| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 525286 | A. Building<br>B. Wing | 02/05/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Juliette Manor | 482 Oak Street<br>Berlin, WI 54923 |

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 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43361<br><br>Based on staff and resident interview and record review, the facility did not report an allegation of abuse to Nursing Home Administrator (NHA)-A or the State Agency (SA) in a timely manner for 1 resident (R) (R2) of 16 sampled residents.<br><br>R2 reported to staff that Certified Nursing Assistant (CNA)-F was rough with cares and yelled at R2. The allegation of abuse was not reported timely to NHA-A or the SA.<br><br>Findings include:<br><br>The facility's Long Term Care (LTC) Resident Abuse Prevention and Reporting Policy, revised 9/12/24, indicates: .G. Reporting: 1. Anyone who witnesses an act that may potentially meet the definition of abuse or any other defined misconduct, or to whom someone has reported abuse or any other defined misconduct, will immediately ensure resident safety and then report the allegations to the Administrator. 2. The proper method of reporting is in-person or phone call to assure prompt notification is made .6. For alleged violations of abuse, or if there is serious bodily injury, the facility must report the allegation immediately, but no later than 2 hours after the allegation is made, in accordance with state law. In addition, local law enforcement will be notified of any reasonable suspicion of a crime against a resident in the facility. 7. For alleged violations of neglect, exploitation .or mistreatment that do not result in great bodily injury, the facility must report the allegations to the Division of Quality Assurance (DQA) no later than 24 hours, in accordance with state law.<br><br>From 2/3/25 to 2/5/25, Surveyor reviewed R2's medical record. R2 was admitted to the facility on [DATE] and had diagnoses including encounter for surgical after care following surgery on the circulatory system, hypertensive heart and chronic kidney disease, type 2 diabetes, and major depressive disorder. R2's Minimum Data Set (MDS) assessment, dated 12/30/24, had a Brief Interview for Mental Status (BIMS) score of 12 out of 15 which indicated R2 had moderate cognitive impairment. R2 was R2's own person.<br><br>Surveyor reviewed the facility's grievance file and noted a grievance, dated 1/20/25, that indicated R2 reported that CNA-F was rough during cares and raised CNA-F's voice at R2. The investigation indicated CNA-F admitted that CNA-F raised CNA-F's voice and reported to the nurse that R2 had a concern. The resolution section indicated Director of Nursing (DON)-B would follow-up/provide disciplinary action for CNA-F. The grievance was signed by Social Worker (SW)-J on 1/21/25 and by NHA-A on 1/24/25 and contained the following interviews:<br><br>(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 |
|---|---|---|

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | ~On 1/20/25, SW-J interviewed R2 who indicated CNA-F assisted R2 to the bathroom. When R2 moved R2's table and items fell on the ground, CNA-F told R2 not to touch the table again in a raised voice. When R2 was finished in the bathroom, CNA-F used a wipe to clean R2's bottom and a towel to dry R2. R2 indicated CNA-F was rough when drying R2 and complained that it hurt. CNA-F raised CNA-F's voice again when R2 told CNA-F to stop because CNA-F was rough. R2 indicated CNA-F was not happy when R2 moved the table and made a mess and CNA-F had to clean it up.<br><br>~On 1/20/25, SW-J interviewed CNA-G who was working with CNA-F on the night of the incident (1/18/25). CNA-G's statement indicated CNA-G did not see a concern when R2 spilled items off the table. CNA-G stated after R2 was assisted to the toilet, CNA-G left. CNA-F assisted R2 off the toilet and then reported to CNA-G that R2 no longer wanted CNA-F in the room. CNA-G indicated CNA-F appeared annoyed or bothered and was apologetic to CNA-G. R2 later told CNA-G that CNA-F was too rough during cares.<br><br>~On 1/20/25, SW-J interviewed Registered Nurse (RN)-H who was the AM nurse on 1/19/25. RN-H indicated RN-I (the night shift nurse) reported that R2 complained that CNA-F was too rough during cares. RN-H told RN-I that R2 said CNA-F yelled at R2 when R2 moved R2's table and made a mess.<br><br>~On 1/20/25, SW-J interviewed RN-I who indicated R2 reported that CNA-F was rough when CNA-F cleaned R2 after R2 used the bathroom. R2 was angry about what occurred and did not want CNA-F to assist R2 anymore. RN-I attempted to have CNA-F enter R2's room with RN-I to check R2's vital signs but R2 demanded CNA-F leave. CNA-F did not return to R2's room and told RN-I that R2 was mad at CNA-F. CNA-F appeared frustrated but RN-I did not hear CNA-F raise CNA-F's voice. RN-I stated CNA-F can be stern when frustrated.<br><br>On 2/5/25 at 10:11 AM and 10:26 AM, Surveyor interviewed DON-B who indicated DON-B received an email on 1/19/25 (Saturday) at 8:40 AM from RN-I that R2 requested to speak with SW-J and management staff on 1/20/25 (Monday). DON-B was off on 1/20/25 and did not see the email on 1/19/25. DON-B indicated the incident occurred overnight on the 1/18/25 to 1/19/25 night shift and CNA-F also worked the 1/19/25-1/20/25 night shift. DON-B indicated CNA-F was removed from caring for R2 but did assist other residents. CNA-F was removed from the next scheduled shift on 1/22/25 because the facility was working through Human Resources after interviews were completed to find out what happened. DON-B indicated the allegation of abuse was not reported to the SA. DON-B indicated if staff have an abuse concern, they should call the shift leader instead of sending an email. DON-B thought RN-I did not consider the incident abuse and indicated the email sent by RN-H did not state why R2 wanted to talk to SW-J and management staff.<br><br>On 2/5/25 at 10:50 AM, Surveyor interviewed R2 who recalled the event and indicated CNA-F was mean and it was not the first time. R2 stated CNA-F rubbed and rubbed so hard down there and R2 was sensitive in that area. R2 tried to grab the towel away but CNA-F yelled at R2 and said CNA-F was doing CNA-F's job. R2 told CNA-F that it hurt but CNA-F kept going. R2 told the night shift nurse what occurred. R2 stated R2 did not want CNA-F in R2's room and when CNA-F tried to enter the room, R2 kicked CNA-F out.<br><br>(continued on next page) |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 2/5/25 at 11:26 AM, Surveyor interviewed RN-I via phone who stated CNA-F assisted R2 to the bathroom on 1/18/25 at approximately 8:00 PM or 9:00 PM. R2 reported that CNA-F was rough and hurt R2 when CNA-F cleaned R2. RN-I indicated R2's groin and buttocks were red and R2 didn't like how CNA-F provided care because R2 was already red in that area. RN-I heard R2 yelling and entered R2's room. R2 said CNA-F was being too aggressive, however, by the time RN-I entered the room, CNA-F had finished cares. CNA-F and RN-I then transferred R2 to bed. R2 repeatedly said I'm hurting and indicated R2 didn't want CNA-F in R2's room. RN-I verified R2 kicked CNA-F out of the room when CNA-F entered the room with RN-I and attempted to get R2's vital signs. RN-I reported the information to the AM shift and stated another CNA worked with R2 on the night of 1/19/25. RN-I stated RN-I wasn't sure if CNA-F was stubborn and continued to try to clean R2 up or if R2 over-reacted.<br><br>On 2/5/25 at 10:56 AM, Surveyor interviewed NHA-A who heard about the incident on 1/20/25 from SW-J and started an investigation. NHA-A indicated it seemed to be more of a care issue and said R2 was upset with how CNA-F provided care and the technique CNA-F used. NHA-A did not feel the incident was an allegation of abuse and indicated CNA-F was a long-term employee with no previous abuse concerns. NHA-A verified CNA-F admitted to raising CNA-F's voice at R2. NHA-A indicated other residents were interviewed with no other concerns. NHA-A stated after gathering statements, NHA-A did not feel the incident was reportable and did not think it was an allegation of abuse since R2 did not want to talk to management until 1/20/25. |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Respond appropriately to all alleged violations.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43361<br><br>Based on staff and resident interview and record review, the facility did not ensure an allegation of abuse was thoroughly investigated for 1 resident (R) (R2) of 16 sampled residents.<br><br>R2 reported that Certified Nursing Assistant (CNA)-F was rough with cares and yelled at R2. R2 informed staff that R2 did not want CNA-F to care for R2. CNA-F attempted to go back into R2's room to obtain R2's vital signs but R2 yelled at CNA-F to get out. CNA-F was not removed from or supervised during resident care until 1/22/25.<br><br>Findings include:<br><br>The facility's Long Term Care (LTC) Resident Abuse Prevention and Reporting Policy, revised 9/12/24, indicates: .E. Protection: 1. Immediately upon receiving a report of alleged abuse or any other defined misconduct, the facility will take all necessary steps to protect residents from additional harm. The facility will coordinate delivery of appropriate medical and/or psychological care and attention. 2. Safety, security, and support of the residents will be provided. The facility will take immediate action to correct the issue to reduce the risk of further harm occurring. This will include as appropriate .The alleged perpetrator will immediately be removed and the resident protected. Team members accused of abuse will be immediately removed from the facility and will remain removed pending the results of a thorough investigation.<br><br>From 2/3/25 to 2/5/25, Surveyor reviewed R2's medical record. R2 was admitted to the facility on [DATE] and had diagnoses including encounter for surgical after care following surgery on the circulatory system, hypertensive heart and chronic kidney disease, type 2 diabetes, and major depressive disorder. R2's Minimum Data Set (MDS) assessment, dated 12/30/24, had a Brief Interview for Mental Status (BIMS) score of 12 out of 15 which indicated R2 had moderate cognitive impairment. R2 was R2's own person.<br><br>Surveyor reviewed the facility's grievance file and noted a grievance, dated 1/20/25, that indicated R2 reported that CNA-F was rough and raised CNA-F's voice at R2 during cares. The investigation indicated CNA-F admitted that CNA-F raised CNA-F's voice at R2 and reported to the nurse that R2 had a concern. The facility interviewed other residents on 1/22/25 and 1/23/25 with no concerns. The resolution section indicated Director of Nursing (DON)-B would follow-up/provide disciplinary action for CNA-F. The grievance was signed by Social Worker (SW)-J on 1/21/25 and by Nursing Home Administrator (NHA)-A on 1/24/25. The grievance contained the following interviews:<br><br>~On 1/20/25, SW-J interviewed R2 who indicated CNA-F assisted R2 to the bathroom. When R2 moved R2's table and items fell on the ground, CNA-F told R2 not to touch the table again in a raised voice. When R2 was finished in the bathroom, CNA-F used a wipe to clean R2's bottom and a towel to dry R2. R2 indicated CNA-F was rough when drying R2 and complained that it hurt. CNA-F raised CNA-F's voice again when R2 told CNA-F to stop. R2 indicated CNA-F was not happy when R2 moved the table and made a mess and CNA-F had to clean it up.<br><br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | ~On 1/20/25, SW-J interviewed CNA-G who worked with CNA-F on the night of the incident (1/18/25). CNA-G's indicated CNA-G did not see a concern when R2 spilled items off the table. CNA-G stated after R2 was assisted to the toilet, CNA-G left. CNA-F assisted R2 off the toilet and then reported to CNA-G that R2 no longer wanted CNA-F in the room. CNA-G indicated CNA-F appeared annoyed or bothered and was apologetic to CNA-G. R2 later reported to CNA-G that CNA-F was too rough during cares. CNA-G had not heard any other residents make other accusations or negative comments about CNA-F.<br><br>~On 1/20/25, SW-J interviewed Registered Nurse (RN)-H who was the AM shift nurse on 1/19/25. RN-H indicated RN-I (the night shift nurse) reported that R2 complained about CNA-F being too rough with cares. RN-H told RN-I that R2 stated CNA-F yelled at R2 when R2 moved R2's table and made a mess.<br><br>~On 1/20/25, SW-J interviewed RN-I who indicated R2 reported that CNA-F was rough when CNA-F cleaned R2 after R2 used the bathroom. R2 was angry about what occurred and did not want CNA-F to assist R2 anymore. RN-I attempted to have CNA-F enter R2's room with RN-I and obtain R2's vital signs but R2 demanded CNA-F leave the room. CNA-F did not return to R2's room and told RN-I that R2 was mad at CNA-F. CNA-F appeared frustrated but RN-I did not hear CNA-F raise CNA-F's voice. RN-I stated CNA-F can be stern when CNA-F is frustrated.<br><br>On 2/5/25 at 10:11 and 10:26 AM, Surveyor interviewed Director of Nursing (DON)-B who indicated DON-B received an email on 1/19/25 (Sunday) at 8:40 AM from RN-I that R2 requested to speak with SW-J and management staff on 1/20/25 (Monday). DON-B was off on 1/20/25 and did not see the email on 1/19/25. The email also was sent to SW-J and a unit manager. DON-B indicated the incident occurred overnight from 1/18/25 to 1/19/25. DON-B indicated CNA-F worked the 1/19/25-1/20/25 night shift. CNA-F was removed from caring for R2 but assisted other residents. DON-B indicated CNA-F was removed from the schedule on 1/22/25 based on the interviews completed and CNA-F's admission that CNA-F raised CNA-F's voice to R2.<br><br>On 2/5/25 at 10:50 AM, Surveyor interviewed R2 who recalled the event and indicated CNA-F was mean and it was not the first time. R2 stated CNA-F rubbed and rubbed so hard down there and R2 was sensitive in that area. R2 tried to grab the towel but CNA-F yelled at R2 and said CNA-F was doing CNA-F's job. R2 told CNA-F that it hurt but CNA-F kept going. R2 told the night shift nurse what happened and stated R2 did not want CNA-F in R2's room. R2 indicated when CNA-F later tried to enter R2's room to take vital signs, R2 kicked CNA-F out.<br><br>On 2/5/25 at 11:26 AM, Surveyor interviewed RN-I via phone who stated R2 had to use the bathroom at approximately 8:00 PM or 9:00 PM on 1/18/25 and CNA-F assisted R2. RN-I indicated when CNA-F cleaned R2, R2 said CNA-F was rough and hurt R2. RN-I indicated R2's groin and buttocks were red and R2 didn't like how CNA-F provided care because R2 was already red in that area. RN-I heard R2 yelling and entered R2's room. R2 said CNA-F was being too aggressive, however, when RN-I entered the room, CNA-F was already finished with cares. CNA-F and RN-I then transferred R2 to bed. R2 repeatedly said I'm hurting and that R2 did not want CNA-F in R2's room any more. RN-I stated CNA-F later attempted to go in R2's room and obtain vital signs with RN-I, however, R2 refused to allow CNA-F in the room and told CNA-F to get out. RN-I reported the information to the AM shift and stated another CNA worked with R2 on the night of 1/19/25. RN-I stated RN-I wasn't sure if CNA-F was stubborn and continued to try to clean R2 or if R2 overreacted.<br><br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 2/5/25 at 10:56 AM, Surveyor interviewed NHA-A who was notified of the incident until 1/20/25. When Surveyor reviewed the timeline with NHA-A, Surveyor noted CNA-F was removed from caring for R2 on 1/18/25, however, CNA-F still provided care for other residents and worked the following night shift. NHA-A indicated the facility gives latitude to nurses to change assignments for CNAs and indicated some residents have a caregiver gender preference so the nurse removed CNA-F from R2's care based on R2's wishes. |

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| F 0803<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43361<br><br>Based on staff interview and record review, the facility did not ensure therapeutic diets were followed for 5 residents (R235, R23, R184, R186, and R10) of 36 sampled residents.<br><br>R235, R23 and R184 had orders for cardiac diets. R235, R23, and R184 did not receive their ordered diets for lunch on 2/4/25.<br><br>R186 had an order for a renal diet. R186 did not receive R186's ordered diet for lunch on 2/4/25.<br><br>R10 had an order for a cardiac/diabetic/renal diet. R10 did not receive R10's ordered diet for lunch on 2/4/25.<br><br>Findings include:<br><br>The facility's extended menu (that contains what residents on therapeutic diets should receive) for the 2/4/25 lunch meal indicated the following:<br><br>~General diet: Breaded chicken, mashed potatoes with gravy, carrots, a raspberry pocket, and milk<br><br>~Cardiac diet: Plain chicken breast, baked potato, fruit, and milk<br><br>~Renal diet: Grilled chicken breast, large garden salad, and fruit<br><br>Between 2/4/25 and 2/5/25, Surveyor reviewed residents' medical records and diet orders and made the following observations:<br><br>~R235 was admitted to the facility on [DATE] and had diagnoses including stroke, atrial fibrillation, hypertension, and carotid artery disease. R235 was prescribed a cardiac diet.<br><br>During the lunch meal on 2/4/25, R235 did not receive a baked potato or fruit. R235 received mashed potatoes and gravy and a raspberry pocket instead.<br><br>.<br><br>~R23 was admitted to the facility on [DATE] and had diagnoses including chronic diastolic (congestive) heart failure and peripheral vascular disease (PVD). R23 was prescribed a cardiac diet.<br><br>During the lunch meal on 2/4/25, R23 did not receive a baked potato or fruit. R23 received mashed potatoes and gravy and a raspberry pocket instead.<br><br>~R184 was admitted to the facility on [DATE] and had diagnoses including chronic systolic (congestive) heart failure and hypertensive heart and chronic kidney disease with heart failure. R184 was prescribed a cardiac diet.<br><br>(continued on next page) |

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| F 0803<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During the lunch meal on 2/4/25, R184 did not receive a baked potato or fruit. R184 received mashed potatoes and gravy and a raspberry pocket instead.<br><br>~R186 was admitted to the facility on [DATE] and had diagnoses including hypertensive heart and chronic kidney disease with heart failure and stage 5 chronic kidney disease, end stage renal disease, and congestive heart failure (CHF). R186 was on dialysis and was prescribed a renal diet.<br><br>During the lunch meal on 2/4/25, R186 did not receive a garden salad or fruit. R186 received mashed potatoes and gravy and a raspberry pocket instead.<br><br>~R10 was admitted to the facility on [DATE] and had diagnoses including end stage renal disease, diabetes, hypertension, atrial fibrillation, stroke, and carotid stenosis. R10 was prescribed a cardiac/diabetic/renal diet.<br><br>During the lunch meal on 2/4/25, R10 did not receive a baked potato, garden salad, or fruit. R10 received mashed potatoes and gravy and a raspberry pocket instead.<br><br>On 2/4/25 at 1:30 PM, Surveyor interviewed Dietary Aid (DA)-D who indicated DA-D was not aware that all diet orders did not receive the same dessert. DA-D indicated the cook usually sets up trays a head of time with desserts.<br><br>On 2/4/25 at 2:36 PM, Surveyor interviewed Dietary Manager (DM)-E and informed DM-E of the observations during meal service. DM-E indicated staff should follow the menus for the therapeutic diets and should have baked potatoes, salad, and fruit available for residents on therapeutic diets. |

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|---|---|
| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43361<br><br>Based on observation, staff interview, and record review, the facility did not maintain an infection prevention and control program designed to prevent the transmission of communicable disease and infection for 1 resident (R) (R2) of 1 resident observed during wound care.<br><br>Registered Nurse (RN)-C did not complete hand hygiene during wound vac dressing changes for R2.<br><br>Findings include<br><br>The facility's Long Term Care (LTC) Infection Prevention and Control Policy, dated 12/23/24, indicates: .2. Hand Decontamination: a. Team members will use an alcohol-based hand rub: .iii. Before and after resident contact; iv. After contact with a resident's surroundings or equipment; v. Prior to performing any aseptic procedures .vii. Prior to contact with a resident's invasive medical device .<br><br>From 2/3/25 to 2/5/25, Surveyor reviewed R2's medical record. R2 was admitted to the facility on [DATE] and had diagnoses including encounter for surgical after care following surgery on the circulatory system, hypertensive heart and chronic kidney disease, type 2 diabetes, and major depressive disorder. R2's Minimum Data Set (MDS) assessment, dated 12/30/24, had a Brief Interview for Mental Status (BIMS) score of 12 out of 15 which indicated R2 had moderate cognitive impairment. R2 was R2's own person.<br><br>R2's medical record indicated the following:<br><br>~R2 was admitted to the facility with lower leg and groin surgical wounds after a hospital stay due to a lower leg thromboembolism and critical limb ischemia (a blood clot that travels and blocks blood flow). At the hospital, R2 underwent thromboectomy (surgical removal of the blood clot) and left anterior tibial compartment fasciotomy due to acute compartment syndrome (a surgical procedure where incisions are made to release pressure caused by a medical emergency called acute compartment syndrome which occurs when high pressure builds up within the muscle compartment, potentially damaging muscle and nerve tissue if not treated promptly).<br><br>~R2 had a history of extended-spectrum beta lactamase (ESBL) (an enzyme that makes bacteria resistant to certain antibiotics) and was to be on enhanced barrier precautions (EBP) for the duration of R2's admission.<br><br>~On 1/30/25, R2 had a vascular surgery appointment. A note indicated R2 had a necrotic left calf fasciotomy site and a right groin open and draining wound. A wound vac was applied to both wounds and was to be changed 3 times weekly.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 525286 | A. Building<br>B. Wing | 02/05/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Juliette Manor | 482 Oak Street<br>Berlin, WI 54923 |

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 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 2/4/25 at 10:45 AM, Surveyor observed RN-C complete R2's wound vac dressing changes. Prior to the dressing change, RN-C completed hand hygiene and donned a gown and gloves. With a gloved hand, RN-C pushed a bedside table that contained a clean towel and dressing change supplies toward R2's bed. With gloved hands, RN-C then picked up and moved R2's wheelchair by the handles and continued to push the table toward the foot of R2's bed. RN-C then walked across the room, picked up a garbage can, and put the can underneath the table. With the same gloved hands, RN-C disconnected the tubing and removed the bandages from R2's leg and groin. After R2's dressings were removed, RN-C removed gloves and completed hand hygiene.<br><br>On 2/4/25 at 11:30 AM, Surveyor interviewed RN-C about not completing hand hygiene after RN-C touched R2's wheelchair and the garbage can and then removed R2's bandages. RN-C indicated RN-C completed all of the dirty tasks before the clean.<br><br>On 2/4/25 at 2:27 PM, Surveyor interviewed Director of Nursing (DON)-B who confirmed RN-C should have completed hand hygiene and donned clean gloves prior to removing R2's dressings. DON-B indicated RN-C thought RN-C was completing all of the dirty tasks first. |