STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525271	A. Building B. Wing	12/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alden Estates of Countryside, Inc	1130 Collins Road Jefferson, WI 53549

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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 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** 20483 Based on interview and record review the Facility did not have evidence all alleged violations of mistreatment were thoroughly investigated for 1 (R1) of 1 residents. R1's allegation of being yelled at and handled roughly was not thoroughly investigated. Findings include: The facility's policy titled, Abuse Policy (For Wisconsin Facilities) and dated 9/20 under policy documents This facility affirms the right of our residents to be free from abuse, neglect, misappropriation of resident property, corporal punishment and involuntary seclusion. The facility will report reasonable suspicion of a crime. This facility therefore prohibits mistreatment, neglect or abuse of its residents and has attempted to establish a resident sensitive and resident secure environment. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of mistreatment, neglect or abuse of our residents. This will be done by: .6. Implementing systems to investigate all reports and allegations of mistreatment promptly and aggressively, and making the necessary changes to prevent future occurrences;. Under 6. Investigation documents a. Appoint an Investigator. Once an allegation has been make, the administrator or designee will investigate the allegation and obtain a copy of any documentation related to the incident. R1 was admitted to the facility on [DATE] and discharged on [DATE]. R1's diagnoses includes hemiplegia and hemiparesis following cerebral infarction affecting left non dominate side, diabetes mellitus, congestive heart failure, aphasia, and epilepsy. R1 does not have an activated power of attorney for healthcare. The admission MDS (minimum data set) with an assessment reference date of 10/28/24 has a BIMS (brief interview mental status) score of 11 which indicates moderate cognitive impairment. On 12/2/24, at 2:46 p.m., Surveyor reviewed the facility's grievance report during the period R1 was a resident at the facility. Surveyor noted there is one grievance dated 10/21/24 for R1 regarding a missing phone which was found on 10/22/24. (continued on next page)

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

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/3/24, at 9:45 a.m., Surveyor spoke with R1's family member-N on the telephone. During this conversation, Surveyor asked how staff treated R1. R1's family member-N informed Surveyor there was a CNA (Certified Nursing Assistant) who yelled and was rough with her R1. R1's family member-N stated it was reported to the Assistant Director. Surveyor asked who this was. R1's family member-N stated it was reported to [the first name of AA (Assistant Administrator)-E]. R1's family member-N informed Surveyor R1 told her that blonde with a pony tail she's not nice, always mean, yelling at me, and anytime she handles her she is rough. R1's family member-N informed Surveyor R1 told AA-E she's mean to her, yelled at her, and handled her rough and that was [first name of CNA-I]. Surveyor asked R1's family member-N what did AA-E say to her & R1. R1's family member-N informed Surveyor he (AA-E) would retrain her and asked R1 if she wanted the aide not to work with her anymore. R1's family member-N informed Surveyor she (R1) said she didn't want her (the CNA) to lose her job, she wanted her to treat her nice. Surveyor asked R1's family member-N if she knew the date when she & R1 were in AA-E's office informing him of being yelled at and treated roughly. R1's family member-N could not provide Surveyor with the date and informed Surveyor her R1 hadn't been there a month. On 12/3/24, at 10:43 a.m., Surveyor interviewed AA-E regarding R1. Surveyor asked AA-E if he had any contact with R1's family. AA-E informed Surveyor he did, meeting with R1's daughter and another family member about the [NAME], getting it set up in R1's room. Surveyor asked AA-E if the family brought any concerns to him. AA-E replied no then stated they had mentioned about R1's blood sugar. AA-E explained anything clinical he brings to the clinical team's attention. Surveyor asked AA-E if there were any concerns about staff. AA-E replied not that I can remember. Surveyor asked AA-E if there were any concerns about a CNA being rough or yelling. AA-E replied yes there was. Surveyor asked AA-E to tell Surveyor about this. AA-E replied what I remember blonde CNA thinks during transfer, when in recliner feet were elevated and didn't like the way the pillow was placed under the leg. Surveyor asked who was the blonde CNA. AA-E replied believe [first name of CNA-I]. Surveyor asked AA-E who told him about this. AA-E informed the daughter. Surveyor asked AA-E if R1 or R1's family member-N informed him the CNA yelled at R1. AA-E replied I don't believe yelling, she's hard of hearing. Surveyor asked AA-E if R1 or R1's daughter informed him the CNA was mean to R1. AA-E replied I would say that is all inclusive, don't know if she said mean verbatim. Surveyor asked AA-E if R1 or R1's family member-N informed him the CNA handled R1 rough. AA-E replied same thing with cares. AA-E informed Surveyor within the same shift he spoke with [first name of CNA-I] who had no idea. AA-E informed Surveyor he told CNA-I he was giving her a heads up to be extra conscientious when doing cares. Surveyor asked AA-E if he asked R1 if she wanted CNA-I to continue to care for her. AA-E replied I don't remember. Surveyor asked AA-E if he has an investigation. AA-E replied not to my knowledge, no I would have to double check. Surveyor asked AA-E to check to see if there is an investigation and let Surveyor know. Surveyor informed AA-E Surveyor had reviewed the grievance log and didn't see any grievance regarding R1 except for a missing phone which was located. Surveyor asked AA-E if any education was provided to staff. AA-E replied I did a formal talking to her. On 12/3/24, at 11:26 a.m., AA-E informed Surveyor he doesn't have anything on paper that he spoke with CNA-I. Surveyor asked AA-E if there was any investigation. AA-E replied in terms of a formal investigation we don't have anything, no. Surveyor asked AA-E why there isn't an investigation. AA-E replied it was on the shift. They just said blonde CNA. I spoke with two CNAs who were blonde, gave heads up to them may have an issue with how giving cares and be more conscientious. On 12/3/24, at 3:33 p.m. NHA (Nursing Home Administrator)-A, DON-B, Regional Nurse Consultant-C and Assistant Administrator-D were informed of the above.

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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 0689 Level of Harm - 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** 20483 Based on interview and record review, the facility did not ensure 2 (R3 & R2) of 2 residents received adequate supervision and assistance devices to prevent accidents. * On 5/25/24 while the night Certified Nursing Assistant (CNA) was providing incontinent cares to R3, R3 indicated she couldn't hold onto the transfer device and rolled out of bed sustaining a laceration to the forehead and a right femur fracture. According to CNA-Q's statement she guided R3 out of bed however, when Surveyor spoke to R3, R3 informed Surveyor the CNA watched her roll out of bed. The facility did not conduct a thorough investigation, as there isn't a statement from the nurse who assessed R3 or a statement from R3, there are no details as to what the position of the bed was in relation to where R3 fell , and whether care plan interventions were in place at the time of the fall. R3's care plan does not address the air mattress on the bed. * R2 sustained multiple falls with one fall resulting in injury. A thorough investigation after every fall was not completed to determine root cause analysis. Some Interventions established were not specific to prevent further falls. Findings include: The facility's policy titled, Management of Falls and dated 8/2020 under Policy documents The facility will assess hazards and risk, develop a plan of care to address hazards and risks, implement appropriate resident interventions, and revise the resident's plan of care in order to minimize the risks for fall incidents and/or injuries to the resident. Under Procedure documents .3. Develop a plan of care to include goals and interventions which address resident's risk factors. Risk factors may include but are not limited to the following: Contributing diagnoses/disorders/disease processes/active infections/other comorbidities, history of fall incidents, Incontinence, Medications (Narcotics, Antihypertensives, etc.), assistance required with ADL's (activities daily living), gait/transfer/balance issues, Behaviors, and/or cognitive status. 1.) R3 was originally admitted to the facility on [DATE]. R3's diagnoses includes multiple sclerosis, chronic inflammatory demyelinating polyneuritis (disorder that involves nerve swelling & irritation that leads to a loss of strength or sensation), contracture of muscle of right & left hand, hypertension, paraplegia, diabetes mellitus, depressive disorder, and anxiety disorder. R3 was admitted with a Stage 3 right gluteal pressure injury. Review of R3's care plans document: The [R3's first name] has an ADL (activities daily living) functional performance deficit r/t (related to) paraplegia, MS (multiple sclerosis), atrophy, contractures, impaired AROM (active range of motion) and DM2 (diabetes mellitus). Has need to assist with mobility and repositioning with use of bilateral quarter assist rails to bed initially initiated 4/18/24 & last initiated date of 10/4/24 documents the following interventions: (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	* Enhanced Barrier Precautions will be implemented during high contact resident care activities. Initiated 4/18/24. * Assist with ADL tasks as needed. Initiated 4/18/24. * Allow enough time for completion of ADL tasks. Do not rush the resident. Initiated 4/29/24. * Ask resident if room temperature is okay. If not contact Maintenance. Initiated 4/29/24. * Assist resident with oral care daily as needed. Initiated 4/29/24. * Assist resident with set up for supplies of bathing as needed. Initiated 4/29/24. * Assist with locomotion as needed. Initiated 4/29/24. * Assist with personal hygiene as needed. Initiated 4/29/24. * Assist with toileting needs as necessary. Initiated 4/29/24. * Assist with transfers as needed. Initiated 4/29/24. * Barrier cream with incontinence care. Initiated 4/29/24. * Check skin for changes during bathing. Initiated 4/29/24. * Encourage to eat slowly. Initiated 4/29/24. * Encourage use of call light for assistance when needed. Initiated 4/29/24. * Encourage use of positioning device for bed mobility as needed. Initiated 4/29/24. * Prompt and use hand over hand assist as needed to enable increased independence with bed mobility and repositioning with aide of bilateral assist rails to bed. Use of bed ladder was not effective. Initiated 4/30/24. * Provide needed level of assistance and support to complete Activities of Daily Living. Document in POC (plan of care). Initiated 11/12/24. * Transfers: Hoyer. Initiated 4/29/24. The at risk for falls care plan initiated 4/18/24 and last revised 10/4/24 documents the following interventions: * Encourage appropriate use of wheelchair. Initiated 4/18/24. * Promote placement of call light with in reach. Initiated 4/18/24. * Encourage resident to keep room free of obstacles. Initiated 4/29/24. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	* Ensure adequate lighting for tasks. Initiated 4/29/24. * Fall risk assessment quarterly and as needed. Initiated 4/29/24. * Keep frequently used items within reach in room. Initiated 4/29/24. * Monitor resident for tolerance and endurance. Schedule tasks accordingly. Initiated 4/29/24. * Notify family and MD (medical doctor) of any new fall. Initiated 4/29/24. * Provide an environment clear of clutter. Initiated 4/29/24. * Apply pillow/pillows to side when doing cares to prevent rolling out of bed. Initiated 5/28/24. R3's fall risk assessment dated [DATE] has a score of 4 which indicates at risk for falls. The admission MDS (minimum data set) with an assessment reference date of 4/26/24 has a BIMS (brief interview mental status) score of 15 which indicates cognitively intact. R3 is assessed as not having any behavior. R3 is assessed as being dependent for chair/bed to chair transfer & toileting hygiene and substantial/maximal assistance for roll left and right. R3 is assessed as being frequently incontinent of urine and bowel. R3 is assessed as not having any falls prior to admission or since admission. R3 is 5 feet 10 inches in height & 179 pounds. The falls CAA (care area assessment) dated 5/1/24 under analysis of findings for nature of problem/condition documents Resident came to [NAME] long term transfer from nursing home in NC (North Carolina). Resident has MS, G-tube that receives fluids and meds (medication) through. Also treatment in place for PU (pressure ulcer) Stage 3 to gluteal fold right. Res (Resident) pain assessment completed. Res is noted to have c/o pain at times occasionally and is noted to be utilizing both PRN (as needed) and scheduled pain medications via G tube. Res is alert and is able to make her needs known and can alert staff about her discomfort. Res does not utilize glasses for vision and is able to see without them. Res is noted to have upper dentures. Res receives a mechanical altered diet and also tube feeding according to the amount that is eaten. Resident is incontinent of bowel and bladder. Resident requires assistance from staff for ADLs/IADLS. Under care plan considerations documents Staff will ensure room is well lit and free from clutter. Staff will follow policies and procedures for bed mobility and transferring a dependent patient utilizing equipment appropriately. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The occupational therapy note for date of service of 4/29/24 and written by OTR (Occupational Therapist Registered)/DOR (Director of Rehabilitation)-O documents Physician's order received, chart reviewed, hx (history) noted, evaluation completed and POT (program of treatment) developed on this date. Due to mm (muscle) atrophy, contractures and impaired AROM (active range of motion) throughout B UE's (bilateral upper extremities), all joints, ulnar nerve symptoms B L including (bilateral left including) hyperextension of MCPs (metacarpophalangeal joint) (knuckle joint of the finger) and flexion of PIPIs (proximal interphalangeal joint) (middle joint of finger), throughout B (bilateral) hands, pt (patient) is unable to roll or reposition herself in bed when needed/desired. She is able to make weak fists B L in order to pull herself over onto her sides. Due to OA (open area) buttock pt is only up for 4 hours in her wc (wheelchair) and spends the rest of her day in bed, and must be repositioned side to side each time by staff. With assist rails pt is able to participate in mobility and reposition in bed to reach items as she chooses, which may not be anticipated prior. Diagnoses which make I (independent) use of body difficult included: paraplegia, chronic inflammatory demyelinating polyneuritis, unspecified pain and MS. Recommend B (bilateral) assist rails. Pt trialed use of wc (wheelchair) next to bed to pull over using arm rests on w/c which was difficult and additionally required mod (moderate) A (assist) to roll R (right) when supine. However wc will be plugged in at night to charge in another room. She attempted reaching to L by grabbing window sill, which was ineffective, and pulling self over with bed ladder however it didn't position high enough to reach and pull. The CNA (Certified Nursing Assistant) Kardex dated 5/25/24 under the category for bed mobility documents Bilateral assist rails to bed to enable participation in bed mobility and repositioning. Prompt and use hand over hand assist as needed to enable increased independence with bed mobility and repositioning with aide of bilateral assist rails to bed. Use of bed ladder was not effective. Under the category for safety documents Elevate the head of the bed while napping or sleeping to avoid shortness of breath while lying flat. Encourage appropriate use of wheelchair. Monitor and report signs/symptoms of abuse. The nurses note dated 5/25/24, at 0735 (7:35 a.m.), by Nursing-P includes documentation of Patient had a fall this AM (morning) witness out of bed, she had a laceration above her left eye pain rated 10/10 to her right leg. Per RN (Registered Nurse) her right knee had a deformity sent out prior to page d/t (due to) urgency. The incident report dated 5/25/24 under incident description for nursing description documents Paged on the radio for help in resident room, on arrival found resident on the floor. Under resident description documents I couldn't hold the rail anymore, I let go. Under the section immediate action taken for description documents Assessed v/s (vital signs) and skin for abrasions and lacerations. Applied pressure to laceration to the forehead. called 911. Under other info (information) documents CNA providing incontinent cares in bed. [R3's first name] was unable to continue holding onto rail and began to slide out of bed to floor. Under statements CNA-Q's statement documents @ (at) 5:00 I entered [R3's first name] room [number] to do her cares. I got all of her essentials needed to perform them as I did proceed to talk with her to let her know that I was going to start cares on her. [R3's first name] replied Ok [NAME]! I asked [R3's first name] to turn as I helped her into the position she was propped up on her left side as I cleaned her bottom, and when doing so she said was slipping out of bed, I tried to ease ger (sic) to the floor as safe as possible without her harming herself. I then proceeded to call for help. Surveyor noted CNA-Q is not listed as a current employee on the staff list provided by the facility. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Under the note section dated 5/28/24 by Assistant Administrator (AA)-E documents IDC (interdisciplinary care) Team reviewed fall on 5/25/24. The goal of the facility is resident safety. The root cause was resident was holding onto side rail during cares, let go and fell . Resident was sent to hospital post fall. The interventions will be a larger bed for positioning during cares and pillow placement if necessary for positioning during cares. Staff member was also educated by DON (Director of Nursing) [Regional Nurse Consultant-C's first name]. [R3's first name] notified and in agreement. Under the note section dated 5/31/24 by RNC (Regional Nurse Consultant)-C documents [R3's name] is a 73 y/o (year old) that admitted on [DATE] for LTC (long term care) from out of state SNF (skilled nursing facility). She has the following medical conditions: chronic inflammatory demyelinating polyneuritis, paraplegia, type 2 diabetes mellitus, with polyneuropathy, multiple sclerosis, major depression, copd (chronic obstructive pulmonary disease), pressure injury stage 3, chronic pain, hypertension, anxiety disorder and achalasia. [R3's first name] is alert and oriented to person, place, time and situation and has a BIMS score of 15. She is able to assist with turning side to side with use of the bilateral transfer bed rails and 1 assist. She is non-ambulatory, and a total lift is required for transfers. On 5/25 @ approx (approximately) 0500 (5:00 a.m.) [R3's first name] was on her left side for peri-care following incontinence, was unable to hold onto transfer rail and slipped off her bed. Due to c/o (complaint of) right leg discomfort and laceration to head she was transferred to the hospital and admitted with right femur fracture. The hospital discharge summary dated 5/28/24 under chief complaint documents Fall out of bed while doing bed change at [NAME] this morning. Head injury, no LOC (loss of consciousness). Under admission information documents Patient is a [AGE] year-old female nursing home resident who is wheelchair-bound from numerous medical issues and who was being helped in bed and ruled (sic) out and fell on the floor. Patient sustained significant pain and deformity of the right leg and was brought in for evaluation. In the ER (emergency room) patient is found to have a right hip fracture causing 8/10 pain and worse with movement. Under physical exam for Musculoskeletal documents Right leg in cast from upper thigh to toe, does not have sensation in feet at baseline, but is able to wiggle toes, and feet are equal warmth. On 12/2/24, at 9:35 a.m., Surveyor observed R3 using the electric wheelchair in the hallway. R3 asked Surveyor who Surveyor was. After Surveyor identified self, R3 informed Surveyor she would like to speak with Surveyor. During this conversation, Surveyor asked R3 if she has had any falls at the facility. R3 replied oh sure she rolled me out of bed and I broke my femur. R3 explained she told them she needed a wider bed, they did put rails on and she rolled over the rail. R3 informed Surveyor she was in a cast for 8 weeks. Surveyor asked if she had any falls after this fall. R3 replied no. R3 informed Surveyor she had to wait until her insurance to kick in to get a wider bed which was June 1st. R3 informed Surveyor she is now on hospice and has a hospice bed. R3 informed Surveyor she transfers with a hoyer lift and has never fallen out of the hoyer lift. On 12/2/24, at 11:08 a.m., Surveyor observed R3 in her electric wheelchair going down the hallway from the front entrance. On 12/2/24, at 12:09 p.m., Surveyor observed R3 sitting in her wheelchair with an over bed table across and her lunch on the over bed table. On 12/2/2, at 1:59 p.m., Surveyor observed R3 sitting in her wheelchair in her room with visitors. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 12/3/24, at 7:17 a.m., Surveyor observed R3 on her back with the head of the bed elevated sleeping in bed. There are two quarter side rails up and there is an air mattress on the bed. On 12/3/24, at 11:03 a.m., Surveyor asked DON (Director of Nursing)-B who Surveyor should speak with regarding R3's fall on 5/25/24. DON-B informed Surveyor she thinks RNC (Regional Nurse Consultant)-C was the acting DON at that time. On 12/3/24, at 11:35 a.m., Surveyor observed R3 reclined slightly back in her wheelchair in the room. Surveyor asked R3 if Surveyor could talk to her again about her fall in May when she fractured her femur. Surveyor asked R3 if she could tell Surveyor what happened again. R3 replied she rolled me off the bed. She purposely turned me. I told her I wouldn't be able to hold on. Surveyor asked if there was one or two staff in the room. R3 replied one. Surveyor asked R3 if the CNA rolled her away from her (the CNA). R3 replied yes. R3 informed Surveyor at the time of the fall she had smaller bars on her bed than she has now. R3 stated I just rolled, she didn't put the bed against the wall as I asked her. I rolled right out. Surveyor asked R3 before rolling out of the bed was she holding onto the bar. R3 replied yes. Surveyor asked R3 what did the CNA do when she started to roll off the bed. R3 replied watched me go to the floor. Surveyor asked R3 if anyone spoke to her about the fall. R3 replied there was a lot of people. Surveyor asked if she remember who spoke with her. R3 replied no was after I came back, probably not even here. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 12/3/24, at 12:14 p.m., Surveyor met with RNC-C to discuss R3's fall on 5/25/24. RNC-C informed Surveyor she thought R3's fall was on the day shift but when she spoke with the day shift CNA, the night CNA was already gone. RNC-C explained CNA-Q from nights was changing R3 & cleaning her up as R3 was incontinent and when R3 has a BM (bowel movement) it is usually large. R3 was holding on the transfer rail, just said she can't hold on and slide down. RNC-C indicated CNA-Q tried to guide her with the sheet and went to the floor. The nurse came in and assessed her. Surveyor inquired who was the nurse. RNC-C informed Surveyor it was a [name of agency] nurse. Surveyor asked RNC-C if she spoke with R3. RNC-C replied afterward, after she came back from the hospital. Surveyor asked RNC-C if she could recall what R3 said. RNC-C informed Surveyor she said she couldn't; hold on. Surveyor asked RNC-C if she knew how the bed was positioned. RNC-C informed Surveyor it wasn't super high but not down all the way, the CNA had put the bed up. RNC-C informed Surveyor R3 likes the bed closer to the wall kind of the same as now. Surveyor asked which way she fell . RNC-C informed Surveyor R3 fell to the right, before she fell she was on the right side. Surveyor asked RNC-C what investigation was done. RNC-C informed Surveyor she had the CNA in the room, had her show her what she was doing, the cares and how R3 came off the bed to the floor. Surveyor asked RNC-C if R3 was close to the edge of the bed. RNC-C replied probably with being turned, the CNA didn't indicate she was at edge of the bed. Surveyor asked RNC-C if she asked the CNA if R3 was at the edge of the bed. RNC-C replied yes and explained R3 has legs which externally rotate, her legs don't go straight from admission. Surveyor asked RNC-C what the nurse did when she came into R3's room as Surveyor did not note any statement from the nurse. RNC-C informed Surveyor went into the room, talked with R3, let the charge nurse know she had discomfort and called 911 to the hospital. RNC-C informed Surveyor R3 has a different bed now and has signed onto hospice so hospice will be getting R3 a bigger bed. Surveyor asked RNC-C if there was any education provided following R3's fall with fracture. RNC-C informed Surveyor they do education all the time and stated she didn't think specifically for this incident. Surveyor showed RNC-C documentation provided regarding R3's fall and asked if there is any additional information. RNC-C informed Surveyor she doesn't think there is anything else. Surveyor informed RNC-C there's isn't a statement from the nurse who assessed R3, what the position of the bed was in relation to where R3 fell , what R3 said had occurred, etc for a thorough investigation of the fall. Surveyor informed RNC-C R3 informed Surveyor the CNA had turned her away. RNC-C replied that doesn't make sense because she bumped her head on the night stand, that's how she got the laceration. Surveyor informed RNC-C R3 informed Surveyor she rolled out of bed and the CNA watched her roll out of the bed. Surveyor asked RNC-C if the CNA guided her to the floor how did she sustain the laceration and femur fracture. On 12/3/24, at 2:42 p.m., Surveyor asked RNC-C at the time of R3's fall did she have an air mattress on her bed. RNC-C replied I believe so at that time. Surveyor asked RNC-C if R3 was assessed as requiring substantial/maximal assistance for bed mobility and dependent for toileting hygiene how did the facility determine R3 could be provided cares with one CNA and had the strength to support her body during cares. RNC-C informed Surveyor with the transfer assist rails R3 could hold on and using a pad or sheet you could pull the person towards you. RNC-C stated she (R3) was alert, orientated, able to follow commands at that time and R3 had talked about assist rails since coming to the building as she had them at the other facility. Surveyor asked RNC-C if she had reviewed R3's ADL care plan. RNC-C informed Surveyor she has reviewed the care plan in the past. Surveyor discussed with RNC-C R3's care plan isn't patient centered as the interventions document to assist as needed which could be for most residents in the facility. Surveyor informed RNC-C the care plan doesn't address R3's air mattress, how long R3 may be able to be on her side holding onto the rail, etc. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alden Estates of Countryside, Inc	1130 Collins Road Jefferson, WI 53549

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 12/3/24, at 3:15 p.m., RNC-C informed Surveyor a moderate assist is an assist of one. R3 is alert, orientated, able to follow commands and wanted independence. R3 had the endurance, that's why it was appropriate for assist rails. On 12/3/24, at 3:33 p.m. NHA (Nursing Home Administrator)-A, DON-B, Regional Nurse Consultant-C and Assistant Administrator-D were informed of the above. Surveyor asked if there is any additional information regarding R3's fall to email to Surveyor. As of 12/5/24 at 2:31 p.m. Surveyor did not receive any additional information. 51014 2.) R2 was admitted to the facility on [DATE] with primary diagnoses of cerebral infarction due to embolism of left middle cerebral artery (stroke), aphasia, abdominal aortic aneurysm, moderate protein-calorie malnutrition, encounter for attention to gastrostomy, unsteadiness on feet, muscle weakness and age-related physical debility. R2's Admission MDS (Minimum Data Set) assessment dated [DATE], documented R2 is severely cognitively impaired with a BIMS (Brief Interview for Mental Status) score of 0 with both short- and long-term memory problems. MDS section GG, documents R2 is dependent with oral hygiene, toileting, shower/bathing, upper/lower body dressing and putting on footwear. R2 needs substantial to maximum assistance with eating and personal hygiene. MDS section H, documents R2 is frequently incontinent of both urine and bowel. MDS, section K, documents R2 has a feeding tube and is on a mechanically soft diet requiring change in texture of food or liquids. Record review of R2's Falls Risk assessment dated [DATE] documents a score of an 8, indicating R2 is at risk for falls. The assessment documents for mobility R2 has an unsteady gait and/or use of ambulatory device. Predisposing conditions documented, include CVA, (cerebral vascular accident) and visual deficit. R2's assessed mentation documents, R2 has impaired memory. R2 has had no falls in the past 3 months. Record review of R2 care plan dated 10/19/24 documents resident is at risk for elopement related to cognitive impairment and will attempt to walk and wander on her own. A Wanderguard was implemented for safety. Interventions include determine preferred setting, consider potential variables such as boredom, thirst, hunger, need for toileting, pain, exercise, companionship, exhaustion and over stimulation. Staff is directed to redirect, calmly and positively guide back to her room, provide 1:1 interaction with encouraging, uplifting comments and attempt to address any agitation. Additionally, staff is to initiate frequent checks and supervision. Record review documents R2's falls occurred on 10/21/2024, 11/05/2024 and 11/24/2024. Review of R2's progress notes dated 10/21/2024 at 11:18 am, documents a post occurrence with a complete body check completed with no injuries. Description of occurrence was [R2] was noted on her knees in from of her closet. [R2] unable to give reason. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 10/21/2024 a Falls Investigation Report was completed which documented, under incident description, CNA (Certified Nursing Assistant) called nurse to resident's room to note resident on her knees in front of her closet. Resident unable to give description. Immediate action taken documented, resident assessed for injuries and pain, neuros completed and assisted off the floor. Resident taken to the dining room for supervision. NP (Nurse Practitioner) guardian, DON, Administrator notified. No injuries observed at time of incident and no hospitalization . Pain is documented at a score of 0. Level of consciousness documented as alert. The following was not documented, mental status, predisposing environmental factors, predisposing physiological factors, and predisposing situation factors to include no known time last seen or last time toileted. There were no staff statements documented nor was a root cause analysis completed. The Falls Risk assessment dated [DATE] following R2's first fall, documents a score of 11, indicating R2 is at risk for falls. R2's mobility includes unsteady gait and/or use of ambulatory device and decreased mobility. Predisposing conditions documented for R2 include, CVA and no visual deficit. R2's mentation assessment is documented as confused. R2 has a history of 1-2 falls in the past 3 months. Documented under medications assessed as risk factors is drugs that have a diuretic effect or increased GI (gastrointestinal) motility. Drugs that affect the thought process. Drugs that create a hypotensive effect. R2's care plan fall interventions documented the following additions post first fall on 10/21/2024: Offer resident to be in common areas while awake. Date initiated, 10/22/2024. Monitor for changes in ability to navigate the environment. Date initiated, 10/23/2024. Keep frequently used items within reach in room. Date initiated, 10/23/2024. Ensure adequate lighting for tasks. Date initiated, 10/23/2024. Encourage resident to report falls. Date initiated, 10/23/2024. Encourage resident to keep room free from obstacles. Date initiated, 10/23/2024. Encourage resident to call, don't fall. Date initiated, 10/23/2024. Encourage participation in activities to keep resident focused and on task. Date initiated, 10/23/2024. Review of R2's progress notes dated 11/05/2024 at 12:06 pm document a post occurrence with a complete body check completed with no injuries. No description of occurrence. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 11/05/2024 a Falls Investigation Report was completed which documented under incident description, Summoned to resident room to observe resident sitting by her doorway by the white trash can. Resident was fully clothed with shoes and socks on Resident unable to give description. Immediate action taken documented, neuros taken No injuries observed at time of incident and no hospitalization . Pain is documented at a score of 0. Mental status documented as orientated to person. Level of consciousness documented as lethargic (drowsy). Predisposing environmental factors documented, wheelchair. Predisposing physiological factors documented incontinent, confused, weakness, gait imbalance, impaired memory, and poor safety awareness. Predisposing situation factors documented, resident last toileted is checked but does not specify a time and resident last observed indicated, staff reports just checking on her prior to event and she was in recliner. There were no staff statements documented nor was a root cause analysis completed. Revised care plan fall interventions for R2 documented the following additions post second fall on 11/05/2024: Medication adjustment and reviews. Resident also likes to crawl/place self in doorway and repeat hi at staff. Date initiated: 11/06/2024. Aromatherapy to promote calmness and relaxation. Date initiated: 11/06/2024. On 11/05/2024 a Falls Investigation Report was completed which documented under incident description, Summoned to resident room to observe resident sitting by her doorway by the white trash can. Resident was fully clothed with shoes and socks on Resident unable to give description. Immediate action taken documented, neuros taken No injuries observed at time of incident and no hospitalization . Pain is documented at a score of 0. Mental status documented as orientated to person. Level of consciousness documented as lethargic (drowsy). Predisposing environmental factors documented, wheelchair. Predisposing physiological factors documented incontinent, confused, weakness, gait imbalance, impaired memory, and poor safety awareness. Predisposing situation factors documented, resident last toileted in a check box but does not specify a time and resident last observed indicated, staff reports just checking on her prior to event and she was in recliner. There were no staff statements documented nor was a root cause analysis completed. Surveyor noted following the 10/21/24 fall R2's care plan indicates to offer to R2 to be in a common area. There is no documentation to indicate if this was offered to R2 and R2 refused or if the care plan had not been implemented to prevent this fall. Record review of R2's Falls Risk Assessment documented on 11/5/24, following second fall, assessed R2 to have a of 10, indicating R2 is at risk for falls. Mobility documented includes unsteady gait and/or use of ambulatory device. Predisposing conditions documented, CVA with no visual deficit. R2's mentation is documented as confused. History of falls documents R2 has had 1-2 falls in the past 3 months. Medications documented includes drugs that have a diuretic effect or increased GI motility. Drugs that affect the thought process. Drugs that create a hypotensive effect. Care plan fall interventions documented the following additions post second fall on 11/05/2024: Medication adjustment and reviews. Resident also (patterns herself) likes to crawl/place self in doorway and repeat hi at staff. Date initiated: 11/06/2024. Aromatherapy to promote calmness and relaxation. Date initiated: 11/06/2024. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Surveyor noted the fall risk assessment dated [DATE] references medication effects that could increase R2's risk for falls. However, it is not documented or individually assessed what specific medications R2 takes in the risk categories and how they may impact R2's falls. On 11/24/2024 at 8:43 pm, progress notes document a post occurrence with a complete body check completed with injury, bruising and hematoma over right eye. Description of occurrence was [R2] was noted on her knees in front of her closet. [R2] unable to give reason. Note text documented, CNA notified writer that resident was noted to be sitting on the floor, near the door of her room. Writer notified RN to come assess, as well as notify the charge RN. When asked what happened resident repeated, no Hello. Hello! I don't know. I don't know. Resident noted to be alert and oriented only to self. It is noted that this is her mental base line for orientation. Upon assessment it was noted that an approximately 5 x 4 cm (centimeter) hematoma was over her R (right) eye, on her forehead. No deformities noted upon head-to-toe assessment. ROM (range of motion) in BUE (bilateral upper extremities) and BLE (bilateral lower extremities) to baseline, able to bear weight. Non-slip socks noted on her feet. Neuro checks immediately initiated and noted to be baseline. Resident is PERLLA, (pupils are equal, round and reactive to light and accommodation). Resident refused to have her blood pressure taken repeatedly. Gathered vitals noted to baseline. Resident not showing any signs of SOB, (shortness of breath). Resident noted to be restless and very challenging to redirect. Writer educated resident to please remain still and remain in the same place until further assessment could be completed, however she continued to move around and even scooted across the floor and placed herself onto the edge of the bed. Staff continued to attempt to attempt to redirect without success. (Name of) , (Medical Doctor), (name of tele-medical group) contacted and provided order to send this resident to the ER (emergency room). Writer reached out to residents Son/POA, (Power of Attorney) (name of) , conveyi [TRUNCATED]

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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. 20483 Based on observation, interview, and record review, the facility did not ensure sufficient nursing staff was provided to allow residents to maintain or attain their highest practicable physical, mental, and psychosocial well-being This deficient practice has the potential to affect all 113 residents residing at the facility. Surveyors conducted interviews with residents and staff in which both expressed concerns regarding low staffing levels. The survey team had observations of resident call lights not being answered for extended periods of time. Surveyors interviewed residents who expressed concerns regarding extensive call light wait times. Surveyors conducted a record review of Facility's nursing schedules and daily staff postings and verified the Facility is not providing staffing levels that meet the Facility identified staffing needs documented in the Facility Assessment. Findings include: * R3's quarterly MDS (minimum data set) with an assessment reference date of 11/21/24 has a BIMS (brief interview mental status) score of 15 which indicates cognitively intact. On 12/2/24, at 9:35 a.m., R3 informed Surveyor they don't have enough help. R3 explained today they have two CNAs (Certified Nursing Assistants) but all weekend long there was only one CNA. R3 stated it's ridiculous, there's not enough staff to take care of the patients and they have to do the dishes, silverware, set the table, its awful. R3 informed Surveyor sometimes have to wait 45 minutes to an hour for the call light to be answered. R3 informed Surveyor they are suppose to have a float but they don't always have one and there wasn't a float this weekend. Surveyor asked R3 when there's not enough staff is there anything that staff isn't able to do for her. R3 replied no because I make them do it. R3 informed Surveyor they have complained at resident council and nothing ever gets done, we complain & complain and nothing gets fixed, nothing gets done. * R5's quarterly MDS (minimum data set) with an assessment reference date of 9/4/24 has a BIMS (brief interview mental status) score of 15 which indicates cognitively intact. On 12/2/224, at 10:07 a.m., Surveyor spoke with R5. During this conversation, Surveyor asked R5 if he attends therapy. R5 replied I'm done, they were suppose to walk me but they don't have time. Surveyor asked if staff ever walks him. R5 replied no. Surveyor asked how often he is suppose to be walk. R5 replied at least three times a week. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	* On 12/2/24, at 10:14 a.m., Surveyor asked CNA (Certified Nursing Assistant)-J, who was on the 300 unit, if the normal staffing is one CNA and a float on the unit. CNA-J replied yes I would say for the weekend, during the week there is normally two. CNA-J explained they take from this unit first as there is only one hoyer transfer. Surveyor asked CNA-J if she is able to complete everything with how staffing is. CNA-J replied I come in very early to get everything done. If I didn't come in early there is no way. Surveyor asked CNA-J if she isn't able to come in early what doesn't get done. CNA-J informed Surveyor she generally leaves the laundry, dishes, things like that but sometimes last rounds don't get done if she can't stay late. * On 12/2/24, at 10:25 a.m., Surveyor asked CNA (Certified Nursing Assistant)-I about the facility's call light system. CNA-I explained on the ceiling at the beginning of each hall there is a light and the computer screen has the room number. CNA-I explained if the call lights are answered the screen is green and if not the screen is red. CNA-I then showed Surveyor the computer screen which at this time showed all lights had been answered as the background is green. On 12/2/24, at 11:58 a.m., Surveyor observed the call light computer screen on the 200 unit. Surveyor observed R10's room number is listed with the call light being activated at 11:54 a.m. and there is a red background for R10's room indicating the call light has not been responded to. Surveyor observed R10's call light was not answered until 12:19 p.m. when RCC (Resident Care Coordinator)-K entered R10's room and shut off the call light. This was 25 minutes after R10 placed on the call light. At 12:21 p.m. Surveyor asked RCC-K why R10 placed the call light on. RCC-K informed Surveyor the resident thought she had a BM (bowel movement). * R6's annual MDS (minimum data set) with an assessment reference date of 10/16/24 has a BIMS (brief interview mental status) score of 15 which indicates cognitively intact. On 12/2/24, at 10:33 a.m. Surveyor asked R6 if there is enough staff to take care of him. R6 replied no, they focus on the Hoyer's, got a routine with Hoyer and left alone. R6 pointed to his facial hair and stated he had not had a beard trim since fall. * R8's annual MDS (minimum data set) with an assessment reference date of 11/5/24 has a BIMS (brief interview mental status) score of 14 which indicates cognitively intact. On 12/2/24, at 10:45 a.m. Surveyor asked R8 if there is enough staff. R8 replied no, constantly running behind schedule. R8 explained when the call light is placed on it takes an hour, an hour and a half to get answered. On 12/3/24, at 3:55 p.m. Nursing Home Administrator (NHA)-A, Director of Nursing (DON)-B, Regional Nurse Consultant-C and Assistant Administrator-D were informed of the above. 51014 On 12/03/2024, at 9:50 AM, Surveyor interviewed R11 who stated, the staffing is just terrible. She also stated, Call light wait times are sometimes over an hour to be answered. R11 stated, there are not nearly enough people to care for us. R11 stated that she is an active member of Resident Council, and she has brought up the concern regarding lack of staffing many times at the monthly meetings. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 12/03/2024 at 9:57 AM, Surveyor interviewed R12 who stated the staff are awesome but there is just not enough staff to properly care for everyone. R12 reported they feel the staff shortage is more apparent on nights and weekends. On 12/03/2024, at 10:00 AM, Surveyor interviewed Certified Nursing Assistant (CNA)-S, who stated staffing is not good at the facility. CNA-S stated she is alone again today with no one to float to her assigned unit (700 unit) to help. CNA-S stated she feels like the facility is always short .there is only me for 17 residents today. CNA-S stated she came in today for her shift at 6:30 AM to find many of the residents very incontinent and soiled as there was no one on the unit past 2:30am, leaving a four-hour gap in time. On 12/03/24, at 10:10 AM, Surveyor interviewed LPN (Licensed Practical Nurse) -R, who stated, staffing is terrible. She stated she only has one primary CNA each day who almost always works alone. LPN-R stated, Eight out of ten times the float (CNA) calls in and there won't be another replacement. LPN-R stated other units get two CNA's but her unit never does. Surveyor asked why she thinks this is and LPN-R stated the Facility supposedly basis staffing on acuity of residents, but she does not feel that makes sense as she has residents who require constant supervision and attention. On 12/03/24, Surveyor reviewed Resident Council meeting minutes for the past six months (June-November 2024). Resident Council meeting minutes documents staffing and long call light wait times during the last three months (August, September, and October 2024). On 12/02/2024 at 8:18 AM, Surveyor interviewed SC (Scheduling Coordinator)-T, who stated she staffs the facility based upon acuity and census. SC-T stated she is made aware of the facility census via a morning email and by the daily staffing report posted in the facility's front lobby. SC-T stated if she cannot provide the appropriate staffing levels with facility employees, she uses Clipboard, a staffing agency to fill in the open shifts. SC-T told Surveyor there is typically less staff on weekends due to more facility call-ins. Surveyor asked SC-T if any incentive programs are utilized for staff retention. SC-T responded the facility does not offer bonuses to staff. On 12/03/224, Surveyor reviewed the Facility Assessment tool which documents the Facility identified staffing requirements for a 24-hour day to include 26 CNA's for a census of 109-113 residents and 27 CNA's for a census of 114-120 residents. On 12/03/24, Surveyor reviewed the census and staffing for 10/19/24-10/21/24. Surveyor notes on 10/19/24 there was a census of 118 residents and the Facility was staffed with 24 CNAs. Sunday, 10/20/2024 there was a census of 116 residents and the Facility was staffed with 22 CNA's. Monday, 10/21/2024 there was a census of 119 residents and the Facility was staffed with 23 CNA's. Based on the facility assessment tool, the assessed need for CNAs from 10/19/24-10/21/24 is 27 CNA's. Surveyor notes the Facility did not have maintain staffing levels met their assessed need and had a deficit of 3 CNAs on 10/19/24, 5 CNAs on 10/20/24, and 4 CNAs on 10/21/24. Surveyor additionally reviewed the census and staffing for the month of November 2024 and 17 out of 30 days the Facility did not meet the staffing requirement for CNAs. On 12/3/24, at 3:33 PM, Surveyor informed Nursing Home Administrator (NHA)-A, Director of Nursing (DON)-B, Regional Nurse Consultant-C and Assistant Administrator-D of the above staffing concern.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20483 Based on interview and record review, the facility did not ensure 1 (R3) of 3 residents were free from unnecessary psychotropic medications ordered on an as needed (PRN) basis. On 11/10/24 R3 was prescribed an anti-anxiety medication, Lorazepam 0.5 mg every four hours PRN without an end date. Findings include: The facility's policy titled, Psychotropic Medications - Use Of and dated 9/2020 does not address stop dates for PRN (as needed) psychotropic medications. R3's diagnoses includes multiple sclerosis, chronic inflammatory demyelinating poly neuritis, diabetes mellitus, paraplegia, depressive disorder and anxiety disorder. R3 was readmitted to the facility on [DATE]. Hospital discharge documentation dated 11/10/24 includes under new medications lorazepam (LORazepam 0.5 mg (milligrams) oral tablet) 1 Tabs Gastrostomy tube/PE (percutaneous endoscopic) every 4 hours as needed anxiety. On 12/2/24, at 11:29 a.m., Surveyor reviewed R3's physician orders and noted an order dated 11/10/24 for Lorazepam 0.5 mg. Give 1 tablet via G (gastrostomy) tube every 4 hours as needed for anxiety. Surveyor noted there is not an end date. On 12/3/24, at 7:19 a.m., Surveyor asked Med Tech-F who is responsible to ensure there is a stop date for PRN psychotropic medications. Med Tech-F informed Surveyor she believes the RN's (Registered Nurse) are. On 12/3/24, at 7:32 a.m., Surveyor rechecked R3's physician orders and noted there is now an end date for R3's Lorazepam 0.5 mg of 12/2/24. On 12/3/24, at 11:01 a.m., Surveyor asked DON (Director of Nursing)-B who is responsible to ensure there is a stop date for resident's PRN psychotropic medication. DON-B replied the nurse who puts in the order. Surveyor informed DON-B on 12/2/24 Surveyor had reviewed R3's physician orders and there was not an end date for R3's Lorazepam 0.5 mg and when Surveyor rechecked R3's physician orders today there is now an end date dated 12/2/24. Surveyor asked DON-B who placed the end date in R3's physician orders. DON-B informed Surveyor Regional Nurse Consultant-C was reviewing R3 record and put it in. On 12/3/24, at 3:33 p.m. NHA (Nursing Home Administrator)-A, DON-B, Regional Nurse Consultant-C and Assistant Administrator-D were informed of the above.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525271	A. Building B. Wing	12/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alden Estates of Countryside, Inc	1130 Collins Road Jefferson, WI 53549

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 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides drinks consistent with resident needs and preferences and sufficient to maintain resident hydration. 20483 Based on interview and observation, the facility did not ensure water was consistently being passed to Residents. This has the potential to affect R3, R4, R5, R6, R7, R9, and other residents residing in the facility who would like water to drink in their rooms. Findings include: The facility's policy titled, Water Passing and dated 9/2020 under purpose documents To maintain fresh drinking water accessible to resident's around the clock. Procedure documents 1. Wash hands. 2. Gather supplies. 3. Fill clean water pitchers/cups with ice and water every shift and as necessary. Resident's on thickened liquids or fluid restrictions will be identified. 4. Knock before entering room. 5. Distribute cups to resident's room. Leave on bedside table with a straw (if able to have straw). 6. Water will not be left at bedside on the dementia unit unless appropriate. 7. Offer each resident a drink. Record on I & O (intake and output) sheet (if applicable). 8. Discard used supplies in appropriate manner. * R3's quarterly MDS (minimum data set) with an assessment reference date of 11/21/24 has a BIMS (brief interview mental status) score of 15 which indicates cognitively intact. On 12/2/24, at 9:35 a.m., Surveyor asked R3 if staff pass water. R3 replied yes, I ask for it. Surveyor asked how often staff passes out water. R3 replied just when I ask for it. * R4's annual MDS (minimum data set) with an assessment reference date of 9/13/24 has a BIMS (brief interview mental status) score of 2 which indicates severe cognitive impairment. On 12/2/24, at 9:54 a.m., Surveyor observed R4 in bed wearing dark glasses. Surveyor did not observe a water glass in R4's room. Surveyor asked R4 if staff passes out water. R4 replied no. * R5's quarterly MDS (minimum data set) with an assessment reference date of 9/4/24 has a BIMS (brief interview mental status) score of 15 which indicates cognitively intact. On 12/2/24, at 10:07 a.m., Surveyor observed R5 sitting in a wheelchair in his room. Surveyor asked R5 if staff provides water to him. R5 replied yes. Surveyor asked R5 how often he receives water. R5 replied when ever I request it. Surveyor asked R5 if he doesn't request it does staff provide him with water. R5 replied no maybe at night. On 12/2/24, at 10:22 a.m., Surveyor asked CNA (Certified Nursing Assistant)-J & CNA-I, who were in the dining room on the 300 unit if they pass out water to residents. CNA-J replied no. CNA-I stated on the other side of the building, they do on 600. * R6's annual MDS (minimum data set) with an assessment reference date of 10/16/24 has a BIMS (brief interview mental status) score of 15 which indicates cognitively intact. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525271	A. Building B. Wing	12/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alden Estates of Countryside, Inc	1130 Collins Road Jefferson, WI 53549

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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 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/2/24, at 10:33 a.m., Surveyor asked R6 if staff passes out water. R6 replied no they give me water with my pills. Surveyor asked R6 if staff passed out water would he drink the water. R6 replied yes. * On 12/2/24, at 10:36 a.m. Surveyor asked R7 if staff passes out water. R7 replied no. * R9's quarterly MDS (minimum data set) with an assessment reference date of 11/13/24 has a BIMS (brief interview mental status) score of 15 which indicates cognitively intact. On 12/2/24, at 11:45 a.m., Surveyor observed R9 sitting in a wheelchair in the room. Surveyor did not observe a water glass. Surveyor asked R9 if staff brings her water. R9 replied no, the CNAs don't have time. Surveyor asked R9 if staff brought her water would she drink it. R9 replied sure. * On 12/2/24, at 1:46 p.m., Surveyor asked CNA-M, who is the day float CNA for units 500, 600, & 700 units, if they pass out water to residents. CNA-M replied when we can and explained sometimes they can get to it if they have help. * On 12/2/24, at 1:55 p.m., Surveyor asked CNA-L, who was on the 600 unit, if they pass out water to residents. CNA-L replied no we don't. * On 12/2/24, at 3:24 p.m., Surveyor asked CNA-H, who is the evening float CNA for units 500, 600, & 700 units, if they pass out water to residents. CNA-H replied yes should be every two hours. * On 12/2/24, at 3:41 p.m., Surveyor asked CNA-G who was on the 400 unit if they pass out water. CNA-G replied yes if we have enough cups and explained there are maybe three cups up there. Surveyor asked if this was unusual to not have cups. CNA-G informed Surveyor it's not unusual to not have mugs. On 12/3/24, at 1:11 p.m., Surveyor asked DON (Director of Nursing)-B how water is passed to residents. DON-B informed Surveyor they have water cups in their room and they are filled as needed. DON-B informed Surveyor anyone can fill water cups. Surveyor asked DON-B if staff passes water once a shift. DON-B replied as needed, at least once a shift they are getting water. Surveyor informed DON-B of the multiple interview from residents and staff that water is not consistently being passed and Surveyor did not observe water being passed. On 12/3/24, at 3:33 p.m., NHA (Nursing Home Administrator)-A, DON-B, Regional Nurse Consultant-C and Assistant Administrator-D were informed of the above. No information was provided to Surveyor as to why water wasn't being passed to residents