

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525316	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/01/2024
NAME OF PROVIDER OR SUPPLIER Manawa Com Nur Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 400 East 4th St Manawa, WI 54949	

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)
<p>F 0605</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that each resident is free from medications that restrain them, unless needed for medical treatment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40342</p> <p>Based on staff interview and record review, the facility did not ensure 1 resident (R) (R2) of 5 sampled residents was free from a chemical restraint administered for behavior and not prescribed to the resident.</p> <p>On 4/9/24, Licensed Practical Nurse (LPN)-C administered lorazepam (a sedative medication) to R2 to stop R2 from pacing. R2 did not have a physician's order for lorazepam and consent was not obtained from R2's activated Power of Attorney for Healthcare (POAHC).</p> <p>Findings include:</p> <p>The facility's Resident Rights policy, with an effective date of 4/4/17, indicates: .be free from mental and physical abuse, and be free from chemical and physical restraints except as authorized in writing by a physician, physician assistant, or advanced practice nurse prescriber for a specified and limited period of time and documented in the resident's medical record .</p> <p>On 5/1/25, Surveyor reviewed R2's medical record. R2 was admitted to the facility on [DATE] with diagnoses including dysthymic disorder (a type of depression that occurs over a long period of time), unspecified dementia, anxiety, and major depressive disorder. R2's Minimum Data Set (MDS) assessment, dated 2/22/24, stated R2's Brief Interview for Mental Status (BIMS) score was 00 out of 15 which indicated R2 had severely impaired cognition. R2's medical record indicated POAHC-H was responsible for R2's healthcare decisions.</p> <p>On 5/1/24, Surveyor reviewed R4's medical record. R4 was admitted to the facility on [DATE] with diagnoses including aortic stenosis (a heart valve disease that reduces or blocks blood flow from the heart to the aorta and body), myocardial infarction (heart attack/death of heart muscle), and chronic kidney disease. R4's MDS assessment, dated 2/28/24, stated R4's BIMS score was 15 out of 15 which indicated R4 had intact cognition. R4's medical record indicated R4's POAHC was responsible for R4's healthcare decisions.</p> <p>(continued on next page)</p>

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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<p>F 0605</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 5/1/24, Surveyor reviewed an investigation that indicated: On 4/10/24, Director of Nursing (DON)-B received a text message from Business Office Manager (BOM)-D. DON-B called BOM-D at 8:05 PM and was notified that Hospitality Aide (HA)-E stated LPN-C told HA-E that LPN-C administered another resident's lorazepam to R2 for anxiety on the 4/9/24 PM shift. HA-E told LPN-F the next evening who advised HA-E to call BOM-D immediately. R2 was not prescribed lorazepam, an order was not obtained to administer lorazepam, and consent to administer lorazepam was not obtained from POAHC-H. LPN-C told staff that LPN-C administered lorazepam because R2 was pacing and upset, however, LPN-C denied actually administering the medication.</p> <p>The facility's investigation included a handwritten statement from HA-E, dated 4/10/24, that indicated: On the 4/9/24 PM shift around dinner time, LPN-C stated to HA-E, I just gave (R2) some of (R4)'s lorazepam. LPN-C also said, I just can't handle this tonight regarding R2. HA-E knew R2 didn't have an order for lorazepam and LPN-C gave R2 lorazepam against POAHC-H's wishes. When HA-E left the building at approximately 6:55 PM, R2 was calm and relaxed which was unlike R2. LPN-C said, Seems like it's finally kicking in.</p> <p>The facility's investigation contained a urine drug panel for R2, collected on 4/11/24, that indicated 135 nanograms per milliliter (ng/ml) of lorazepam were detected in R2's urine. A urine drug panel for R4, collected on 4/11/24, indicated 110 ng/ml of lorazepam were detected in R4's urine.</p> <p>R2's medical record did not contain a physician's order for lorazepam or any documentation from 4/9/24. R2's nursing notes contained documentation prior to and after 4/9/24 that indicated R2's behaviors were unchanged as a result of the incident on 4/9/24.</p> <p>R4's medical record contained the following orders:</p> <p>~ Lorazepam oral tablet 0.5 mg (milligrams) give 1 tablet by mouth every 2 hours as needed for anxiety</p> <p>~ Lorazepam oral tablet 0.5 mg give 2 tablets by mouth every 2 hours as needed for moderate to severe anxiety</p> <p>R4's April 2024 Medication Administration Record (MAR) indicated LPN-C administered two 0.5 mg tablets of lorazepam to R4 on 4/9/24 at 3:00 PM.</p> <p>On 5/1/24, Surveyor reviewed an email from Police Chief (PC)-G to DON-B, dated 4/11/24, that indicated: PC-G interviewed LPN-C who said the Certified Nursing Assistants (CNAs) and HA-E were yelling back and forth with R2 and LPN-C told them LPN-C gave R2 medication to calm R2 down. LPN-C told the staff to let R2 sit in the chair and LPN-C would be back in 15 minutes to talk to R2. LPN-C said LPN-C was busy and didn't have time to deal with it.</p> <p>On 5/1/24 at 2:56 PM, Surveyor interviewed DON-B via phone who verified LPN-C's actions were considered a chemical restraint which was against the facility's policy.</p> <p>(continued on next page)</p>		

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<p>F 0605</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 5/3/24, following an open records request to PC-G, Surveyor reviewed a Deputy Supplemental Report completed by PC-G, dated 4/16/24, that indicated: PC-G asked DON-B and BOM-D for records regarding the delivery of medication for R4 and R2. DON-B provided the records and explained them to PC-G. On 4/9/24 at 3:00 PM, LPN-C documented that LPN-C administered two 0.5 mg tablets of lorazepam to R4 and none to R2. DON-B and BOM-D interpreted the lab results as proof that LPN-C administered one 0.5 mg tablet of lorazepam to R4 and one 0.5 mg tablet of lorazepam to R2. At approximately 4:00 PM, PC-G interviewed HA-E who stated HA-E worked at the facility on 4/9/24 after school. HA-E said R2 was R2's normal self when HA-E saw R2. HA-E stated R2 walks around and talks to people and tells them what's on R2's mind. At approximately 5:30 PM, R2 was sitting in a chair by the dinning room and the nurses' station. LPN-C approached R2 and administered R2's medication in applesauce. LPN-C stated LPN-C couldn't handle this tonight and gave R2 some of R4's lorazepam. HA-E said R2 became drowsy and sat quietly in the chair until HA-E went home at 7:00 PM, however, R2 was usually very active and followed LPN-C around during HA-E's shift. When HA-E was ready to go home, LPN-C indicated something was finally kicking in. HA-E took that to mean the lorazepam LPN-C stated LPN-C gave R2.</p> <p>On 5/3/24, Surveyor reviewed a Deputy Supplemental Report completed by PC-G, dated 4/24/24, that indicated: On 4/24/24 at approximately 7:30 AM, PC-G spoke to POAHC-H and confirmed that POAHC-H did not give consent to treat or administer any prescription medication to R2 without proper prescription or consent.</p>

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40342</p> <p>Based on staff interview and record review, the facility did not ensure allegations of abuse and misappropriation were reported to the Nursing Home Administrator (NHA), the State Agency (SA), or local law enforcement in a timely manner for 4 residents (R) (R2, R4, R5, and R3) of 5 sampled residents.</p> <p>On 4/9/24, Licensed Practical Nurse (LPN)-C administered a dose of R4's lorazepam (a sedative medication) to R2 to stop R2 from pacing. R2 did not have a physician's order for lorazepam or consent from R2's Power of Attorney for Healthcare (POAHC). Staff did not report the allegations of abuse and misappropriation to administration or local law enforcement in a timely manner.</p> <p>On 4/10/24, Hospitality Aide (HA)-E alleged that Certified Nursing Assistant (CNA)-J physically abused R5 with a hot washcloth on an undisclosed date. Staff did not report the incident to administration in a timely manner and did not report the allegation of abuse to the SA.</p> <p>On 4/25/24, CNA-I alleged LPN-C misappropriated a dose of R3's lorazepam on 7/17/23. Staff did not report the incident to administration in a timely manner and did not report the allegation of misappropriation to the SA.</p> <p>Findings include:</p> <p>The facility's undated Freedom from Abuse, Neglect and Exploitation Policy and Procedure indicates: All staff will be trained during orientation and on an annual basis .The training program will consist of but not be limited to: .How and when to report suspected abuse, neglect and misappropriation .How to recognize resident and staff behaviors that could suggest a potential for abuse .Any allegation involving mistreatment, neglect or abuse, including those of .misappropriation of resident property will immediately be reported to the charge nurse and the charge nurse will immediately notify the RN (Registered Nurse) on call. The RN on call will contact the Administrator or designee if applicable. The Administrator or designee will complete the online report (to the SA) immediately .Allegations of abuse will be reported to other agencies, such as Adult Protective Services or law enforcement immediately .</p> <p>1. On 5/1/25, Surveyor reviewed R2's medical record. R2 was admitted to the facility on [DATE] with diagnoses including dysthymic disorder (a type of depression that occurs over a long period of time), unspecified dementia, anxiety, and major depressive disorder. R2's Minimum Data Set (MDS) assessment, dated 2/22/24, stated R2's Brief Interview for Mental Status (BIMS) score was 00 out of 15 which indicated R2 had severely impaired cognition. R2's medical record indicated POAHC-H was responsible for R2's healthcare decisions.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 5/1/24, Surveyor reviewed R4's medical record. R4 was admitted to the facility on [DATE] with diagnoses including aortic stenosis (a heart valve disease that reduces or blocks blood flow from the heart to the aorta and body), myocardial infarction (heart attack/death of heart muscle), and chronic kidney disease. R4's MDS assessment, dated 2/28/24, stated R4's BIMS score was 15 out of 15 which indicated R4 had intact cognition. R4's medical record indicated R4's POAHC was responsible for R4's healthcare decisions.</p> <p>On 5/1/24, Surveyor reviewed a facility investigation that indicated: On 4/10/24, Director of Nursing (DON)-B received a text message from Business Office Manager (BOM)-D. DON-B called BOM-D at 8:05 PM and was notified that HA-E stated LPN-C told HA-E that LPN-C administered lorazepam to R2 for R2's anxiety on the 4/9/24 PM shift and the lorazepam came from another resident (R4). HA-E initially told LPN-F the next evening who advised HA-E to call BOM-D immediately. The investigation indicated R2 was not prescribed lorazepam, an order was not obtained to administer lorazepam, and consent was not obtained from POAHC-H. LPN-C told the staff that LPN-C gave R2 the lorazepam because R2 was pacing and upset, however, but LPN-C denied actually administering the medication.</p> <p>The facility's investigation contained a handwritten statement from HA-E, dated 4/10/24, that indicated: On the 4/9/24 PM shift around dinner time, LPN-C stated to HA-E, I just gave (R2) some of (R4)'s lorazepam. LPN-C also said, I just can't handle this tonight regarding R2. HA-E knew R2 didn't have an order for lorazepam and that LPN-C gave R2 lorazepam against POAHC-H's wishes. When HA-E left the building at approximately 6:55 PM, R2 was calm and relaxed which was unlike R2. LPN-C said, Seems like it's finally kicking in.</p> <p>On 5/1/24, Surveyor reviewed an email from Police Chief (PC)-G to DON-B, dated 4/11/24, that indicated: PC-G interviewed LPN-C who said the CNAs and HA-E were yelling back and forth with R2 and LPN-C told them that LPN-C gave R2 medication to calm R2 down. LPN-C told staff to let R2 sit in the chair and LPN-C would be back in 15 minutes to talk to R2. LPN-C said LPN-C was busy and didn't have time to deal with it.</p> <p>On 5/1/24 at 1:34 PM, Surveyor interviewed DON-B who verified HA-E did not report the above incident to administration in a timely manner. DON-B indicated HA-E was educated on timely reporting. DON-B verified the facility did not educate all staff on timely reporting. DON-B stated the facility reported the above incident to law enforcement on 4/11/24.</p> <p>On 5/3/24, following an open records request, Surveyor reviewed a report completed by PC-G that indicated: On 4/11/24 at 9:31 AM, PC-G received a call from DON-B who stated earlier in the week an LPN told a staff member that the LPN gave another resident's medication to R2 to calm R2 down. DON-B indicated the facility notified the SA and would like the police to do an investigation.</p> <p>2. On 5/1/24, Surveyor reviewed R5's medical record. R5 was admitted to the facility on [DATE] with diagnoses including unspecified dementia without behavioral disturbances and major depressive disorder. R5's MDS assessment, dated 4/11/24, indicated R5 was rarely/never understood. R5's medical record indicated R5's POAHC was responsible for R5's healthcare decisions.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 5/1/24, Surveyor reviewed a facility investigation that included a handwritten statement from HA-E, dated 4/10/24, that indicated: HA-E was asked to help put R5 to bed. HA-E turned on the faucet and put washcloths in the sink. HA-E lowered R5's bed and retrieved a brief. When CNA-J wiped R5's face, CNA-J did not allow the washcloth to cool which caused R5 pain. R5 yelled ow, ow stop, that's hot, and please stop it's hot. HA-E stated R5 might lack the ability to form sentences, but it was very very clear that R5 was in pain.</p> <p>The investigation contained a document that indicated: Reviewed note from HA-E. Education was provided to staff on 4/10/24 related to Hospitality Aide duties that outlined what Hospitality Aides are able to do. Regarding R5 stating the water was hot, skin checks were done with no reports of injury. HA-E and CNA-J both worked on 4/5/24. R5's progress notes indicated there was no incident or concern with behaviors or injuries.</p> <p>On 5/1/24 at 1:34 PM, Surveyor interviewed DON-B who verified HA-E did not report the incident to administration in a timely manner. DON-B indicated HA-E was educated on timely reporting. DON-B verified the facility did not educate all staff on timely reporting. DON-B verified when CNA-J did not stop when R5 indicated the water was too hot could be considered abuse and should have been reported to the SA.</p> <p>3. On 5/1/24, Surveyor reviewed R3's medical record. R3 was admitted to the facility on [DATE] with diagnoses including Alzheimer's disease. R3's MDS assessment, dated 2/9/24, indicated R3 was rarely/never understood. R3's medical record indicated R3's POAHC was responsible for R3's healthcare decisions.</p> <p>On 5/1/24, Surveyor reviewed a facility investigation that contained a handwritten statement from CNA-I, dated 4/25/24, that indicated: On 7/17/23, Assisted Living Resident (ALR)-K started to have behaviors and showed signs of anxiety when ALR-K couldn't go to the farm to milk cows which was a normal behavior that occurred on the PM shift. CNA-I stated ALR-K's behavior started when CNA-I started work. CNA-I stated LPN-C administered ALR-K's scheduled dose of 0.5 mg of lorazepam during medication pass. After supper, ALR-K was still unable to be redirected. CNA-I and LPN-C went to LPN-C's medication cart which was in front of the medication room in the nurses' station. CNA-I didn't realize until later in the night that LPN-C took R3's lorazepam card and punched one tablet into a medication cup. CNA-I stated LPN-C went to the Skilled Nursing Narcotics binder, crossed out the medication, and wrote wasted at approximately 6:00 PM.</p> <p>On 5/1/24 at 10:51 AM, Surveyor interviewed DON-B who verified the facility did not report the allegation of misappropriation to the SA. DON-B verified CNA-I did not report incident to administration in a timely manner. DON-B indicated CNA-I initially reported the incident during a police interview regarding the incident on 4/9/24 (listed above) and then provided a handwritten report on 4/25/24.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40342</p> <p>Based on staff interview and record review, the facility did not ensure all allegations of abuse and misappropriation were thoroughly investigated for 4 residents (R) (R2, R4, R5 and R3) of 5 sampled residents.</p> <p>On 4/9/24, Licensed Practical Nurse (LPN)-C administered a dose of R4's lorazepam (a sedative medication) to R2 to stop R2 from pacing. R2 did not have a physician's order for lorazepam and the facility did not obtain consent from R2's Power of Attorney for Healthcare (POAHC) to administer lorazepam. The facility did not thoroughly investigate the allegations of abuse and misappropriation.</p> <p>On 4/10/24, Hospitality Aide (HA)-E alleged Certified Nursing Assistant (CNA)-J physically abused R5 with a hot washcloth on an undisclosed date. The facility did not thoroughly investigate the allegation of abuse.</p> <p>On 4/25/24, CNA-I alleged LPN-C misappropriated a dose of R3's lorazepam on 7/17/23. The facility did not thoroughly investigate the allegation of misappropriation.</p> <p>Findings include:</p> <p>The facility's undated Freedom from Abuse, Neglect and Exploitation Policy and Procedure indicates: .A designated staff member will conduct and complete the internal investigation .When an incident of suspected abuse is reported, the Administrator or designee will investigate the incident with the assistance of appropriate personnel. The investigation will include: i. Who was involved; ii. Resident statements; a. For non-verbal residents, cognitively impaired residents, or residents who refuse to be interviewed, attempt to interview the resident first. If unable, observe the resident, complete an evaluation of the resident's behavior including the affect and response of the interaction, and document the findings; iii. Resident roommate's statement (if applicable); iv. Involved staff and witness statements of events and timeline; v. A description of the resident's behavior and environment at the time of the incident; vi. Injuries present including a resident assessment; vii. Observation of resident and staff behaviors during the investigation; viii. Environmental considerations .The investigation is the process used to try to determine what happened. Designated facility personnel will begin the investigation immediately. A root cause investigation and analysis will be completed .</p> <p>1. On 5/1/24, Surveyor reviewed R2's medical record. R2 was admitted to the facility on [DATE] with diagnoses including dysthymic disorder (a type of depression that occurs over a long period of time), unspecified dementia, anxiety, and major depressive disorder. R2's Minimum Data Set (MDS) assessment, dated 2/22/24, stated R2's Brief Interview for Mental Status (BIMS) score was 00 out of 15 which indicated R2 had severely impaired cognition. R2's medical record indicated POAHC-H was responsible for R2's healthcare decisions.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 5/1/24, Surveyor reviewed R4's medical record. R4 was admitted to the facility on [DATE] with diagnoses including aortic stenosis (a heart valve disease that reduces or blocks blood flow from the heart to the aorta and body), myocardial infarction (heart attack/death of heart muscle), and chronic kidney disease. R4's MDS assessment, dated 2/28/24, stated R4's BIMS score was 15 out of 15 which indicated R4 had intact cognition. R4's medical record indicated R4's POAHC agent was responsible for R4's healthcare decisions.</p> <p>On 5/1/24, Surveyor reviewed a facility investigation that indicated: On 4/10/24, Director of Nursing (DON)-B received a text message from Business Office Manager (BOM)-D. DON-B called BOM-D at 8:05 PM and was notified that HA-E stated LPN-C told HA-E that LPN-C administered another resident's (R4) lorazepam to R2 for anxiety on the 4/9/24 PM shift. HA-E told LPN-F the next evening who advised HA-E to call BOM-D immediately. R2 was not prescribed lorazepam, an order was not obtained to administer lorazepam, and permission to administer lorazepam was not obtained from POAHC-H. LPN-C told staff that LPN-C gave R2 lorazepam because R2 was pacing and upset, however, LPN-C denied actually administering the medication.</p> <p>The facility's investigation included a handwritten statement from HA-E, dated 4/10/24, that indicated: On the 4/9/24 PM shift around dinner time, LPN-C stated to HA-E, I just gave (R2) some of (R4)'s lorazepam. LPN-C also said, I just can't handle this tonight regarding R2. HA-E knew R2 didn't have an order for lorazepam and that LPN-C gave R2 lorazepam against POAHC-H's wishes. When HA-E left the building at approximately 6:55 PM, R2 was calm and relaxed which was unlike R2. LPN-C said, Seems like it's finally kicking in.</p> <p>The investigation included a urine drug panel for R2, collected on 4/11/24, that indicated 135 nanograms per milliliter (ng/ml) of lorazepam was detected in R2's urine. A urine drug panel for R4, collected on 4/11/24, indicated 110 ng/ml of lorazepam was detected in R4's urine.</p> <p>R2's medical record did not contain a physician's order for lorazepam and R2's nursing notes did not contain any documentation for 4/9/24. R2's nursing notes contained documentation prior to and after 4/9/24 that indicated R2's behaviors were unchanged as a result of the incident on 4/9/24.</p> <p>R4's medical record contained the following orders:</p> <p>~ Lorazepam oral tablet 0.5 mg (milligrams) give 1 tablet by mouth every 2 hours as needed for anxiety</p> <p>~ Lorazepam oral tablet 0.5 mg give 2 tablets by mouth every 2 hours as needed for moderate to severe anxiety</p> <p>R4's April 2024 Medication Administration Record (MAR) indicated LPN-C administered two tablets of lorazepam 0.5 mg to R4 at 3:00 PM on 4/9/24.</p> <p>On 5/1/24, Surveyor reviewed an email from Police Chief (PC)-G to DON-B, dated 4/11/24, that indicated: PC-G interviewed LPN-C who said the CNAs and HA-E were yelling back and forth with R2 and LPN-C told them LPN-C gave R2 medication to calm R2 down. LPN-C told staff to let R2 sit in the chair and LPN-C would be back in 15 minutes to talk to R2. LPN-C said LPN-C was busy and didn't have time to deal with it.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525316	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/01/2024
NAME OF PROVIDER OR SUPPLIER Manawa Com Nur Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 400 East 4th St Manawa, WI 54949	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 5/1/24 at 1:34 PM, Surveyor interviewed DON-B who verified the facility did not interview other residents to determine if other residents were affected. DON-B also verified not all staff were interviewed, including the night shift nurses who conducted controlled substance counts with LPN-C.</p> <p>On 5/1/24 at 1:52 PM, Surveyor interviewed LPN-L who verified LPN-L worked night shifts at the facility. LPN-L stated LPN-L was not interviewed regarding the incident and indicated LPN-L did not notice anything unusual about the controlled substance counts LPN-L completed with LPN-C.</p> <p>2. On 5/1/24, Surveyor reviewed R5's medical record. R5 was admitted to the facility on [DATE] with diagnoses including unspecified dementia without behavioral disturbances and major depressive disorder. R5's MDS assessment, dated 4/11/24, indicated R5 was rarely/never understood. R5's medical record indicated R5's POAHC was responsible for R5's healthcare decisions.</p> <p>On 5/1/24, Surveyor reviewed a facility investigation that contained a handwritten statement from HA-E, dated 4/10/24, that indicated: HA-E was asked to help put R5 to bed. HA-E turned on the faucet and put washcloths in the sink. HA-E lowered R5's bed and retrieved a brief. When CNA-J wiped R5's face, CNA-J did not allow the washcloth to cool which caused R5 pain. R5 yelled ow, ow stop, that's hot, and please stop it's hot. HA-E stated R5 might lack the ability to form sentences, but it was very very clear that R5 was in pain.</p> <p>The investigation contained a document that indicated: Reviewed note from HA-E. Education was provided to staff on 4/10/24 related to Hospitality Aide duties that outlined what Hospitality Aides were able to do. Regarding R5 stating the water was hot, skin checks were done with no reports of injury. HA-E and CNA-J both worked on 4/5/24. R5's progress notes indicated there was no incident or concern with behaviors or injuries.</p> <p>The investigation included water temperature audits conducted on 4/18/24 that indicated all water temperatures were found in acceptable ranges. The investigation also included perineal care competency checklists (which indicated the use of warm water was expected) for several CNAs, including CNA-J (dated 4/18/24).</p> <p>CNA-J's time cards indicated CNA-J worked on 4/10/24 from 2:00 PM to 8:10 PM, on 4/11/24 from 2:00 PM to 8:00 PM, and on 4/18/24 from 2:00 PM to 8:00 PM.</p> <p>On 5/1/24 at 12:00 PM, Surveyor interviewed DON-B who indicated administration talked to CNA-J regarding the allegation of abuse but did not document the interview.</p> <p>On 5/1/24 at 12:18 PM, Surveyor interviewed CNA-J via phone. CNA-J did not recall administration talking to CNA-J about a hot water concern and stated CNA-J did not receive education regarding hot water temperatures while providing cares.</p> <p>On 5/1/24 at 1:34 PM, Surveyor interviewed DON-B who verified the facility did not interview other residents to determine if other residents were affected. DON-B verified other staff were not interviewed, including staff who routinely worked with CNA-J.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Manawa Com Nur Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 400 East 4th St Manawa, WI 54949	
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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>3. On 5/1/24, Surveyor reviewed R3's medical record. R3 was admitted to the facility on [DATE] with diagnoses including Alzheimer's disease. R3's MDS assessment, dated 2/9/24, indicated R3 was rarely/never understood. R3's medical record indicated R3's POAHC was responsible for R3's healthcare decisions.</p> <p>On 5/1/24, Surveyor reviewed a facility investigation that included a handwritten statement from CNA-I, dated 4/25/24, that indicated: On 7/17/23, Assisted Living Resident (ALR)-K started to have behaviors and showed signs of anxiety when ALR-K couldn't go to the farm to milk cows which was a normal behavior that occurred on the PM shift. CNA-I stated ALR-K's behavior started when CNA-I started work. LPN-C administered ALR-K's scheduled dose of 0.5 mg of lorazepam during medication pass. After supper, ALR-K was still unable to be redirected. CNA-I and LPN-C went to LPN-C's medication cart which was in front of the medication room in the nurses' station. CNA-I didn't realize until later in the night that LPN-C took R3's lorazepam card and punched one tablet into a medication cup. CNA-I stated LPN-C went to the Skilled Nursing Narcotics binder, crossed out the medication, and wrote wasted at approximately 6:00 PM.</p> <p>The investigation also contained information that indicated: During an interview regarding the incident on 4/9/24, CNA-I stated CNA-I was aware of a situation that occurred in which ALR-K received lorazepam that was not ALR-K's. The date on the controlled drug use record was crossed off and the time was altered. Admission notes for ALR-K indicated ALR-K was combative and assaulted staff. On 7/2/23, a telephone order was obtained for lorazepam. In the CBRF (community-based residential facility) (which was attached to skilled nursing facility), staff were not allowed to pull from contingency and had to wait for the pharmacy to deliver the medication. CNA-I submitted a verbal statement to the police on 4/25/24 that the incident occurred in the fall of 2023. While reviewing CNA-I's statement and the controlled substance sign out forms, the writer noted there was a day in July where a dose of R3's lorazepam was wasted. The date was difficult to read. Based on CNA-I's statement, the date was narrowed to 7/17/23 when ALR-K was administered ALR-K's scheduled 3:00 PM dose of lorazepam, continued to be difficult to redirect, and was administered another PRN (as needed) dose by CNA-I and LPN-C at 6:00 PM.</p> <p>Surveyor reviewed R3's nursing notes which did not contain documentation from LPN-C on 7/17/23. R3's July 2023 MAR indicated R3 was administered 0.5 mg of lorazepam at 10:22 AM by another nurse on 7/18/23. There were no other lorazepam doses documented for R3.</p> <p>On 5/1/24 at 1:34 PM, Surveyor interviewed DON-B who verified the facility did not interview other residents to determine if other residents were affected. DON-B also verified other staff were not interviewed, including night shift nurses who conducted controlled substance counts with LPN-C.</p>		