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	04/17/2025

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16584 Based on observation, staff interviews, and record review the facility did not ensure they provided ongoing-re-evaluation of the need for a seatbelt while seated in a wheelchair for 1 (R24) of 1 residents reviewed for physical restraints. R24 uses a seatbelt to aide in positioning while seated in his wheelchair. The facility initially assessed the use of the restraint on 10/11/23 and has not re-evaluated the use of the seatbelt since then. Evidenced by: The facility policy, entitled Restraint Free Environment, (no date), states Each resident shall attain and maintain his; her highest practicable well-being in an environment that prohibits the use of restraints for discipline or convenience and limits restraint use to circumstances in which the resident had medical symptoms that warrant the use of the restraint. Physical restraints may include, but are not limited to: . d.) Using devices in conjunction with a chair, such as trays, tables, cushions, bars or belts, that the resident cannot remove and prevents the resident from rising. Compliance guidelines: 4.) A physician's order alone is not sufficient to warrant the use of a physical restraint. The facility is responsible for the appropriateness of the determination to use a restraint. 6.) Medical symptoms warranting the use of restraints should be documented in the resident's medical record. The resident's record needs to include documentation that less restrictive alternatives were attempted to treat the medical symptom by were ineffective, ongoing re-evaluation of the need for the restraint, and the effectiveness of the restraint treating the medical symptom. The care plan should be updated accordingly to include the development and implementation of interventions, to address any risks related to the use of the restraint. R24 was originally admitted to the facility on [DATE] with diagnosis that included unspecified convulsions, and Cognitive Communication Deficit. (continued on next page)

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

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the most recent quarterly MDS (Minimum Data Set), dated 3/21/25 documents R24 has a BIMS (brief interview for mental status) score of zero indicating severe cognitive impairment. R24 has had a fall at the facility without injury and is frequently incontinent of urine and always incontinent of bowel. The MDS also documents there are no restraints being used with R24. A review of R24's current physician orders for April 2025 , documents and order to Remove self-release belt at meals with meals. This order was originally ordered on 11/7/23. On 4/9/25, at 3:30 p.m., Surveyor asked to review the most recent Restraint assessment for R24. On 4/10/25, at 8:00 a.m., Surveyor was provided with the Pre- Restraint/Restraint Evaluation with the effective date of 10/11/2023. Section A documents - R24 is alert but does not comprehend surroundings. R24 slides down in chair and slumps when walking or sitting. R24 has poor balance while sitting and is unsteady on feet. R24 has a history of falls, vision is poor. Interventions: low bed/placing matt(s) bedside bed, visual or verbal reminders. Provide explanation: Seat belt is due to forward tilt, resident screened by therapy, able to release himself. Date of utilization decision: 10/12/2023. Was reviewed in IDT (Interdisciplinary Team) multiple times since admission to ensure not a restraint. Surveyor noted this was the only comprehensive assessment of the use of the seat belt for R24 in the medical record. R24's individual plan of care documents R24 is at risk for injury related potential physical restraint due to: Lap belt present on admission for positioning : Resident able to release per self. DX (Diagnosis) seizure and history TBI (traumatic brain injury). Date Initiated: 10/12/2023 Interventions included: o Maintain current physical functioning level. Date Initiated: 10/12/2023. Revision on: 03/31/2024 o Complete appropriate restraint and/or side rail assessment per living center policy. Date Initiated: 10/12/2023 o Education family/responsible party regarding risk of restraint use. Date Initiated: 10/12/2023 o Reassess for potential reduction. Date Initiated: 10/12/2023 o Release seatbelt BID (two times per day) to ensure operability. Date Initiated: 10/12/2023 A review of the Visual/ Bedside Kardex Report, dated 4/14/25 documents under the ADL (activities of daily living) section R24 uses assistive devices wheelchair with dumped seat and self-releasing belt to aid in proper positioning. Ensure R24 can self-release and allow seatbelt free times. On 04/08/25, at 12:23 PM , Surveyor made observations of R24 seated in dining room. At this time it was observed R24 was getting assistance with his lunch meal with staff sitting to his right side. R24 was seated in his wheelchair and the seatbelt was in use. Staff did not release the seat belt during the lunch meal, as per the physician order. (continued on next page)

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	525262	A. Building B. Wing	04/17/2025

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/10/25, at 08:55 AM, Surveyor observed R24 seated in the wheelchair in the dining room. Staff was assisting R24 with the breakfast meal and were seated to R24's right side. Surveyor observed the seatbelt to be in use and staff did not release the seat belt during the breakfast meal. On 04/14/25, at 10:43 AM, Surveyor interviewed Director of Nursing (DON)- B regarding R24's use of the seatbelt when seated in the wheelchair. DON- B stated they asked R24 several times a day to release the belt himself and he can comply. Surveyor asked DON- B why R24 had the seatbelt in place. DON- B stated it is her understanding the main reason is R24 has seizures. Surveyor asked DON- B if R24 has been assessed since 10/11/23 for the appropriateness of the use of the seatbelt and if R24 still remains safe when it is in use. DON- B stated she could only locate the original assessment, and the use of the seat belt should be comprehensively assessed at least annually. Surveyor then shared there is a physician order that the seat belt is released at meals and observations were made on 4/8/25 at lunch and 4/10/25 at breakfast when the seatbelt was not released with staff present. DON- B was unable to provide any additional information. On 04/14/25, at 01:15 PM, Surveyor interviewed Medication Tech (MT)- K who stated she has worked with R24. Surveyor asked MT- K why R24 uses the seatbelt when he is in the wheelchair. MT- K responded she thinks it is for his safety because he will flip out of the wheelchair. Med Tech- K stated R24 can usually get the seatbelt undone if you ask him. As of the time of exit on 4/14/25, the facility was not able to provide any additional evidence they had continued to comprehensively assess R24's use of the seatbelt while seated in the wheelchair.

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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** 21855 Based on record review and interview, the facility did not conduct a thorough investigation of alleged staff abuse. The facility did not report an allegation of physical abuse to the local law enforcement. This was observed with 1 (R20) of 2 Facility Reported Incidents (FRI) reviewed. R20 alleged a staff member hit them on the head. The facility's completed 5-day investigation did not include that law enforcement was notified. The facility's policy and procedure titled, Abuse/Neglect/Exploitation, undated documents: The definitions of physical abuse includes, but is not limited to hitting, slapping, punching, biting, and kicking. The procedure document: . Section VII. Reporting/Response; A.1. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g. law enforcement when applicable) within specified timeframe's: a. Immediately, but no later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or b. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. Findings include: R2O was admitted to the facility on [DATE], with diagnoses that include alcohol dependence and epilepsy. R20's Quarterly minimum data set (MDS) assessment completed on 2/14/25, documents R20 had a Brief Interview of Mental Status (BIMS) score of 13/15, which indicates intact cognition. R20 is assessed to be independent with activities of daily living (ADL) with staff supervision. R20's behavior concerns include, refusal of ADL's, and can be verbally aggressive towards staff. R20 alleged on 3/18/25 Certified Nursing Assistant (CNA)-I hit them in the head a couple days ago. The facility completed a FRI and submitted it to the state agency. The completed FRI does not document law enforcement was notified. The section for law enforcement notification indicates no. On 4/08/25, at 9:31 AM, Surveyor interviewed CNA-I. CNA-I stated they were removed from the resident care areas after the allegation was made and they did not have any contact with law enforcement related to the allegation. On 4/08/25, at 12:28 PM, Surveyor interviewed R20 in their room. R20 stated they don't recall any staff hitting them. R20 has no concerns with staff at the facility. (continued on next page)

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	525262	A. Building B. Wing	04/17/2025

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/09/25, at 3:02 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A and [NAME] President of Clinical Services (VPCS)-J. Surveyor asked NHA-A why the police were not contacted related to R20's allegation. NHA-A stated they thought R20's allegation was vague and there was no physical evidence. NHA-A stated they did not think a crime occurred, didn't think there was evidence, R20 did not request police be called and was alert when interviewed. VPCS-J stated she is aware law enforcement should be called for allegations of physical abuse and explained there is new administration in the facility as to the reason law enforcement wasn't contacted. On 4/10/25, at 12:54 PM, the NHA-A stated to Surveyor they called the police yesterday. The police did not come out to the facility.

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	525262	A. Building B. Wing	04/17/2025

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 48391 Based on observation, interview and record review, the facility did not ensure sufficient nursing staff was provided to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. The facility had low staffing on the evening (PM) shift on 4/2/25, while having a census of 30 residents. 2 Certified Nursing Assistants (CNA)s called in on the PM shift on 4/2/25 which left 1 Licensed Practical Nurse (LPN) alone for a census of 30 residents. The facility has made recent staffing changes at the end of March 2025, that allow one dietary staff member on the PM shift, 2.5 Certified Nursing Assistants (CNA)s on the days shift, and 1.5 CNAs on the night shift. This change in staffing puts 1 CNA from 10:00 PM until 2:00 AM with a census of 30 residents. The facility has 12 residents that require a Hoyer lift and 6 residents that require two staff members for assistance. Findings include: Surveyor reviewed the Facility Assessment, last reviewed by the facility on 4/3/25, and 1/13/25, which documents the following General Staffing Plan: Dietary Cooks 1-2 Dietary Aides 2-4 Hands on Registered Nurse (RN) 1-3 Hands on LPN 1-3 Hands on CNA 6-7 Surveyor reviewed facility staff schedules, dated 3/1/25 - 4/14/25. Surveyor notes the following concerns: *3/13/25 - No RN on the schedule with 1 med tech working the day shift *3/28/25 - No RN on the schedule with 1 med tech working the PM shift *4/2/25 - 2 CNAs called in on the PM shift which left 1 LPN alone for 30 residents *Surveyor notes DON- B and/or Assistant Director of Nursing (ADON)- F working as a floor nurse. This occurred 25 out of 41 days reviewed. (continued on next page)

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	525262	A. Building B. Wing	04/17/2025

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Surveyor reviewed a facility summary of a list of residents and the level of acuity which includes bed mobility, transfer requirements, assistive devices requirements, toileting needs, safety precautions, diet/fluid orders, and special instructions. Surveyor notes the following requirements for residents: *Transferring: 12 residents require a Hoyer lift 6 residents require 2 person assistance 4 residents require 1 person assistance 8 residents are independent *Dietary Orders/Needs: 2 residents require a pureed diet 6 residents require a mechanical soft diet 2 residents require a staff member to feed them 2 residents require a staff member to cue them to eat 1 resident requires a staff member to set up their meal tray and cut/prepare food for eating. *Code Status: 22 residents have elected a full code status which requires at least 2 staff members to administer Basic Life Support (BLS) *Safety/Special Precautions: 3 residents are at risk for elopement 10 residents are at risk for falling 14 residents are incontinent of urine and/or bowels 4 residents require a bed pan for assistance with toileting (continued on next page)

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	525262	A. Building B. Wing	04/17/2025

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 4/3/25, at 8:34 AM, Surveyor interviewed Scheduler- Q who states she was notified by facility management to make staffing changes at the end of March. Scheduler- Q states the facility was previously staffing 2-3 CNAs on the night shift prior to the staffing changes and now she is to schedule 1 CNA on the night shift. Scheduler- Q states a CNA is scheduled a split shift (2:00 AM - 10:00AM) to help the CNA on the night shift and assist with getting residents out of bed in the morning on day shift. Surveyor asked Scheduler- Q how many CNAs work on night shift and Scheduler- Q responded 1.5 CNAs. Scheduler- Q then states there is only 1 CNA from 10:00 PM until 2:00 AM. Scheduler- Q was unable to provide the exact date she was instructed to make staffing changes, however Surveyor notes staffing changes are reflected on the 3/25/25 schedule. Scheduler- Q states she was notified to make these schedule changes due to overstaffing and the facility having a census of 30 residents. Surveyor asked how the facility handles staff call ins. Scheduler- Q states staff have been picking up shifts or staying late. Scheduler- Q states she has not had any staff call in on the night shift since the scheduling changes has happened and then knocked on the table. Scheduler- Q indicates staff are unhappy about the scheduling changes and she has brought their concerns to management. Scheduler- Q states the facility does not use agency staff. On 4/3/25, at 8:59 AM, Surveyor observed the Director of Nursing (DON)- B passing morning medications and working as a floor nurse. On 4/3/25, at 9:40 AM, Surveyor interviewed Dietary Director- R who states she was instructed by facility management to make staffing changes. Dietary Director- R states she would staff 1 cook and 2 dietary aides for day shift and PM shift prior to the scheduling changes. Dietary Director- R states she was notified to make scheduling changes and only schedule 1 cook and 1 dietary aide on day shift, and 1 cook and 0 dietary aides on PM shift. Dietary Director- R states it's not working out well since the new scheduling changes and she has been working as the cook and the cook has been working as the dietary aide. Dietary Director- R indicates eating times have been pushed back due to staffing changes. Dietary Director- R states breakfast was served 20 minutes late today on 4/3/25 due to staffing changes. Dietary Director- R states she has reported staffing concerns to facility management. Dietary Director- R states she was notified to make staffing changes due to having a census of 30 residents and the facility not accepting new residents. Cook- S entered the conversation and states she has been working as a dietary aide which is all new to her. Dietary Director- R indicates staff will come in early and work off the clock to help prepare for their shift. On 4/3/25, at 11:42 AM, Surveyor interviewed Scheduler- Q who states she remembers the staffing changes happened last week, but the staffing changes have been brewing for the last couple of weeks. Surveyor asked Scheduler- Q about the schedule on 4/2/25. Scheduler- Q states the 2 CNAs scheduled on the PM shift called in, which left 1 nurse by themselves in the facility for about 2 hours, with a census of 30 residents. Scheduler- Q states the 2 CNAs planned on calling in due to being upset about the recent staffing changes and were notifying other staff members that they were going to call in. Scheduler- Q states it will happen again, and they are putting residents at risk by doing this. On 4/3/25, at 1:22 PM, Surveyor interviewed Ombudsman- T who states she makes frequent visits to the facility and recently attended Resident Council in March 2025. Ombudsman- T states she also plans to attend Resident Council in April 2025. Ombudsman- T states a staff member had approached her with staffing concerns and Ombudsman- T had directed that staff member to contact the State Agency. (continued on next page)

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	525262	A. Building B. Wing	04/17/2025

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 4/3/25, at 2:23 PM, Surveyor interviewed Nursing Home Administrator (NHA)- A and DON- B who indicate nursing staff are required to hold a current BLS certification and CNAs are not required. Surveyor expressed concerns with the facility staffing one nurse at times, and not having a second nurse or staff member who is BLS certified to perform BLS appropriately if a resident is noted to be unresponsive and has elected a full code status. On 4/3/25, at 4:04 PM, Surveyor notified NHA- A and DON- B of staffing concerns listed above. NHA- A and DON- B acknowledged these concerns. On 4/9/25, at 12:33 PM, Surveyor interviewed Medication Technician (MT)- L. MT- L stated the facility is short staffed, and staff are stretched to the max. MT- L indicated staff have to rush through assessments and cares because there is not enough time to do everything. MT- L stated MT- L believes things are missed because of low staffing levels. MT- L stated MT- L has expressed concerns to management, but the staffing has only gotten worse the last month and a half. MT- L stated they can not care for the elderly the way they deserve because they do not have the time to do it. On 4/10/25, at 10:14 AM, Surveyor interviewed DON- B. DON- B informed Surveyor that Surveyor is not getting a full picture of what is going on with a resident because of lack of documentation. DON- B indicated CNAs are not charting as they should. DON- B showed Surveyor DON- B's computer screen with a dashboard. DON-B pointed to an area on the screen that indicates how much of the CNA charting is being completed. Surveyor noted CNAs are not fully completing their charting within the medical record. DON-B stated CNAs are not charting because it is their way of rebelling against a recent change in staffing numbers. CNAs are upset staffing numbers are lower and are not charting because of it. On 4/14/25 at 1:04 PM, Surveyor interviewed CNA- O. CNA- O stated CNA- O has concerns with staffing. CNA- O stated the facility has decreased staffing to a skeleton crew. CNA- O stated there is a resident that requires cares in pairs. CNA- O indicated at times it is impossible to follow this resident's care plan because there is not enough staff. CNA- O indicated the staffing levels are not safe for proper resident care. On 4/10/25, at 1:24 PM, Surveyor interviewed DON- B and ADON- F who state they never use to work the floor and now they are scheduled to work the floor all the time since the recent scheduling changes. DON- B indicate the facility has enough staff and staff use to pick up shifts to cover scheduling needs. DON- B and ADON- F state staff are no longer picking up shifts to cover scheduling needs which is why DON- B and ADON- F are now being added to the schedule to work the floor to cover shifts. DON- B states staff are not picking up shifts because they are upset with the recent scheduling changes. Surveyor expressed staffing concerns as listed above. DON- B and ADON- F both acknowledged staffing concerns.

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	525262	A. Building B. Wing	04/17/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 21855 Based on observation, interview, and record review, the facility did not implement an effective Infection Prevention and Control Program (IPCP). This has the potential to effect all 30 residents in the facility. The facility did not ensure medication was administered in a sanitary manner. This was observed with 1 (R29) of 1 resident receiving eye medication. * The IPCP did not have documentation of an effective water management program (WMP) to prevent the spread of Legionella. * The facility did not have documentation of identifying infections and completing corrective actions to prevent their spread. * The facility did not utilize preventative potential infection measures when administering eye medications to R29. Findings include: The facility's policy and procedure titled, Infection Prevention and Control Program, dated 10/2/22, was reviewed. The Policy documents: This facility has established and maintains an infection prevention and control program (IPCP) designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections as per accepted national standards and guidelines. Policy Expectations and Compliance Guidelines: 1. The designated Infection Preventionist (IP) is responsible for oversight of the program and serves as a consultant to our staff on infectious diseases, resident room placement, implementing isolation precautions, staff and resident exposures, surveillance, and epidemiological investigations of exposures of infectious diseases. 2. All staff are responsible for following all policies and procedures related to the program. 3. Surveillance: a. A system of surveillance is utilized for prevention, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon a facility assessment and accepted national standards. b. The IP serves as the leader in surveillance activities, maintains documentation of incidents, findings, and any corrective actions made by the facility and reports surveillance findings to the facility's Quality Assessment and Assurance Committee.; . 16. Water Management: a. A water management program has been established as part of the overall infection prevention and control program. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	b. Control measures and testing protocols are in place to address potential hazards associated with the facility's water systems. c. The Maintenance Director serves as the leader of the water management program. The facility's policy and procedures titled, Water Management Program, dated 10/1/22, was reviewed. The policy documents: It is the policy of this facility to establish water management plans for reducing the risk of Legionella and other opportunistic pathogens . in the facility's water systems based on nationally accepted standards.; Policy Explanation and Compliance Guidelines: 1. A water management team has been established to develop and implement the facility's water management program, including facility leadership, the Infection Preventionist, maintenance employees, safety officers, risk and quality management staff, and Director of Nursing. 2. The Maintenance Director maintains documentation that describes the facility's water system. 8. The water management team shall regularly verify that the water management program is being implemented as designed. Auditing assignments will reflect that individuals will not verify the program activity for which they are responsible. 13. In the event of an update to the water management program, the water management team shall: a. Update the water system schematic/description, associated control points, control limits, and any pre-determined corrective actions. b. Train those responsible for implementing and monitoring the updated program. 14. Documentation of all the activities related to the water management program shall be maintained with the water management program binder for a minimum of 3 years. Findings include: 1. On 4/08/25, at 8:22 AM, Surveyor interviewed Nursing Home Administrator (NHA)-A. NHA-A stated the Director of Nurses (DON)-B is the current Infection Preventionist (IP) for the facility. Surveyor requested Infection Prevention and Control Program (IPCP) documents to review. This included the facility water management plan (WMP). The Facility Assessment was reviewed. This has a revision date of 1/13/25. The IP position is not listed for involvement in the facility assessment. The assessment documents the IPCP is maintained by the Director of Nurses or designee. Surveyor reviewed the facility WMP. The WMP is dated 8/14/24. The WMP team identifies a previous Maintenance Director and a previous Nursing Home Administrator as part of the team. These previous staff are listed as contacts. The WMP team does not include an Infection Preventionist. The WMP was not updated to identify current responsible team members. (continued on next page)

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	525262	A. Building B. Wing	04/17/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The WMP includes a risk assessment with control measures. The control measures document they were verified by a previous Maintenance Director and Nursing Home Administrator. The verification section documents: as digitally signed, and verified, by previous members. The WMP does not contain documentation, of verified control measures, with current staff. On 4/9/25, at 10:25 AM, Surveyor interviewed Nursing Home Administrator (NHA)-A. NHA-A started at the facility on 2/25/25. DON-B started on 1/14/25 and has been in the IP role as well. NHA-A was not aware the documentation in the WMP, and the facility assessment, does not include an IP. On 4/09/25, at 11:04 AM, Surveyor interviewed DON-B and Assistant Director of Nurses (ADON)-F. DON-B stated she has not had time to complete infection control training. DON-B stated this has been due to working on the Statement of Deficiencies from January, and State being in the facility all the time. ADON-F is still in training for the IP position. DON-B stated they discuss water in the Quality Assurance (QA) meetings and they have not been involved in the WMP assessment. On 4/10/25, at 10:13 AM, Surveyor interviewed Director of Maintenance (DOM)-N and NHA-A. DOM-N has been in this position for 9-10 months. DOM-N stated they share results with the current NHA-A. DOM-N stated they do weekly water testing per a wing. Each week is a different wing. They run the faucets, flush toilets and run shower heads. The water is run every 4 days for at least 5-6 minutes. They oil the ice machine coils and change the filters every 3 months. They test the chlorine in the water every week. They take temperatures at the water heaters and flow areas. DOM-N stated they do not retain documentation of the chlorine testing and water temperatures. SURVEILLANCE The facility's October 2024 Infection Surveillance Monthly Report documents: - 3 skin conditions, with 1 antifungal and 2 with antibiotics. - 4 unitary tract infections with no organism. - 4 other infection with no identification, or type or organism, documented. Surveyor notes the document does not include the definitions for treating infections. There is not an infectious organism identified. There is no corrective actions documented related to identified infections in the facility. The November 2024 Infection Surveillance Monthly Report documents: - 7 urinary tract infections with no organism. - 2 pneumonia listed. - 3 skin conditions, with 2 antifungal and 1 antibiotic. (continued on next page)

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	525262	A. Building B. Wing	04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Surveyor note the document does not include the definitions for treating infections. There is not an infectious organism identified. There is no corrective actions documented related to identified infections in the facility. The December 2024 Infection Surveillance Monthly Report documents: - 2 eye infections. - 6 skin conditions, with 5 antifungal and 1 antibiotic. - 6 urinary tract infections with 1 cystitis and no organisms. - 1 other, with no identification and organism. Surveyor note the document does not include the definitions for treating infections. There is not an infectious organism identified. There is no corrective actions documented related to identified infections in the facility. On 4/10/25, at 11:26 AM, Surveyor interviewed [NAME] President of Clinical Services (VPCS) - J and DON-B. DON-B is currently covering the IP role. DON-B started in the facility January 2025. VPCS-J reviewed the October 2024, November 2024 and December 2024 surveillance Monthly Reports with Surveyor. VPCS-J stated the December other was for training purposes and not real. VPCS-J stated there is a infection screener form that is not attached to the logs. VPCS-J did not know what the October other infections were. VPCS-J stated they will look for supporting criteria and education for corrective actions. VPCS-J stated the facility uses McGeer's for definitions of infections. On 4/14/25, at 3:00 PM, during the exit meeting with NHA-A and DON-B, Surveyor shared concerns the facility IPCP. The facility did not have an accurate and comprehensive water management plan. The facility did not implement an effective surveillance program to prevent, and identify, infections in the facility. 42037 *On 4/10/2025, at 8:15 AM, Surveyor observed Director of Nursing (DON)-B conducting morning medication pass. On 4/10/2025 Surveyor observed DON-B administer R29's morning medications. Surveyor observed DON-B performing hand hygiene with an alcohol based hand sanitizer and administer R29's scheduled artificial tear eye drops. Surveyor did not observe DON-B donning gloves prior to administering R29's artificial tear eye drops. On 4/14/2025, at 10:10 AM, Surveyor conducted interview with DON-B. Surveyor asked DON-B what the proper protocol would be for administering a resident's eye drops. DON-B told Surveyor nurses should perform hand hygiene, don gloves, administer eye drops per physician order then perform hand hygiene again. On 4/14/2025, at 11:15 AM, Surveyor shared concern with Nursing Home Administrator (NHA)-A that on 4/10/2025, Surveyor observed DON-B administering R29's scheduled eye drops without donning gloves. No additional information was provided at this time.

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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 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. 21855 Based on record review and interview, the facility not have a designated, and qualified Infection Preventionist (IP), responsible for the facility's Infection Prevention and Control Program (IPCP). This has the potential to affect all 30 residents in the facility. The Facility Assessment does not include the role of the Infection Preventionist. The Director of Nurses (DON)-B has not completed training in infection prevention and control. The facility's policy and procedure titled, Infection Preventionist, dated 10/1/22, was reviewed. The policy documents: The facility will employ one or more qualified individuals with responsibility for implementing the facility's infection prevention and control program.; Policy Explanation and Compliance Guidelines: 2. The facility will ensure the IP is qualified by education, training, experience or certification. 4. The IP will have the knowledge to perform the role and remain current with infection prevention and control issues and be aware of national organizations' guidelines, as well as those from national/state/local public health authorities. 6. The IP must be employed at least part-time and the amount of time should be determined by the facility assessment, to determine the resources it needs for it's IPCP (Infection Prevention and Control Program). Designated IP hours per week may vary based on the facility and it's resident population. 7. The facility, based upon the facility assessment, will determine if the individual functioning as the IP should be dedicated solely to the IPCP. The IP must have the time necessary to properly assess, develop, implement, monitor, and manage the IPCP for the facility, address training requirements, and participate in required committees such as Quality Assessment and Assurance (QAA) 8. The IP will physically work onsite in the facility. 9. The IP must be sufficiently trained in infection prevention and control. 10. The IP must have obtained specialized infection prevention and control (IPC) training beyond initial professional training or education prior to assuming the role and must provide evidence of training through a certificate(s) of completion or equivalent documentation. 11. The IP reports to the Director of Nursing. Findings include: (continued on next page)

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	1. On 4/08/25, at 8:22 AM, Surveyor interviewed Nursing Home Administrator (NHA)-A. NHA-A stated the Director of Nurses (DON)-B is the current IP for the facility. Surveyor requested IPCP documents to review. The Facility Assessment was reviewed. The Facility Assessment has a revision date of 1/13/25. The IP position is not listed for involvement in the facility assessment. The assessment documents the IPCP is maintained by the Director of Nurses or designee. It does not identify the role for a Infection Preventionist (IP). The IP role is not included in the facility staffing hours. On 4/09/25, at 10:42 AM, Surveyor interviewed NHA-A. NHA-A started at the facility 2/25/25 and the DON-B started 1/14/25. NHA-A stated DON-B, and Assistant Director of Nursing (ADON)-F, are working on their infection control certification. NHA-A did not know why the IP was not included in the facility assessment, including hours and the position. On 4/09/25, at 11:04 AM, Surveyor interviewed DON-B and ADON-F. DON-B stated she has not had time to complete infection control training. DON-B stated this has been due to working on the Statement of Deficiencies from January, and State being in the facility all the time. ADON-F is still in training for the IP position. Surveyor notes DON-B and ADON-F, do not have specialized infection control training. The facility does not have a designated, and qualified, IP for the IPCP.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21855 Based on interview and record review, the facility did not ensure residents immunizations were offered, or refused, as eligible. This was observed with 2 (R32 and R9) of 5 residents immunization record reviewed. * R32 did not have documentation of any pneumococcal vaccines. * R9 did not have documentation of the influenza vaccine 2024-2025 timeframe. Findings include: The facility's policy and procedure titled, Vaccine Information Statements, dated 3/1/2019 was reviewed. The policy documents: Prior to the administration of any vaccine, a copy of the most current, relevant Center for Disease Control (CDC) Vaccine Information Statement (VIS) will be provided to any child or adult receiving the vaccine or such information will be provided to the legal representative who has the authority to consent to the immunization of a minor child or incompetent adult.; Policy Explanation and Compliance Guidelines: 3. A notation will be made in each resident's medical record at the time vaccine information materials are provided indicating: 3.a. The edition date of the VIS provided, and; 3.b. The date the VIS was provided. The facility's policy and procedure titled, Influenza Vaccination, dated 3/1/2019, was reviewed. The policy documents: It is the policy of this facility to minimize the risk of acquiring, transmitting or experiencing complications from influenza by offering our residents, staff members, and volunteer workers annual immunization against influenza.; Policy Explanation and Compliance Guidelines: 2. Influenza vaccinations will be routinely offered annually from October 1st through March 31st unless such immunization is medically contraindicated, the individual has already been immunized during this time period or refuses to receive the vaccine. 9. The resident's medical record will include documentation that the resident and/or the resident's representative was provided education regarding the benefits and potential side effects of immunization, and that the resident received or did not receive the immunization due to medical contraindication or refusal. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's policy and procedures titled, Pneumococcal Vaccine (Series), dated 3/1/2029, was reviewed. The policy documents: It is our policy to offer residents, staff, and volunteer workers immunization against pneumococcal disease in accordance with current CDC (Centers for Disease Control and Prevention) guidelines and recommendations.; Policy Explanation and Compliance Guidelines: 1. Each resident will be assessed for pneumococcal immunization upon admission. Self-report of immunization shall be accepted. Any additional efforts to obtain information shall be documented, including efforts to determine date of immunization or type of vaccine received. 2. Each resident will be offered a pneumococcal immunization unless it is medically contraindicated or the resident has already been immunized. Following assessment for any medical contraindications, the immunization may be administered in accordance with physician-approved standing orders. 1. R32 was admitted [DATE] with diagnoses, including, type 2 diabetes mellitus (A condition in which the body has trouble controlling blood sugar and using it for energy), acute and subacute respiratory conditions (An illness affecting the airways and lungs.) due to chemicals, gases, fumes and vapors. R32 is under [AGE] year. There is no documentation of any pneumococcal vaccines. The Wisconsin Immunization Registry (WIR) does not have any pneumococcal vaccine administration on record. R32 would be eligible for the PCV15 (Pneumococcal Conjugate Vaccine), PCV20, or PCV21. If PCV15 was administered, they would be eligible after a year for the PCV23. On 4/08/25, at 8:22 AM, Surveyor interviewed the Nursing Home Administrator (NHA) -A. NHA-A stated Director of Nurses (DON)-B is performing the Infection Preventionist (IP) role at this time. Surveyor requested any information related to R32's vaccine administrations. On 4/08/25, at 12:44 PM Surveyor interviewed DON-B. DON-B stated they were not in the facility during this time and is still looking for things. Surveyor notes there was no documentation of R32 being offered pneumococcal vaccines in the facility. 2. R9 was admitted to the facility on [DATE] with diagnoses, including, severe morbid obesity, pneumonia (An infection that inflames the air sacs in one or both lungs). R9 is over [AGE] year. There is no documentation R9 was offered or administered the influenza vaccine for the 2024-2025 timeframe. There is no documentation of contraindications for administration in the medical record. On 4/08/25, at 8:22 AM, Surveyor interviewed the Nursing Home Administrator (NHA) -A. NHA-A stated Director of Nurses (DON)-B is performing the Infection Preventionist (IP) role at this time. Surveyor requested any information related to R9's vaccines administrations. On 4/08/25, at 12:44 PM Surveyor interviewed DON-B. DON-B stated they were not in the facility during this time and is still looking for things. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	There was no documentation of R9 being offered the influenza vaccine for the 2024-2025 timeframe.