial HVAC contractor. MD-I then called around to commercial HVAC contractors, but multiple contractors were not able to come out. MD-I stated that a local commercial HVAC company agreed to come out. The techs arrived on 12/11/24. MD-I stated that two techs went up to the roof, looked at the unit and returned to MD-I to tell MD-I that they would not be able to service the unit. MD-I then reached out to the regional director and the regional director found a commercial HVAC contractor to come out to service the unit. On 12/12/24, the commercial HVAC company arrived at the facility and stated that the control module was faulty. A new control module was ordered. On 12/16/24, MD-I installed new control module and MD-I stated the heating unit did kick on. MD-I stated that the building did get warmer and at one point MD-I was asked to turn the heat down because the heat was too much. MD-I stated the unit had a new issue that appeared this last weekend. MD-I stated he called the commercial HVAC company on 1/3/25 and 1/5/25 to come service the unit. MD-I was told that the HVAC company would come on 1/6/24 but then on 1/6/24 the tech got stuck in a different city and was unable to come. MD-I stated that a tech is coming out tomorrow (1/7/24). Surveyor reviewed the temperature logs provided by MD-I. The logs include an AM and PM temperature taken in the north hallway of the facility. The following dates are the when the temperature readings were below 71 degrees Fahrenheit: -From the AM temperature reading on 11/21/24 through AM temperature reading on 11/26/24, the temperatures ranged from 67 to 70 degrees Fahrenheit. Surveyor noted that the temperatures were below 71 degrees for five and a half days. -From the AM temperature reading on 12/2/24 through the PM temperature reading on 12/3/24, the temperatures ranged from 66 to 68 degrees Fahrenheit. Surveyor noted that the temperatures were below 71 degrees for 2 days. -From the AM temperature reading on 1/2/25 through the PM temperature reading on 1/7/25, the temperatures ranged from 65 to 70 degrees Fahrenheit. Surveyor noted that the temperatures were below 71 degrees for 6 days. (continued on next page)

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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)
F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 1/6/25 at 3:40 PM, Surveyor interviewed Director of Nursing (DON)-B. Surveyor asked when DON-B was made aware of the heating issue in the building. DON-B stated that DON-B was aware when she first started at this facility on December 21st or 22nd. DON-B stated that MD-I was taking temperature readings and that she expected them to be completed daily. DON-B stated that if the temperature was to go below 60 degrees Fahrenheit, the residents would have to be moved. DON-B stated that a question was added to their Caring Partner sheets to address the temperature in a resident's room and ask if the resident is comfortable. Surveyor asked what Caring Partners were. DON-B stated that the IDT team will do daily rounding with each resident and address any concerns. On 1/7/24 at 7:30 AM, Surveyor observed a commercial HVAC company van parked in the facility parking lot and a HVAC technician on the roof of the facility. On 1/7/24 at 11:15 AM, Surveyor and MD-I took temperatures of the north hallway resident rooms together. -room [ROOM NUMBER] occupied by R17 was 63 degrees Fahrenheit. -room [ROOM NUMBER] occupied by R18 was 61 degrees Fahrenheit. -room [ROOM NUMBER] occupied by R19 was 60 degrees Fahrenheit. -room [ROOM NUMBER] occupied by R1 was 59 degrees Fahrenheit. -room [ROOM NUMBER] occupied by R20 was 57 degrees Fahrenheit. -room [ROOM NUMBER] occupied by R12 was 61 degrees Fahrenheit. -room [ROOM NUMBER] occupied by R21 was 59 degrees Fahrenheit. On 1/7/24 at 1:00 PM, DON-B informed Surveyor that the facility had made the decision to shut down the north wing until the heating unit is fixed. DON-B stated that the facility is moving residents to rooms where the heat is functioning properly. On 1/8/25 at 2:07 PM, Surveyor interviewed Regional Maintenance Director (RMD)-GG regarding the management of the facility's HVAC system. Surveyor asked RMD-GG why the facility did not have a contractor maintain the HVAC system regularly so that the heating issues would be resolved in a timely manner. RMD-GG informed Surveyor that the facility previously had a contract with an HVAC contractor and that the contractor would service and maintain the HVAC system regularly. RMD-GG informed Surveyor that sometime last year RMD-GG was told by corporate that the facility could no longer use the normal HVAC contractor as they no longer had an agreement with the HVAC contractor. Surveyor asked RMD-GG why the HVAC contractor was no longer used and asked if it was due to financial issues. RMD-GG stated that RMD-GG was unsure as to why the contract was canceled but believed it could be financial as they could no longer use the HVAC contractor as the facility's account with the contractor was no longer active. The facility's Governing Body failed to ensure they are being responsible regarding the management and operation of the facility, which includes the maintenance of the HVAC system. This has the potential to affect all residents residing in the facility at the time of the survey.

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 01/15/2025
NAME OF PROVIDER OR SUPPLIER: Fort Atkinson Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 430 Wilcox St Fort Atkinson, WI 53538	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20483 Based on interview and record review the facility did not ensure 1 (R5) of 21 residents reviewed was maintained in accordance with accepted professional standards and practices. R5's July 2024, August 2024, & September 2024 TAR (treatment administration record) had multiple dates which were blank. These blank areas are not explained in the medical record as to whether R5 refused the treatments, the treatments were not completed or the licensed nurse did not document the treatment was completed. Findings include: The facility's policy titled Administration Procedures For All Medications with an effective date 10/25/14 under procedures J. documents After administration, return to cart, replace medication container (if multi-dose and does remain), and document administration in the MAR (medication administration record) or TAR (treatment administration record) and controlled substance sign out record, if indicated. L. documents If resident refuses medication, document refusal on MAR or TAR. Research refusals for possibility of dry mouth, resident reluctance, development of swallowing difficulty. 1.) R5 was originally admitted on [DATE], discharged to the hospital on 8/20/24, readmitted to the facility on [DATE] and discharged to the hospital on 9/12/24. R5 did not return to the facility after being discharged to the hospital on 9/12/24. The July 204 TAR (treatment administration record) includes the following: * Diabetic foot check every evening shift for diagnosis of diabetes with an order date of 4/23/24. Surveyor noted 7/1/24, 7/4/24, 7/6/24, 7/9/24, 7/11/24, and 7/28/24 are blank. * Wound care left great toe: cleanse area and apply betadine paint. Every day shift for wound healing with an order date of 7/16/24. Surveyor noted 7/20/24 & 7/27/24 are blank. * Wound care left plantar foot: cleanse area and apply betadine pain. Every day shift for wound healing with an order date of 7/16/24. Surveyor noted 7/20/24 & 7/27/24 are blank. * Wound care left proximal 3rd toe: Cleanse area and apply betadine paint. Every day shift for wound healing with an order date of 7/16/24. Surveyor noted 7/20/24 & 7/27/24 are blank. * Wound care right anterior arm: Cleanse area, pat dry, protect with bordered gauze MWF (Monday, Wednesday, Friday) and prn (as needed) missing or soiled. Every day shift every Mon, Wed, Fri for wound healing with an order date of 6/14/24. Surveyor noted 7/31/24 is blank. * Wound care right plantar foot: Cleanse area and apply betadine paint. Every day shift for wound healing with an order date of 7/16/24. Surveyor noted 7/20/24, 7/27/24, & 7/31/24 are blank. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fort Atkinson Care Center	430 Wilcox St Fort Atkinson, WI 53538

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)

F 0842

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

* Wound care to right foot partial amputation: Cleanse with soap/water or wound cleanser, pat dry, apply isdosorb gel with non adherent pad, cover with abd (abdominal) pad and wrap with kerlix. Every day shift with an order date of 5/1/24. Surveyor noted 7/6/24,7/14/24, 7/20/24, & 7/27/24 are blank.

* Nystatin External Powder 100000 unit/gm (gram) Apply to bilateral groins topically every day and evening shift for redness per [Physician-Q] with an order date of 5/9/24. Surveyor noted 7/1/24 evening shift, 7/4/24 evening shift, 7/6/24 day & evening shift, 7/9/14 evening shift, 7/11/24 evening shift, 7/23/24 evening shift, 7/27/24 day shift and 7/28/24 evening shift are blank.

The August 2024 TAR includes the following:

* Diabetic foot check every evening shift for diagnosis of diabetes with an order date of 4/23/24. Surveyor noted 8/2/24, 8/10/24, 8/11/24, 8/13/24, 8/14/24, 8/15/24, 8/17/24, 8/21/24, 8/22/24, 8/24/24, 8/25/24, 8/26/24, 8/27/24, 8/29/24, & 8/30/24 are blank.

* Wound care left plantar foot: Cleanse area and apply betadine paint. Every day shift for wound healing with an order date of 7/16/24. Surveyor noted 8/9/24 & 8/11/24 are blank.

* Wound care Rt (right) anterior arm: Cleanse the wound with cleanser and pat dry with gauze. Skin prep daily leave OTA (open to air). Every day shift for wound healing with an order date of 8/7/24 & d/c (discontinued) on 8/20/24. Surveyor noted 8/9/24 & 8/11/24 are blank.

* Wound care to right foot partial amputation: Cleanse with soap/water or wound cleanser, pat dry, apply isdosorb gel with non-adherent pad, cover with abd pad and wrap with kerlix. Every day shift with an order date of 5/1/24. Surveyor noted 8/9/24 & 8/11/24 are blank.

* Wound care left great toe: Cleanse area and apply betadine paint. Every day and evening shift for wound healing with an order date of 8/7/24. Surveyor noted 8/9/24 day shift, 8/10/24 evening shift, 8/11/24 day & evening shift, 8/13/24, 8/14/24 & 8/15/24 evening shifts, & 8/17/24 evening shift are blank.

* Wound care left proximal 3rd toe: Cleanse area and apply betadine paint. Every day and evening shift for wound healing with an order date of 8/7/24. Surveyor noted 8/9/24 day shift, 8/10/24 evening shift, 8/11/24 day & evening shift, 8/13/24, 8/14/24 & 8/15/24 evening shifts, & 8/17/24 evening shift are blank.

* Wound care right plantar foot: Cleanse area and apply iodosorb and dry dressing. Every day and night shift for wound healing with an order date of 8/7/24 and discontinued on 8/15/24. Surveyor noted 8/9/24 day shift, 8/11/24 day shift, 8/12 evening shift, and 8/15/24 day shift are blank.

* Nystatin External Powder 100000 unit/gm (gram) Apply to bilateral groins topically every day and evening shift for redness per [Physician-Q] with an order date of 5/9/24. Surveyor note 8/2/24 evening shift, 8/9/24 day shift, 8/10/24 evening shift, 8/11/24 day & evening shift, 8/13/24, 8/14/24, & 8/15/24 evening shift, 8/17/24 day & evening shift, and 8/20/24 day shift are blank.

The September 2024 TAR includes:

(continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Fort Atkinson Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 430 Wilcox St, Fort Atkinson, WI 53538	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	* Diabetic foot check every evening shift for diagnosis of diabetes with an order date of 4/23/24. Surveyor noted 9/2/24 & 9/6/24 are blank. * Nystatin External Powder 100000 unit/gm (gram) Apply to bilateral groins topically every day and evening shift for redness per [Physician-Q] with an order date of 5/9/24. Surveyor noted 9/2 evening shift, 9/3/24 day shift, 9/4/24 day shift, 9/6/24 evening shift, 9/8/24 day shift, & 9/12/24 evening shift are blank. On 1/8/25, at approximately 10:30 a.m., Surveyor informed DON (Director of Nursing)-B Surveyor had reviewed R5's TAR for July 2024, August 2024, & September 2024 and noted multiple blank dates. Surveyor informed DON-B Surveyor was unable to determine if the treatments were not completed, R5 refused or the licensed nurse did not initial the treatments as being completed. Surveyor informed DON-B Surveyor reviewed R5's progress notes and was unable to locate any progress note regarding these blank dates. DON-B informed Surveyor she had noted the blanks on R5's TAR. No additional information was provided as to why the facility did not ensure that R5's medical record was maintained in accordance with accepted professional standards and practices.

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 01/15/2025
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0941 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Develop, implement, and/or maintain an effective training program that includes effective communications for direct care staff members. 38829 Based on staff interview and record review, the facility did not ensure 5 of 5 Certified Nurse Aides (CNAs)(CNA-H, CNA-J, CNA-DD, CNA-EE, CNA-FF) reviewed received the annual required Effective Communication training. This practice had the potential to affect all 35 Residents in the facility receiving care from these 5 CNAs. The facility did not provide staff with the required annual effective communication training for 5 of 5 Certified Nurse Aides (CNAs)(CNA-H, CNA-J, CNA-DD, CNA-EE, CNA-FF). Findings Include: The facility's policy Required Training, Certification and Continuing Education of Nurse Aides dated 10/1/22 documents: .It is the policy of this facility to comply with State and Federal regulations and requirements as they pertain to the training, certification, and continuing education of its nurse aides. 5. The facility will provide at least 12 hours of in-service training annually, based on the employment date, not calendar year. a. Documentation of in-services will forwarded to the HR Director and maintained in the employee's personnel file. 6. In-service training will be provided by qualified personnel and will be based on the needs of Residents in the facility and any areas of weakness as determined in the nurse aide's performance reviews and facility assessment. Minimum training will include: a. Effective communication b. Dementia management and care of the cognitively impaired c. Abuse, neglect, and exploitation prevention d. Elements and goals of the facility's QAPI program e. Resident rights and facility responsibilities f. Written standards, policies, and procedures for the facility's infection prevention and control program g. Requirements under the facility's compliance and ethics programs h. Safety and emergency procedures (continued on next page)

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 01/15/2025
NAME OF PROVIDER OR SUPPLIER Fort Atkinson Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 430 Wilcox St Fort Atkinson, WI 53538	

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F 0941 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	i. Behavioral health(mental, psychosocial, or substance use disorders, a history of trauma and/or post-traumatic stress disorder, or other behavioral health conditions) j. Identification of changes in condition k. Cultural competency . The facility's Facility Assessment Tool policy, updated 1/13/25, contains the following information: .CNAs-to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year: -Infection control -Dementia training -Resident rights -Abuse and neglect -Additional training to meet the needs of the staff member and current Residents -Promoting healthy skin -Blood borne pathogens Consider the following training topics: -Communication-effective communications for direct care staff -Resident rights and facility responsibilities -Abuse, neglect, and exploitation and care management for persons with dementia -Infection control -Caring for Residents with mental and psychosocial disorders, as well as Residents with a history of trauma and/or post-traumatic stress disorder, and implementing nonpharmacological interventions. Surveyor notes both the facility policy and facility assessment documents Effective Communication to be included in the annual trainings of CNAs. On 1/15/25 at 9:00 AM, Surveyors requested from Director of Nursing (DON)-B all trainings completed by CNA-H, CNA-J, CNA-DD, CNA-EE, CNA-FF for the following time periods based on date of hire: CNA-H 1/28/23-1/28/24 (continued on next page)

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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)
F 0941 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	CNA-J 12/1/23-12/1/24 CNA-DD 3/1/23-3/1/24 CNA-EE 9/6/23-9/6/24 CNA-FF 4/28/23-4/28/24 On 1/15/24, at 12:15 PM, DON-B was interviewed and indicated no trainings could be found in the facility for CNA-H for the timeframe of 1/28/23 to 1/28/24, CNA-J for the timeframe 12/1/23-12/1/24, CNA-DD for the timeframe of 3/1/23 to 3/124, CNA-EE for the timeframe of 9/6/23 to 9/6/24, and CNA-FF for the timeframe of 4/28/23 to 4/28/24. DON-B indicated the trainings may be kept offsite and would need to be found. DON-B confirmed the required trainings must be completed on a yearly basis based on date of hire for the CNAs. DON-B is aware of the federal regulations and Surveyor reviewed with DON-B the regulations On 1/15/25, at 12:20 PM, Nursing Home Administrator-A and DON-B were informed that any additional information on the trainings is requested, if available. Surveyor shared the concern at this time that CNA-H, CNA-J, CNA-DD, CNA-EE, CNA-FF has no documentation that CNA-H, CNA-J, CNA-DD, CNA-EE, CNA-FF received the required Effective Communication training at this time. On 1/16/25, at 7:12 PM, Surveyor received four emails with training documentation. On 1/21/24, at 6:30 AM, Surveyor reviewed the facility's additional information of trainings completed by CNA-H, CNA-J, CNA-DD, CNA-EE, CNA-FF. CNA-H was hired by the facility on 1/28/21 and did not receive Effective Communication Training. CNA-J was hired by the facility on 12/10/20 and did not receive Effective Communication Training. CNA-DD was hired by the facility on 3/1/23 and did not receive Effective Communication Training. CNA-EE was hired by the facility on 9/6/2001 and did not receive Effective Communication Training. CNA-FF was hired by the facility on 4/28/23 and did not receive Effective Communication Training. No additional information was provided as to why CNA-H, CNA-J, CNA-DD, CNA-EE and CNA-FF did not receive the required annual effective communication training.

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 01/15/2025
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)
F 0942 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that staff members are educated on resident rights and facility responsibilities to properly care for its residents. 38829 Based on staff interview and record review, the facility did not ensure 2 of 5 Certified Nurse Aides (CNAs)(CNA-H and CNA-DD) received the required annual Resident Rights and the responsibility of the facility to properly care for the Residents trainings. This practice had the potential to affect all 35 Residents in the facility. The facility did not provide staff with the required annual Resident Rights training for 2 of 5 Certified Nurse Aides (CNAs)(CNA-H). Findings Include: The facility's policy Required Training, Certification and Continuing Education of Nurse Aides dated 10/1/22 documents: .It is the policy of this facility to comply with State and Federal regulations and requirements as they pertain to the training, certification, and continuing education of its nurse aides. 5. The facility will provide at least 12 hours of in-service training annually, based on the employment date, not calendar year. a. Documentation of in-services will forwarded to the HR Director and maintained in the employee's personnel file. 6. In-service training will be provided by qualified personnel and will be based on the needs of Residents in the facility and any areas of weakness as determined in the nurse aide's performance reviews and facility assessment. Minimum training will include: a. Effective communication b. Dementia management and care of the cognitively impaired c. Abuse, neglect, and exploitation prevention d. Elements and goals of the facility's QAPI program e. Resident rights and facility responsibilities f. Written standards, policies, and procedures for the facility's infection prevention and control program g. Requirements under the facility's compliance and ethics programs h. Safety and emergency procedures (continued on next page)

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 01/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fort Atkinson Care Center	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)

F 0942

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

i. Behavioral health(mental, psychosocial, or substance use disorders, a history of trauma and/or post-traumatic stress disorder, or other behavioral health conditions)

j. Identification of changes in condition

k. Cultural competency .

The facility's Facility Assessment Tool policy, updated 1/13/25, contains the following information:

.CNAs-to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year:

-Infection control

-Dementia training

-Resident rights

-Abuse and neglect

-Additional training to meet the needs of the staff member and current Residents

-Promoting healthy skin

-Blood borne pathogens

Consider the following training topics:

-Communication-effective communications for direct care staff

-Resident rights and facility responsibilities

-Abuse, neglect, and exploitation and care management for persons with dementia

-Infection control

-Caring for Residents with mental and psychosocial disorders, as well as Residents with a history of trauma and/or post-traumatic stress disorder, and implementing nonpharmacological interventions.

The facility's policy and Facility Assessment Tool policy includes Resident Rights as a required training for CNAs.

On 1/15/25 at 9:00 AM, Surveyors requested from Director of Nursing (DON)-B all trainings completed by CNA-H, CNA-J, CNA-DD, CNA-EE, CNA-FF for the following time periods based on date of hire:

CNA-H 1/28/23-1/28/24

(continued on next page)

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 01/15/2025
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)
F 0942 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CNA-J 12/1/23-12/1/24 CNA-DD 3/1/23-3/1/24 CNA-EE 9/6/23-9/6/24 CNA-FF 4/28/23-4/28/24 On 1/15/24, at 12:15 PM, DON-B was interviewed and indicated no trainings could be found in the facility for CNA-H for the timeframe of 1/28/23 to 1/28/24,CNA-J for the timeframe 12/1/23-12/1/24, CNA-DD for the timeframe of 3/1/23 to 3/124, CNA-EE for the timeframe of 9/6/23 to 9/6/24, and CNA-FF for the timeframe of 4/28/23 to 4/28/24. DON-B indicated the trainings may be kept offsite and would need to be found. DON-B confirmed the required trainings must be completed on a yearly basis based on date of hire for the CNAs. DON-B is aware of the federal regulations and Surveyor reviewed with DON-B the regulations On 1/15/25, at 12:20 PM, Administrator-A and DON-B were informed that any additional information on the trainings is requested, if available. Surveyor shared the concern at this time that CNA-H, CNA-J, CNA-DD, CNA-EE, CNA-FF has no documentation that CNA-H, CNA-J, CNA-DD, CNA-EE, CNA-FF received the required Resident Rights training at this time. On 1/16/25, at 7:12 PM, Surveyor received four emails with training documentation. On 1/21/24, at 6:30 AM, Surveyor reviewed the facility's additional information of trainings completed by CNA-H, CNA-J, CNA-DD, CNA-EE, CNA-FF. CNA-H was hired by the facility on 1/28/21 and did not receive Resident Rights Training within the timeframe of hire date. Documentation indicates CNA-H last received Resident Rights Training on 12/6/23, which would not be within the year timeframe from hire date. CNA-DD was hired by the facility on 3/1/23 and did not receive Resident Rights Training within the timeframe of hire date. CNA-DD last received Resident Rights Training on 4/3/24, which would not be within the year timeframe from hire date. No additional information was provided as to why CNA-H and CNA-DD did not recieve the required annual Resident Rights and the responsibility of the facility to properly care for the Residents trainings.

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 01/15/2025
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)
F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. 38829 Based on staff interview and record review, the facility did not ensure 1 of 5 Certified Nurse Aides (CNAs)(CNA-H) received the annual require Abuse/Neglect and Dementia training which includes education on abuse, neglect and exploitation, activities that constitute abuse, neglect, exploitation, and misappropriation procedures for reporting incidents of abuse, neglect, exploitation and misappropriation and dementia management and Resident abuse prevention. This deficient practice had the potential to affect all 35 Residents in the facility. The facility did not provide staff with the required annual Abuse and Dementia training for 1 of 5 Certified Nurse Aides(CNA-H). Findings Include: The facility's policy Required Training, Certification and Continuing Education of Nurse Aides dated 10/1/22 documents: .It is the policy of this facility to comply with State and Federal regulations and requirements as they pertain to the training, certification, and continuing education of its nurse aides. 5. The facility will provide at least 12 hours of in-service training annually, based on the employment date, not calendar year. a. Documentation of in-services will forwarded to the HR Director and maintained in the employee's personnel file. 6. In-service training will be provided by qualified personnel and will be based on the needs of Residents in the facility and any areas of weakness as determined in the nurse aide's performance reviews and facility assessment. Minimum training will include: a. Effective communication b. Dementia management and care of the cognitively impaired c. Abuse, neglect, and exploitation prevention d. Elements and goals of the facility's QAPI program e. Resident rights and facility responsibilities f. Written standards, policies, and procedures for the facility's infection prevention and control program g. Requirements under the facility's compliance and ethics programs (continued on next page)

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 01/15/2025
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)
F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	h. Safety and emergency procedures i. Behavioral health(mental, psychosocial, or substance use disorders, a history of trauma and/or post-traumatic stress disorder, or other behavioral health conditions) j. Identification of changes in condition k. Cultural competency . The facility's Facility Assessment Tool policy, updated 1/13/25, contains the following information: .CNAs-to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year: -Infection control -Dementia training -Resident rights -Abuse and neglect -Additional training to meet the needs of the staff member and current Residents -Promoting healthy skin -Blood borne pathogens Consider the following training topics: -Communication-effective communications for direct care staff -Resident rights and facility responsibilities -Abuse, neglect, and exploitation and care management for persons with dementia -Infection control -Caring for Residents with mental and psychosocial disorders, as well as Residents with a history of trauma and/or post-traumatic stress disorder, and implementing nonpharmacological interventions. The facility's policy and Facility Assessment Tool policy includes Abuse and Dementia as a required training for staff. On 1/15/25 at 9:00 AM, Surveyors requested from Director of Nursing (DON)-B all trainings completed by CNA-H, CNA-J, CNA-DD, CNA-EE, CNA-FF for the following time periods based on date of hire: (continued on next page)

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 01/15/2025
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)
F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CNA-H 1/28/23-1/28/24 CNA-J 12/1/23-12/1/24 CNA-DD 3/1/23-3/1/24 CNA-EE 9/6/23-9/6/24 CNA-FF 4/28/23-4/28/24 On 1/15/24, at 12:15 PM, DON-B was interviewed and indicated no trainings could be found in the facility for CNA-H for the timeframe of 1/28/23 to 1/28/24,CNA-J for the timeframe 12/1/23-12/1/24, CNA-DD for the timeframe of 3/1/23 to 3/124, CNA-EE for the timeframe of 9/6/23 to 9/6/24, and CNA-FF for the timeframe of 4/28/23 to 4/28/24. DON-B indicated the trainings may be kept offsite and would need to be found. DON-B confirmed the required trainings must be completed on a yearly basis based on date of hire for the CNAs. DON-B is aware of the federal regulations and Surveyor reviewed with DON-B the regulations On 1/15/25, at 12:20 PM, Administrator-A and DON-B were informed that any additional information on the trainings is requested, if available. Surveyor shared the concern at this time that CNA-H, CNA-J, CNA-DD, CNA-EE, CNA-FF has no documentation that CNA-H, CNA-J, CNA-DD, CNA-EE, CNA-FF received the required Abuse and Dementia training at this time. On 1/16/25, at 7:12 PM, Surveyor received four emails with training documentation. On 1/21/24, at 6:30 AM, Surveyor reviewed the facility's additional information of trainings completed by CNA-H, CNA-J, CNA-DD, CNA-EE, CNA-FF. CNA-H was hired by the facility on 1/28/21 and did not receive Abuse and Dementia Training within the timeframe of hire date. Documentation indicates CNA-H last received Abuse Training, not Dementia training on 12/6/23 which would not be within the year timeframe from hire date. No additional information was provided as to why the facility did not provide staff with the required annual Abuse and Dementia training for CNA-H.

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 01/15/2025
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)
F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct mandatory training, for all staff, on the facility's Quality Assurance and Performance Improvement Program. 38829 Based on staff interview and record review, the facility did not ensure 5 of 5 Certified Nurse Aides (CNAs)(CNA-H, CNA-J, CNA-DD, CNA-EE, CNA-FF) received the annual required QAPI (quality assurance performance improvement) training on the elements & goals of the Facility's QAPI program. This practice had the potential to affect all 35 Residents in the facility. The facility did not provide staff with the required annual QAPI training for 5 of 5 Certified Nurse Aides (CNAs)(CNA-H, CNA-J, CNA-DD, CNA-EE and CNA-FF). Findings Include: The facility's policy Required Training, Certification and Continuing Education of Nurse Aides dated 10/1/22 documents: .It is the policy of this facility to comply with State and Federal regulations and requirements as they pertain to the training, certification, and continuing education of its nurse aides. 5. The facility will provide at least 12 hours of in-service training annually, based on the employment date, not calendar year. a. Documentation of in-services will forwarded to the HR Director and maintained in the employee's personnel file. 6. In-service training will be provided by qualified personnel and will be based on the needs of Residents in the facility and any areas of weakness as determined in the nurse aide's performance reviews and facility assessment. Minimum training will include: a. Effective communication b. Dementia management and care of the cognitively impaired c. Abuse, neglect, and exploitation prevention d. Elements and goals of the facility's QAPI program e. Resident rights and facility responsibilities f. Written standards, policies, and procedures for the facility's infection prevention and control program g. Requirements under the facility's compliance and ethics programs h. Safety and emergency procedures (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525262	A. Building B. Wing	01/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fort Atkinson Care Center	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)
F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	i. Behavioral health(mental, psychosocial, or substance use disorders, a history of trauma and/or post-traumatic stress disorder, or other behavioral health conditions) j. Identification of changes in condition k. Cultural competency . The facility's Facility Assessment Tool policy, updated 1/13/25, contains the following information: .CNAs-to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year: -Infection control -Dementia training -Resident rights -Abuse and neglect -Additional training to meet the needs of the staff member and current Residents -Promoting healthy skin -Blood borne pathogens Consider the following training topics: -Communication-effective communications for direct care staff -Resident rights and facility responsibilities -Abuse, neglect, and exploitation and care management for persons with dementia -Infection control -Caring for Residents with mental and psychosocial disorders, as well as Residents with a history of trauma and/or post-traumatic stress disorder, and implementing nonpharmacological interventions. The facility's Assessment Tool policy does not include QAPI training. 1.) On 1/15/25 at 9:00 AM, Surveyors requested from Director of Nursing (DON)-B all trainings completed by CNA-H, CNA-J, CNA-DD, CNA-EE, CNA-FF for the following time periods based on date of hire: CNA-H 1/28/23-1/28/24 CNA-J 12/1/23-12/1/24 (continued on next page)

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 01/15/2025
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)
F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	CNA-DD 3/1/23-3/1/24 CNA-EE 9/6/23-9/6/24 CNA-FF 4/28/23-4/28/24 On 1/15/24, at 12:15 PM, DON-B was interviewed and indicated no trainings could be found in the facility for CNA-H for the timeframe of 1/28/23 to 1/28/24,CNA-J for the timeframe 12/1/23-12/1/24, CNA-DD for the timeframe of 3/1/23 to 3/124, CNA-EE for the timeframe of 9/6/23 to 9/6/24 and CNA-FF for the timeframe of 4/28/23 to 4/28/24. DON-B indicated the trainings may be kept offsite and would need to be found. DON-B confirmed the required trainings must be completed on a yearly basis based on date of hire for the CNAs. DON-B is aware of the federal regulations and Surveyor reviewed with DON-B the regulations On 1/15/25, at 12:20 PM, Administrator-A and DON-B were informed that any additional information on the trainings is requested, if available. Surveyor shared the concern at this time that CNA-H, CNA-J, CNA-DD, CNA-EE, CNA-FF has no documentation that CNA-H, CNA-J, CNA-DD, CNA-EE, CNA-FF received the required QAPI training at this time. On 1/16/25, at 7:12 PM, Surveyor received four emails with training documentation. On 1/21/24, at 6:30 AM, Surveyor reviewed the facility's additional information of trainings completed by CNA-H, CNA-J, CNA-DD, CNA-EE, CNA-FF. CNA-H was hired by the facility on 1/28/21 and did not receive QAPI Training. CNA-J was hired by the facility on 12/10/20 and did not receive QAPI Training. CNA-DD was hired by the facility on 3/1/23 and did not receive QAPI Training. CNA-EE was hired by the facility on 9/6/2001 and did not receive QAPI Training. CNA-FF was hired by the facility on 4/28/23 and did not receive QAPI Training. No additional information was provided as to why the facility failed to provide the required annual QAPI training for CNA-H, CNA-J, CNA-DD, CNA-EE and CNA-FF.

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 01/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fort Atkinson Care Center	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)
F 0945 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Include as part of its infection prevention and control program, mandatory training that includes written standards, policies, and procedures for the program. 38829 Based on staff interview and record review, the facility did not ensure 2 of 5 Certified Nurse Aides (CNAs)(CNA-H, and CNA-DD) received the required annual Infection Control training which includes the written standards, policies, and procedures for Infection Control. This practice had the potential to affect all 35 Residents in the facility. The facility did not provide staff with the required annual Infection Control training for 2 of 5 Certified Nurse Aides (CNAs)(CNA-H, and CNA-DD) on an annual basis. Findings Include: The facility's policy Required Training, Certification and Continuing Education of Nurse Aides dated 10/1/22 documents: .It is the policy of this facility to comply with State and Federal regulations and requirements as they pertain to the training, certification, and continuing education of its nurse aides. 5. The facility will provide at least 12 hours of in-service training annually, based on the employment date, not calendar year. a. Documentation of in-services will forwarded to the HR Director and maintained in the employee's personnel file. 6. In-service training will be provided by qualified personnel and will be based on the needs of Residents in the facility and any areas of weakness as determined in the nurse aide's performance reviews and facility assessment. Minimum training will include: a. Effective communication b. Dementia management and care of the cognitively impaired c. Abuse, neglect, and exploitation prevention d. Elements and goals of the facility's QAPI program e. Resident rights and facility responsibilities f. Written standards, policies, and procedures for the facility's infection prevention and control program g. Requirements under the facility's compliance and ethics programs h. Safety and emergency procedures (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525262	A. Building B. Wing	01/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fort Atkinson Care Center	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)
F 0945 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	i. Behavioral health(mental, psychosocial, or substance use disorders, a history of trauma and/or post-traumatic stress disorder, or other behavioral health conditions) j. Identification of changes in condition k. Cultural competency . The facility's Facility Assessment Tool policy, updated 1/13/25, contains the following information: .CNAs-to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year: -Infection control -Dementia training -Resident rights -Abuse and neglect -Additional training to meet the needs of the staff member and current Residents -Promoting healthy skin -Blood borne pathogens Consider the following training topics: -Communication-effective communications for direct care staff -Resident rights and facility responsibilities -Abuse, neglect, and exploitation and care management for persons with dementia -Infection control -Caring for Residents with mental and psychosocial disorders, as well as Residents with a history of trauma and/or post-traumatic stress disorder, and implementing nonpharmacological interventions. The facility's policy and Facility Assessment Tool policy includes Infection Control as a required training for staff. On 1/15/25 at 9:00 AM, Surveyors requested from Director of Nursing (DON)-B all trainings completed by CNA-H, CNA-J, CNA-DD, CNA-EE, CNA-FF for the following time periods based on date of hire: CNA-H 1/28/23-1/28/24 (continued on next page)

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 01/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fort Atkinson Care Center	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)
F 0945 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CNA-J 12/1/23-12/1/24 CNA-DD 3/1/23-3/1/24 CNA-EE 9/6/23-9/6/24 CNA-FF 4/28/23-4/28/24 On 1/15/24, at 12:15 PM, DON-B was interviewed and indicated no trainings could be found in the facility for CNA-H for the timeframe of 1/28/23 to 1/28/24,CNA-J for the timeframe 12/1/23-12/1/24, CNA-DD for the timeframe of 3/1/23 to 3/124, CNA-EE for the timeframe of 9/6/23 to 9/6/24, and CNA-FF for the timeframe of 4/28/23 to 4/28/24. DON-B indicated the trainings may be kept offsite and would need to be found. DON-B confirmed the required trainings must be completed on a yearly basis based on date of hire for the CNAs. DON-B is aware of the federal regulations and Surveyor reviewed with DON-B the regulations On 1/15/25, at 12:20 PM, Administrator-A and DON-B were informed that any additional information on the trainings is requested, if available. Surveyor shared the concern at this time that CNA-H, CNA-J, CNA-DD, CNA-EE, CNA-FF has no documentation that CNA-H, CNA-J, CNA-DD, CNA-EE, CNA-FF received the required Infection Control at this time. On 1/16/25, at 7:12 PM, Surveyor received four emails with training documentation. On 1/21/24, at 6:30 AM, Surveyor reviewed the facility's additional information of trainings completed by CNA-H, CNA-J, CNA-DD, CNA-EE, CNA-FF. CNA-H was hired by the facility on 1/28/21 and did not receive Infection Control Training. CNA-DD was hired by the facility on 3/1/23 and did not receive Infection Control Training within the timeframe of hire date. CNA-DD last received Infection Control Training on 4/3/24 which would not be within the year timeframe from hire date. No additional information was provided.

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 01/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fort Atkinson Care Center	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)
F 0946 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide training in compliance and ethics. 38829 Based on staff interview and record review, the facility did not ensure staff received the annual Compliance and Ethics training. This practice had the potential to affect all 35 Residents in the facility. The facility did not provide staff with the required annual Compliance and Ethics training for 5 of 5 Certified Nurse Aides (CNAs)(CNA-H, CNA-J, CNA-DD, CNA-EE, CNA-FF) on an annual basis. Findings Include: The facility's policy Required Training, Certification and Continuing Education of Nurse Aides dated 10/1/22 documents: .It is the policy of this facility to comply with State and Federal regulations and requirements as they pertain to the training, certification, and continuing education of its nurse aides. 5. The facility will provide at least 12 hours of in-service training annually, based on the employment date, not calendar year. a. Documentation of in-services will forwarded to the HR Director and maintained in the employee's personnel file. 6. In-service training will be provided by qualified personnel and will be based on the needs of Residents in the facility and any areas of weakness as determined in the nurse aide's performance reviews and facility assessment. Minimum training will include: a. Effective communication b. Dementia management and care of the cognitively impaired c. Abuse, neglect, and exploitation prevention d. Elements and goals of the facility's QAPI program e. Resident rights and facility responsibilities f. Written standards, policies, and procedures for the facility's infection prevention and control program g. Requirements under the facility's compliance and ethics programs h. Safety and emergency procedures (continued on next page)

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 01/15/2025
NAME OF PROVIDER OR SUPPLIER: Fort Atkinson Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 430 Wilcox St, Fort Atkinson, WI 53538	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0946 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	i. Behavioral health(mental, psychosocial, or substance use disorders, a history of trauma and/or post-traumatic stress disorder, or other behavioral health conditions) j. Identification of changes in condition k. Cultural competency . The facility's Facility Assessment Tool policy, updated 1/13/25, contains the following information: .CNAs-to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year: -Infection control -Dementia training -Resident rights -Abuse and neglect -Additional training to meet the needs of the staff member and current Residents -Promoting healthy skin -Blood borne pathogens Consider the following training topics: -Communication-effective communications for direct care staff -Resident rights and facility responsibilities -Abuse, neglect, and exploitation and care management for persons with dementia -Infection control -Caring for Residents with mental and psychosocial disorders, as well as Residents with a history of trauma and/or post-traumatic stress disorder, and implementing nonpharmacological interventions. The facility's Facility Assessment Tool policy does not include Compliance and Ethics training. On 1/15/25 at 9:00 AM, Surveyors requested from Director of Nursing (DON)-B all trainings completed by CNA-H, CNA-J, CNA-DD, CNA-EE, CNA-FF for the following time periods based on date of hire: CNA-H 1/28/23-1/28/24 CNA-J 12/1/23-12/1/24 (continued on next page)

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 01/15/2025
NAME OF PROVIDER OR SUPPLIER Fort Atkinson Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 430 Wilcox St Fort Atkinson, WI 53538	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0946 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	CNA-DD 3/1/23-3/1/24 CNA-EE 9/6/23-9/6/24 CNA-FF 4/28/23-4/28/24 On 1/15/24, at 12:15 PM, DON-B was interviewed and indicated no trainings could be found in the facility for CNA-H for the timeframe of 1/28/23 to 1/28/24,CNA-J for the timeframe 12/1/23-12/1/24, CNA-DD for the timeframe of 3/1/23 to 3/124, CNA-EE for the timeframe of 9/6/23 to 9/6/24, and CNA-FF for the timeframe of 4/28/23 to 4/28/24. DON-B indicated the trainings may be kept offsite and would need to be found. DON-B confirmed the required trainings must be completed on a yearly basis based on date of hire for the CNAs. DON-B is aware of the federal regulations and Surveyor reviewed with DON-B the regulations On 1/15/25, at 12:20 PM, Administrator-A and DON-B were informed that any additional information on the trainings is requested, if available. Surveyor shared the concern at this time that CNA-H, CNA-J, CNA-DD, CNA-EE, CNA-FF has no documentation that CNA-H, CNA-J, CNA-DD, CNA-EE, CNA-FF received the required compliance and ethics training at this time. On 1/16/25, at 7:12 PM, Surveyor received four emails with training documentation. On 1/21/24, at 6:30 AM, Surveyor reviewed the facility's additional information of trainings completed by CNA-H, CNA-J, CNA-DD, CNA-EE, CNA-FF. CNA-H was hired by the facility on 1/28/21 and did not receive Compliance and Ethics Training. CNA-J was hired by the facility on 12/10/20 and did not receive Compliance and Ethics Training. CNA-DD was hired by the facility on 3/1/23 and did not receive Compliance and Ethics Training. CNA-EE was hired by the facility on 9/6/2001 and did not receive Compliance and Ethics Training. CNA-FF was hired by the facility on 4/28/23 and did not receive Compliance and Ethics Training. No additional information was provided.

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 01/15/2025
NAME OF PROVIDER OR SUPPLIER: Fort Atkinson Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 430 Wilcox St, Fort Atkinson, WI 53538	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide behavior health training consistent with the requirements and as determined by a facility assessment. 38829 Based on record review and interview, the facility did not ensure direct care staff 5 of 5 Certified Nurse Aides (CNAs)(CNA-H, CNA-J, CNA-DD, CNA-EE, CNA-FF) reviewed received behavioral health training to care for Residents diagnosed with mental, psychosocial, a history of trauma, or substance use disorder as indicated on the facility assessment. This deficient practice has the potential for all staff to lack current knowledge to work with the unique challenges mental health illnesses present. The facility did not provide staff with required annual training on the facility's behavioral health services. Findings Include: The facility's policy Required Training, Certification and Continuing Education of Nurse Aides dated 10/1/22 documents: .It is the policy of this facility to comply with State and Federal regulations and requirements as they pertain to the training, certification, and continuing education of its nurse aides. 5. The facility will provide at least 12 hours of in-service training annually, based on the employment date, not calendar year. a. Documentation of in-services will forwarded to the HR Director and maintained in the employee's personnel file. 6. In-service training will be provided by qualified personnel and will be based on the needs of Residents in the facility and any areas of weakness as determined in the nurse aide's performance reviews and facility assessment. Minimum training will include: a. Effective communication b. Dementia management and care of the cognitively impaired c. Abuse, neglect, and exploitation prevention d. Elements and goals of the facility's QAPI program e. Resident rights and facility responsibilities f. Written standards, policies, and procedures for the facility's infection prevention and control program g. Requirements under the facility's compliance and ethics programs (continued on next page)

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 01/15/2025
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	h. Safety and emergency procedures i. Behavioral health(mental, psychosocial, or substance use disorders, a history of trauma and/or post-traumatic stress disorder, or other behavioral health conditions) j. Identification of changes in condition k. Cultural competency . The facility's Facility Assessment Tool policy, updated 1/13/25, contains the following information: .The facility admits Residents with Psychosis(Hallucinations, Delusions), Impaired Cognition, Mental Disorder, Depression, Bipolar, Schizophrenia, Post-Traumatic Stress Disorder, Anxiety Disorder, Behavior that Needs Interventions. The facility assessment documents that the facility has an average of 5-10 Residents with behavioral health needs. Services and care offered by the facility for mental health and behavior is to 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, care of individuals with depression, trauma/PTSD, other psychiatric diagnoses, intellectual or developmental disabilities. CNAs-to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year: -Infection control -Dementia training -Resident rights -Abuse and neglect -Additional training to meet the needs of the staff member and current Residents -Promoting healthy skin -Blood borne pathogens Consider the following training topics: -Communication-effective communications for direct care staff -Resident rights and facility responsibilities (continued on next page)

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 01/15/2025

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F 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Abuse, neglect, and exploitation and care management for persons with dementia -Infection control -Caring for Residents with mental and psychosocial disorders, as well as Residents with a history of trauma and/or post-traumatic stress disorder, and implementing nonpharmacological interventions. On 1/15/25 at 9:00 AM, Surveyors requested from Director of Nursing (DON)-B all trainings completed by CNA-H, CNA-J, CNA-DD, CNA-EE, CNA-FF for the following time periods based on date of hire: CNA-H 1/28/23-1/28/24 CNA-J 12/1/23-12/1/24 CNA-DD 3/1/23-3/1/24 CNA-EE 9/6/23-9/6/24 CNA-FF 4/28/23-4/28/24 On 1/15/24, at 12:15 PM, DON-B was interviewed and indicated no trainings could be found in the facility for CNA-H for the timeframe of 1/28/23 to 1/28/24,CNA-J for the timeframe 12/1/23-12/1/24, CNA-DD for the timeframe of 3/1/23 to 3/124, CNA-EE for the timeframe of 9/6/23 to 9/6/24, and CNA-FF for the timeframe of 4/28/23 to 4/28/24. DON-B indicated the trainings may be kept offsite and would need to be found. DON-B confirmed the required trainings must be completed on a yearly basis based on date of hire for the CNAs. DON-B is aware of the federal regulations and Surveyor reviewed with DON-B the regulations On 1/15/25, at 12:20 PM, Administrator-A and DON-B were informed that any additional information on the trainings is requested, if available. Surveyor shared the concern at this time that CNA-H, CNA-J, CNA-DD, CNA-EE, CNA-FF has no documentation that CNA-H, CNA-J, CNA-DD, CNA-EE, CNA-FF received the required behavioral health training at this time. On 1/16/25, at 7:12 PM, Surveyor received four emails with training documentation. On 1/21/24, at 6:30 AM, Surveyor reviewed the facility's additional information of trainings completed by CNA-H, CNA-J, CNA-DD, CNA-EE, CNA-FF. CNA-H was hired by the facility on 1/28/21 and did not receive Behavioral Health Training. CNA-J was hired by the facility on 12/10/20 and did not receive Behavioral Health Training. CNA-DD was hired by the facility on 3/1/23 and did not receive Behavioral Health Training. CNA-EE was hired by the facility on 9/6/2001 and did not receive Behavioral Health Training. CNA-FF was hired by the facility on 4/28/23 and did not receive Behavioral Health Training. (continued on next page)

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F 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	No additional information was provided.