STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525276	A. Building B. Wing	03/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Mary's Care and Rehab Center LLC	3401 Maple Grove Dr Madison, WI 53719

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 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** 26190 Based on interview, record review, and policy review the facility failed to ensure that the facility was free of accident hazards in 1 of 7 residents R9 reviewed for accident hazards of 14 sample residents. The facility failed to prevent a fall for R9 Findings include: Review of the facility's policy titled, Fall Prevention Program, dated 02/28/25, indicated Policy: Each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls. Definitions: A fall is an event in which an individual unintentionally comes to rest on the ground, floor or other level, but not as result of an overwhelming external force .Policy Explanation and Compliance Guidelines: 1. The facility utilizes a standardized risk assessment for determining a resident's fall risk. A. The risk assessment categorizes resident according to low, moderate, or high risk .5. Low/Moderate Risk Protocols: a. Implement universal environmental interventions that decrease the risk of resident falling .b. Implement routine rounding schedule. C. Monitor for changes in resident's cognition, gait, ability to rise/sit and balance .g. Complete a fall risk assessment every 90 days and as indicated when resident's condition changes .8. Each resident's risk factors and environmental hazards will be evaluated when developing the resident's comprehensive plan of care . (continued on next page)

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

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the facility's policy titled, Elopements and Wandering Residents, dated 02/28/25, indicated Policy: This facility ensures that residents who exhibit wandering behavior and/or risk for elopement receive adequate supervision to prevent accidents and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk. Definitions .Elopement occurs when a resident leaves the premises or a safe area without authorization .and or any necessary supervision to do so. Policy Explanation and Compliance Guidelines: 1. The facility shall establish and utilize a systemic approach to monitoring and managing residents at risk for elopement or unsafe wandering, including identification and assessment of risks, evaluation and analysis of hazards and risks, implementing interventions to reduce hazards and risks, and monitoring for effectiveness and modifying interventions when necessary. 2. Monitoring and Managing Residents at Risk for Elopement or Unsafe Wandering. A Residents will be assessed for risk of elopement and unsafe wandering upon admission and throughout their stay by the interdisciplinary care plan team .Procedure Post-Elopement a. A nurse will perform a physical assessment, document and report findings to physician .d. The resident and family/authorized representative will be included in the plan of care. E. Staff may be educated on the reasons for elopement and possible strategies for avoiding such behavior .g. Documentation in the medical record: findings from nursing and social service assessments, physician/family notification, care plan discussion . Example 1 Review of R9's Face Sheet located under the Profile tab of the electronic medical record (EMR) revealed R9 was admitted to the facility on [DATE] with diagnoses of anemia, history of falling, age related osteoporosis, major depression disorder, and dementia. Review of R9's significant change Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/24/25, located under the Resident Assessment Instrument (RAI) tab indicated R9 was substantial/ maximum assistance for eating; partial/ moderate assistance for oral hygiene; dependent on toileting hygiene, dressing, transfers, and personal hygiene; and substantial/ maximum assistance to dependent for bed mobility. The MDS revealed a Brief Interview for Mental Status (BIMS) of 13 out of 15 indicating R9 was cognitively intact. Review of R9's Progress Notes under the Progress Note tab of the EMR, dated 10/24/24 Note Text: CNA reported resident noted sliding out of recliner. Writer immediately assessed resident and noted resident sitting in recliner with legs sliding off recliner. No fall. Writer and 2 CNA's repositioned resident into recliner appropriately with BLE's elevated. Writer called Therapy department to request non slip gripper for recliner or recommendations to prevent a fall and therapy recommended green Posey non-slip matting available in med room to prevent fall. Writer updated ADON and states will update care plan. Resident in no apparent distress, in good spirits. Resident denies pain or discomfort. Will continue to monitor until end of shift. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of R9's Progress Notes under the Progress Note tab of the EMR, dated 11/05/24, indicated Resident noted on the floor, on her back with feet towards the door and head towards recliner. Remote to recliner in resident's hand and recliner noted tilted in the highest position. Resident assessed at this time. She denies any pain or discomfort. Tylenol administered as scheduled. No new injuries or bruises noted at this time. Neuros WNL [within normal limits]. ROM [range of motion] WNL for resident. Resident stated, she does not know why she held button until falling out of it. VSS [vital signs stable]. -New intervention: Unplug recliner due to resident's lack of safety awareness. CP [care plan] and Kardex updated. Charge nurse, nurse manager .NP [Nurse Practitioner], and POA [power of attorney] notified. R9's plan of care states in part; Complications with or falls related to current medical physical status. Goal: Reduced risk with falls with interventions through next review date. Interventions: Unplug recliner due to resident lack of safety awareness, initiated date: 11/5/24. Resolved date: 11/6/24. Reinforce nonskid strips in front of recliner intiated date: 11/6/24. It should be noted R9's lift chair was plugged back in allowing R9 to use the lift function, the facility did not have evidence of assessing R9's safety to utilize the lift chair safely prior to plugging the lift chair back in. It should be noted R9 had a fall out of the lift chair on 1/20/25 due to lifting the chair in upright position this resulted in a femur fracture, Review of R9's Progress Notes under the Progress Note tab of the EMR, dated 01/20/25, indicated writer found resident in her room on the floor around 8pm. Resident had used electric control for recliner and put the chair all the way up causing her to fall out on her left side. Fully clothed with shoes on, her head was toward the bed and feet next to the recliner and throw blanket was under her. All needed items were on table next to chair with call button on her neck. Stated she did not hit her head. Review of R9's Progress Notes under the Progress Note tab of the EMR, dated 01/21/25, indicated IDT [Interdisciplinary Team] NOTE . The recliner chair was observed all the way up at the time of occurrence. Most likely she used the electric control and put the recliner all the way up causing her to fall out onto her left side. Increased rounding after dinner provided. Upon return from hospital therapy to eval for recliner safety and therapy needs s/p [status post] left femur fracture with ORIF (open reduction internal fixation) .Will monitor the effectiveness of the interventions and modify as necessary. Review of R9's Progress Notes under the Progress Note tab of the EMR, dated 01/24/25, indicated SW [Social Worker] contact .Son to inform, recliner has been removed due to non-usage and inability to safely operate furniture . Review of R9's Fall Risk Screening Tool under the Assessments tab of the EMR indicated the following completed screenings: 09/28/24 no falls; 11/05/24 - three to no falls, resident was incontinent, had cognitive impairment, resident did not always use call light appropriately, problem with cognition, judgement, memory and safety awareness; unsteady with gait, patient alert to self; 01/04/25 quarterly no falls, was resident at risk for falls - no. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 03/28/25 at 3:24 PM, the Administrator stated we really do not have fall prevention education for staff that is specific at orientation but when CNAs go to floor fall prevention is covered when they review the Kardex. Said no specific fall prevention training for staff in past 6 months. Explained that they have a charge nurse that is over building each shift and that nurse attends stand up and stand down meeting where falls and new interventions would be discussed and then brought to unit staff and Kardex changed. Surveyor inquired about R9's falls from the lift chair. Administrator stated he could not locate a document or discussion between Therapy and Nursing regarding why R9's recliner control was plugged back in. The Administrator explained the therapy group is no longer employed by the facility and documentation for R9 is not been located. The Administrator stated Therapy/Nursing discussion about recliner and plugging back in was done between staff and will try to locate something about decision. Said have one PT that is still here that may have knowledge. No further information is provided. The facility failed to assess R9's ability to safely operate a lift chair. R9 was found sliding out of the lift chair on 10/24/24, had a fall out of the lift chair on 11/5/24 when R9 raised the chair in the upright position and slid out of the chair on to the floor. The facility is unable to produce evidence they assessed R9's ability to safely use the lift chair. R9 had a second fall out of the lift chair when R9 lifted the chair in the upright position R9 fell out of the lift chair and was found with a femur fracture. The facility completed a performance improvement plan related to the fall with fracture however there the facility was unable to provide evidence of staff education regarding the changes in recliner/lift chair process.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26190 Based on observations, record review, interviews, and policy review, the facility failed to follow the prescribed easy to chew diet for 1 of 1 resident (R6) reviewed for proper diet texture out of 14 sampled residents. R6's diet orders stated Level & easy to chew. R6 had several snacks in R6's room that did not follow this diet order. The facility failed to have an order in R6's medical record indicating exceptions to the diet order or a risk and benefit to consume items outside the diet order. Findings include: Review of the undated document provided by the facility titled: Level 7: Easy to Chew revealed: This diet is for individuals who have difficulty chewing and/or swallowing regular textured foods. This diet requires the ability to bite soft foods and chew and orally process food for long enough that the person forms a soft cohesive - bolus that is swallow ready. Tongue force and control is required to move the food for chewing and to keep it within the mouth during chewing, and tongue force is required to move the bolus for swallowing: Individuals who may benefit from this diet include those who find hard and/or chewy foods difficult or painful to chew and swallow. This diet can be eaten with a fork, spoon, or chopsticks. It can be mashed/broken down with pressure from a fork, spoon, or chopsticks. A knife is not required to cut this food, but may be used to help loading a fork or spoon. Chewing is required before swallowing. The food is soft, tender, and moist throughout but with no separate thin liquid. Size is not restricted at level 7, therefore, foods may be a range of sizes. Individual menu modifications may be made in the residents' Geri Menu Profile and stated on tickets. Foods to avoid .Dry, tough or crusty bread, crackers, etc. dry cereals or such as shredded wheat, bran cereal or granola, any broken apart into smaller pieces with the side of a with nuts or seeds if not tolerated. Review of facility's policy titled, Therapeutic Diet Orders, implemented 10/24 and reviewed 01/25, revealed: Policy: The facility provides all residents with foods in the appropriate form and/or the appropriate nutritive content as prescribed by a physician, and/or assessed by the interdisciplinary team to support the resident's treatment/plan of care, in accordance with his/her goals and preferences . 5. Dietary and nursing staff are responsible for providing therapeutic diets in the appropriate form and/or the appropriate nutritive content as prescribed . Review of R6's annual Minimum Data Set (MDS) located in the MDS tab of the electronic medical record (EMR) with an Assessment Reference Date (ARD) of 02/02/25 revealed R6 was admitted to the facility on [DATE] with diagnoses that included Parkinson's disease without dyskinesia, parkinsonism, generalized muscle weakness, reduced mobility, adult failure to thrive, and dysphagia. R6 had a Brief Interview for Mental Status (BIMS) score of 12 out of 15, which indicated R6 was moderately cognitively impaired. The MDS further revealed that R6 had broken or loosely fitting full or partial denture and was on a mechanically altered diet. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R6's nutrition/hydration care plan located on the Care Plan tab of the EMR initiated 10/14/24 and revised 02/28/25, revealed Diet Type: General/Standard Diet - Texture: Level 7: Easy to chew . Review of R6's orders located under the Orders tab of the EMR revealed dietary order, dated 11/27/24, General diet, [Name]-Level 7: Easy to chew texture, Thin Liquids consistency for updated diet. During an observation on 03/27/25 at 12:57 PM, an open, clear bag of cheese crackers was observed on R6's bedside table. During an observation on 03/27/25 at 1:10 PM, in the dining room it was revealed that R6 was in a wheelchair, eating independently. Lunch consisted of soft, easy-to-chew diet with ice cream for dessert. During an interview on 03/27/25 at 1:11 PM, Certified Nursing Assistant 2 (CNA) stated R6's diet was soft chewable. When asked why R6 had a bag of cheese crackers in her room, CNA2 stated R6 could have Cheetos, chips, and crackers. CNA2 stated she had heard the speech therapist say it was ok for R6 to have Cheez-its. During an interview on 03/27/25 at 12:56 PM the Speech Therapist and Language Pathologist (ST) stated R6's diet was level seven, easy to chew. The ST stated she allowed the resident to have snacks for quality of life. The ST stated R6 liked Cheetos, and she could have them. ST stated R6 still had teeth, and upper dentures and she could handle the texture of allowed snacks. When asked if the crackers, Cheetos, and other such snacks were within the residents' diet restrictions, the ST stated she did not embrace an all or nothing stance when it came to dietary restrictions and permitted R6 to enjoy some snacks because R6 would be unhappy without her snacks. The ST stated R6's family also brought her snacks and that there have been no bad outcomes, that it was not a swallowing issue, and that she would discuss a risk and benefit analysis with the resident. The ST stated she made exceptions to certain diets for quality-of-life issues. When asked if those exceptions had been communicated in writing to the interdisciplinary team and reflected in the resident's care plan, she said no. During a telephone interview on 03/28/25 at 1:34 PM, CNA3 stated R6 was labeled a level six, but got chips, root beer, and Cheez-it's for snacks. CNA3 stated R6 loved potato chips the best. When asked if those snacks were in compliance with R6's diet, CNA3 stated it was not, but if R6 did not get her snacks she got mad and so did R6's family. When asked if dietary services were aware of R6's snack preferences, CNA3 stated we don't tell dietary. CNA3 stated the snacks came from the pantry in the household. CNA3 confirmed that facility staff obtained the snacks from the facility to give to R6. During an interview on 03/27/25 at 2:49 PM the Registered Dietician (RD) stated Cheetos and Cheez-its were not in compliance with a level seven diet. When told, the ST had said it was ok for R6 to have crackers and other snacks that were not in line with R6's diet. The RD stated quality of life exceptions to diets needed to be in the resident's care plan and she was unaware of the ST's recommendation as they were not documented in R6's medical record. The RD acknowledged the ST's exception to R6's diet was not in the current care plan and that she was unaware of the ST's dietary exceptions for R6. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/28/25 at 4:13 PM, R6 stated she liked Cheetos, but they were hard. R6 stated she liked cheese puffs because they were melt-in-your-mouth. R6 stated she liked potato chips but sometimes they did not have them. R6 stated she did not have any problem with eating her snacks and she loved them. R6 stated staff provided her with her snacks. During an interview on 03/28/25 at 4:13 PM, Family Member 2 (FM) stated the facility staff and family all provided chips and other snacks for R6 in line with R6's preferences and that she eats pretty much whatever she likes. During an interview on 03/27/25 at 2:49 PM, the Director of Nursing (DON) acknowledged the ST did not document that R6's diet would not be followed strictly and that this was also not in R6's care plan.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26190 Based on interviews, record review, and policy review, the facility failed to ensure medical records were complete and accurate for 1 out of 14 sample residents (R5) reviewed for medical records. R5's plan of care had conflicting information regarding R5's ability to self-administer medication. Findings include: Review of the facility's policy titled, Comprehensive Care Plans, dated 02/28/25, revealed It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs and ALL services that are identified in the resident's comprehensive assessment and meet professional standards of quality .5. The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS assessment. Review of R5's quarterly Minimum Data Set (MDS) located in the MDS tab of the electronic medical record (EMR) with an Assessment Reference Date (ARD) of 01/09/25 revealed R5 was originally admitted to the facility on [DATE] with latest admission on 08/31/17 and diagnoses that included malignant neoplasm of ileum, urinary tract infection, sepsis due to Escherichia coli, acute respiratory failure with hypoxia, diabetes mellitus, depression, mild cognitive impairment, and insomnia. R5 had a Brief Interview for Mental Status (BIMS) score of 13 out of 15 which indicated R5 was cognitively intact. Review of R5's care plan located on the Care Plan tab of the EMR revealed an undated notation on the first page as follows: Medications Given: Whole, may self-administer scheduled oral meds after set-up . Further review of the care plan located under the Care Plan tab of the EMR, revealed the following intervention, dated 05/02/24, under the activities of daily living (ADL) section as follows: May not self-administer medications and must be observed that medications are taken. Review of the care plan located under the Care Plan tab of the EMR, revealed a focus item titled Self-Administration: Oral medications, initiated on 01/02/25. The goal of the care plan was that R5 Will be safe in self-administration of medications through next review date. During an interview on 03/28/25 at 3:19 PM, Licensed Practical Nurse 2 (LPN) stated she was familiar with R5 and had given her medications before. LPN2 stated R5 had orders to self-medicate. LPN2 stated that a banner with special instructions popped up on the screen in the EMR and was also in the resident's care plan. When told that R5's care plan stated both that the resident could, and could not self-medicate, LPN2 stated she did not know that, but that she was aware LPN2 could self-medicate. When asked if there was an order stating R5 could self-medicate, LPN2 stated she followed the special order banner in the EMR. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R5's orders located under the orders tab of the EMR failed to reveal an order that R5 could self-medicate. During an interview on 03/28/25 at 6:15 PM the Director of Nursing (DON) acknowledged there were two conflicting items on R5's care plan about R5's self-medication status.