

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525330	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/07/2025
NAME OF PROVIDER OR SUPPLIER Middleton Village Nursing and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 6201 Elmwood Ave Middleton, WI 53562	

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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50698</p> <p>Based on observation, interview, and record review, the facility did not ensure each resident had the right to a safe, clean, comfortable, and homelike environment for 3 of 9 sampled Residents (R5, R7 and R8), 3 of 3 shower rooms, and 1 of 1 kitchen.</p> <p>Surveyor observed a kitchen door to be detached from the hinges and leaning against the kitchen sink.</p> <p>Surveyor observed meal trays for R7 and R8 to be in their rooms without R7 and R8 present.</p> <p>R5 voiced concerns regarding cleanliness of shower room.</p> <p>[NAME], Harbor, and Depot shower rooms were observed to be cluttered with equipment/shower chairs, unclean, and not homelike.</p> <p>Depot Shower room was observed to have mechanical concerns with the shower and dripping water from the ceiling.</p> <p>This is evidenced by:</p> <p>The facility policy, Quality of Life - Homelike Environment, revised April 2014, includes, in part: Policy Statement: Residents are provided with a safe, clean comfortable and homelike environment and encouraged to use their personal belongings to the extent possible. Policy Interpretation and Implementation: .2. The facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include: a. Cleanliness and order .</p> <p>Example 1</p> <p>On 5/5/25 at 11:05 AM, Surveyor made a visit to the kitchen and observed the kitchen door which connects the dish room and main dining room to be detached from the side hinges and only attached by a hydraulic hinge at the very top of the door. This door was leaning up against the kitchen sink.</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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Of note, when Surveyor made a follow up visit to the kitchen on 5/7/25 around 11:15 AM, Surveyor observed the door to be completely unattached from the top hinge as well, and being held upright by the kitchen sink.</p> <p>On 5/5/25 at 11:08 AM, Surveyor interviewed DC C (Dietary Cook) and asked how long the door has been unattached to the hinges and propped up against the sink. DC C indicated the door has been hanging like this for about a week and maintenance is working on fixing it.</p> <p>On 5/6/25 at 8:41 AM, Surveyor interviewed MD D (Maintenance Director) about the kitchen door. MD D told Surveyor he was made aware of the door not being attached to the hinges a few months ago. MD D indicated regional management is trying to find a new door, regional management is supposed to be handling this, unsure of the status of the door. MD D told Surveyor he thinks there is risk for cross-contamination from the water spraying and the mist going into the dining room, potentially containing food particles or bacteria. He stated he has expressed his concerns to the owner and regional manager.</p> <p>Following the interview, MD D showed Surveyor two email threads/conversations relating to the kitchen door needing to be replaced and these conversations go back to January and February of 2025. The first email thread is between MD D and a third-party company the facility uses for ordering items. The emails are from 1/3/25 to 1/8/25 and there is discussion of verifying receiving the request, verifying measurements, hinge and latch type, fire rating needed. The second email thread is between MD D, NHA A (Nursing Home Administrator), ordering company, and regional director. The emails are from 1/22/25 to 2/13/25 and there is discussion about door quotes, getting additional quotes. On 2/13/25 at 12:24 PM, there is an email from NHA A to regional director and ordering company stating the following: We've attempted to repair but are unable to do so because the doors are rotted from water damage. What are you recommending we do now as the doors should be in place for sanitation purposes in relation to life safety code. The ordering company replied back on 2/13/25 at 1:02 PM stating they have reached out to a company in [NAME] for a third quote. (of note, that was the last email in the thread.)</p> <p>On 5/7/25 at 12:01 PM, Surveyor interviewed NHA A regarding the kitchen door. NHA A indicated during the interview she was made aware of the kitchen door not being on the hinges about a week and a half ago. NHA A stated she believes the door is ordered.</p> <p>Of note, Surveyor observed email correspondence indicating NHA A was a recipient and sender of emails with knowledge of the door needing to be replaced as early as January 2025.</p> <p>Surveyor asked NHA A if there's been any other follow up with the door since the email last sent on 2/13/25. NHA A indicated the door getting ordered is the follow up. NHA A is unable to recall exactly when the door was ordered.</p> <p>Example 2</p> <p>On 5/5/25 at 2:16 PM, Surveyor was making resident observations throughout the building. R8's meal tray was observed sitting in resident's room on over bed table when R8 was not in the room.</p> <p>On 5/5/25 at 2:52 PM, Surveyor observed R7's meal tray to be sitting in resident's room on over bed table and resident was not in the room.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 5/7/25 at 9:34 AM, Surveyor interviewed R7 and asked how she feels when a meal tray gets left in her room after she's done eating. R7 indicated it bothers her.</p> <p>R8 refused an interview with Surveyor.</p> <p>On 5/7/25 at 4:15 PM, Surveyor interviewed CNA G (Certified Nursing Assistant) and asked when staff would take a meal tray out of someone's room. CNA G indicated she would take the tray out when resident was done eating, when they are ready.</p> <p>On 5/7/25 at 4:20 PM, Surveyor interviewed DON B (Director of Nursing) about expectation for taking meal trays out of resident rooms. DON B indicated it's based on resident preference and when resident is fully finished with their meal.</p> <p>39849</p> <p>Example 3</p> <p>On 5/5/25 at 2:49 PM Surveyors interviewed R5 who indicated she had a shower that morning and that she feels the shower room is cluttered, congested, not clean, and does not feel homelike. R5 indicated she does not always get her shower on Depot and sometimes is taken to [NAME] hall. R5 indicated last week was the last time she had been to the one on [NAME] and indicated it is more homelike than depot but still cluttered and indicated they need to take some of that stuff down to the basement.</p> <p>Example 4</p> <p>On 5/5/25 at approximately 8:15 AM Surveyors began observations of the facility shower rooms and completed staff interviews regarding the shower rooms which included the following:</p> <p>[NAME] Hall shower room:</p> <ol style="list-style-type: none"> 1) Two lifts and Multiple shower chairs were present with some shower chairs being stacked on top of each other. 2) Wet white paper like substance on the tile by the shower as well as other white substance noted on floor. 3) A shelving unit containing the following: Multiple bottles of open, unlabeled skin and hair cleanser, dust present on shelves, a pair of gripper socks noted to be stained with a used bar of soap sitting directly on top of them, a pair of glasses. 4) Open bottles of skin and hair cleanser on the metal rail in the shower. <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 5/5/25 at 8:40 AM Surveyors interviewed CNA H (Certified Nursing Assistant) in the [NAME] Hall shower room. During the observation and interview CNA H indicated that the bottles of skin and hair cleanser should either be taken back to the room with the resident or tossed. CNA H indicated some residents bring their own soaps and things and they should always be taken back out with the resident. Surveyors asked CNA H how she would know whose bottles belong to whom and she indicated they do not label them because they are supposed to stay with the resident and go back with them or get tossed. CNA H was not able to identify who the glasses belong to, who's bar of soap was on the gripper socks and indicated this should be in a container, agreed the floor and shelving unit were not clean and indicated if she was a resident she would not want to shower in this room.</p> <p>Depot Hall shower room:</p> <ol style="list-style-type: none"> 1) Sign on half tile wall with the handwritten message, Caution 116 (on low) in spa room. 2) Tub: dead insect, tannish/brown colored streaks at front of tub, wheelchair foot pedals in the tub. 3) Multiple shower chairs with one having a brown substance noted on the seat portion. 4) Handheld shower head on floor and running. 5) Ceiling tile above shower dripping water. 6) A black substance in and around the grout on the shower side of the half tile wall. 7) No shower handle was noted for adjusting water. The portion of the shower where the handle should be had a towel over it and the towel was saturated and water was leaking from the area where the handle would attach. There is a yellow discoloration of the tile where the water runs down. 8) A white substance on the metal plate where the shower handle should be connected. <p>On 5/5/25 at 8:30 AM Surveyors interviewed CNA J in the Depot shower room. During the observation and interview CNA J indicated the following: She thought the brown substance on the shower chair was BM (Bowel Movement) and not considered clean, the tub is not used, however, would still not be considered clean and supplies should not be stored in the tub, the shower head should not be left on the ground, she did not know why the ceiling was leaking and indicated if something like this is happening a maintenance form should be completed. CNA J indicated she did not consider the shower room to be a homelike environment and suggested we speak with CNA I who had showered a resident in this room that morning.</p> <p>On 5/5/25 at 2:10 PM Surveyors interviewed CNA I about the Depot shower room. CNA I indicated she is the only one who knows how to use that shower. There is no handle and she uses a towel to grip the part you can still turn. CNA I indicated she did not know when the Caution sign was put on the half tile wall. CNA I indicated she has seen the ceiling dripping and indicated it does this all the time not just when the shower is in use. CNA I indicated the depot shower never shuts off and that she puts a towel over where the handle should be because that knob shoots water directly out, so the towel has to be there during showers. CNA I indicated this would not be considered a homelike environment.</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 - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>38725</p> <p>Based on interview and record review the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made for 2 of 6 residents (R2 and R5) reviewed for abuse.</p> <p>R2's POA (Power of Attorney) reported an alleged sexual abuse allegation and did not report this to the State Agency or Law Enforcement.</p> <p>R5 reported an allegation of abuse that was not reported to other officials (including to the State Survey Agency) within two hours of discovery.</p> <p>This is evidenced by:</p> <p>The Facilities Policy and Procedure entitled Abuse, Neglect, and Exploitation dated 1/5/24 documents, in part: .Verbal Abuse means the use of oral, written or gestured communication or sounds that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance regardless of their age, ability to comprehend, or disability. Sexual Abuse is non-consensual sexual contact of any type with a resident .VII. Reporting/Response .1. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) .</p> <p>On 5/5/25 at 9:48 AM, Surveyor interviewed POA O (Power of Attorney). Surveyor asked POA O if there was any additional concerns or information she wanted to share, POA O stated The Administrator, NHA A (Nursing Home Administrator) still has not gotten back to me about the staff member that went in his room and touched him, she just said they viewed the cameras and that no males cared for him.</p> <p>The Facility had a documented grievance form dated 4/29/25, Describe the concern: Resident told POA that he did not like the male caregiver 4/29/25 morning .Action taken: Schedule reviewed, and resident had female CNA (Certified Nursing Assistant) and nurse. Camera reviewed .</p> <p>On 5/7/25 at 11:44 AM, Surveyor interviewed NHA A. Surveyor gave NHA A the grievance form filed on 4/29/25 and asked, what did POA O say to you regarding this document (grievance form), NHA A replied first it was that he didn't like his caregiver and then it was a male caregiver touched his (private area). Surveyor asked NHA A if this allegation should have been more than a grievance, NHA A said they did a full investigation on it.</p> <p>On 5/7/25 at 4:08 PM, Surveyor interviewed NHA A. Surveyor gave NHA A the Abuse, Neglect and Misappropriation Policy and Procedure and asked, does this allegation meet the definition of sexual abuse, NHA A stated yes. Surveyor asked NHA A if allegations of sexual abuse are reportable incidents, NHA A stated yes.</p> <p>It is important to note that this allegation while investigated thoroughly, was not reported to the State Agency or Law Enforcement.</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 - Few</p>	<p>39849</p> <p>Example 2</p> <p>R5's most recent Minimum Data Set (MDS), target date 3/8/25, indicates a Brief Interview of Mental Status (BIMS) of 13. Indicating that R5 is cognitively intact.</p> <p>On 5/5/25 at 2:49PM Surveyors interviewed R5 who indicated last week when she was in activities R9 said to her If I had a gun I'd shoot you. R5 indicated she did not believe any staff witnessed the event. R5 indicated she did not tell anyone until the next day when she reported it during her therapy session to OT K (Occupational Therapist) who told her she would report it to NHA A (Nursing Home Administrator). R5 indicated it makes her feel anxious.</p> <p>On 5/5/25 at 3:42PM Surveyors interviewed OT K who indicated that R5 did report to her that R9 had said to her If I had a gun I would shoot you. OT K could not recall if it was Thursday or Friday of last week as R5 was on the schedule for both days, but indicated she reported this to NHA A right away. At 3:50PM PT L (Physical Therapist) joined the interview and indicated she was present when R5 reported this and that she went with OT K to report the incident to NHA A.</p> <p>On 5/7/25 at approximately 9:35AM Surveyors interviewed NHA A (Nursing Home Administrator) and DON B (Director of Nursing) and asked what the process is when a resident reports an allegation of abuse. NHA A indicated first intervene and make sure the resident is safe. NHA A indicated ideally it would be reported to her immediately, if she can't be reached, then to DON B. They would begin an investigation right away and if it needed to be reported they would report it to the state and call police if needed. Surveyor asked if anyone had reported that R5 told staff that R9 said to her, If I had a gun I'd shoot you. NHA A indicated she would have to double check. Surveyors asked NHA A if that would warrant a self-report. NHA A indicated, yes.</p> <p>On 5/7/25 at 10:15AM NHA A provided a Grievance Form with a Date occurred of 5/2/25 for R5. The form includes, in part: Describe the concern: Another resident made a comment that made R5 uncomfortable. Surveyors verified with NHA A that the grievance form is referring to the comment that R9 made to R5 that if she had a gun she would shoot her. Surveyors asked NHA A if she considered what R9 had said to R5 a threat. NHA A indicated, yes. Surveyor asked NHA A if she considered this an allegation of abuse when therapy reported it to her. NHA A indicated, yes. Of note, there is no information on the form to indicate the time the allegation was reported. Surveyors read the definition of verbal abuse from the facility abuse policy and asked NHA A if the statement made by R9 to R5 would be considered verbal abuse and therefore a reportable incident. NHA A indicated, yes and that it was not reported.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>39849</p> <p>Based on interview and record review the facility did not thoroughly investigate an allegation of abuse this has the potential to affect 1 of 6 investigations reviewed affecting resident (R5).</p> <p>R5 reported an allegation of abuse that was not thoroughly investigated by the facility.</p> <p>R5's most recent Minimum Data Set (MDS), target date 3/8/25, indicates a Brief Interview of Mental Status (BIMS) of 13. Indicating that R5 is cognitively intact.</p> <p>On 5/5/25 at 2:49PM Surveyors interviewed R5 who indicated last week when she was in activities R9 said to her If I had a gun, I'd shoot you. R5 indicated she did not believe any staff witnessed the event. R5 indicated she did not tell anyone until the next day when she reported it during her therapy session to OT K (Occupational Therapist) who told her she would report it to NHA A (Nursing Home Administrator). R5 indicated it makes her feel anxious.</p> <p>On 5/5/25 at 3:42PM Surveyors interviewed OT K who indicated that R5 did report to her that R9 had said to her If I had a gun, I would shoot you. At 3:50PM PT L (Physical Therapist) joined the interview and indicated she was present when R5 reported this. OT K and PT L both indicated they had not been interviewed or asked to complete a statement by anyone.</p> <p>On 5/7/25 at 9:35AM Surveyors interviewed NHA A (Nursing Home Administrator) and DON B (Director of Nursing) and asked what the process is when a resident reports an allegation of abuse. NHA A indicated first intervene and make sure the resident is safe. NHA A indicated ideally it would be reported to her immediately and they would begin an investigation right away. NHA A indicated they would complete the following: Interview the resident; If the resident is able to identify staff or give a description - take steps to identify; If identified staff, suspend if necessary; if not identified they would try to identify the person through other staff and resident interviews; conduct further resident interviews to ask if they have experienced the issue; talk to staff, have they witnessed anything; resident assessments if needed. Surveyor asked if anyone had reported that R5 told staff that R9 said to her, If I had a gun I'd shoot you. NHA A indicated she would have to double check. Surveyors requested any information regarding an investigation.</p> <p>On 5/7/25 at 10:15AM NHA A provided a Grievance Form with a Date occurred of 5/2/25 for R5. The form includes, in part: Describe the concern: Another resident made a comment that made R5 uncomfortable. Surveyors verified with NHA A that the grievance form is referring to the comment that R9 made to R5 that if she had a gun, she would shoot her. Of note, the form does not contain the name of the resident that made the comment, the name of the staff member(s) who reported the allegation, or information regarding interviews with staff or other residents.</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 - Few</p>	<p>Surveyor asked NHA A if she considered this an allegation of abuse when therapy reported it to her. NHA A indicated, yes, and that they began the investigation process immediately. Surveyors asked NHA A if she interviewed other staff or residents to see if anyone else had information or concerns about R9 making threats to other residents. NHA A indicated, no, and that they should have seen if it happened to others. Surveyors asked NHA A how they protected R5 and other residents. NHA A indicated that R5 reported she wheeled herself away when it happened and there was no one else around. R9 was in her room when she met with her and that R9 had indicated staff had wheeled her in there. NHA A indicated she spoke with R9, and she indicated she would never do this and doesn't have the means and that she knew she shouldn't have made the comment. NHA A indicated she also searched R9's room. NHA A indicated this would not be considered a thorough investigation.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>38725</p> <p>Based on interview and record review, the facility did not ensure that each resident receives adequate supervision and assistance devices to prevent accidents for 1 of 3 residents (R2) reviewed for elopement.</p> <p>R2 did not have an order to check the function of his elopement device.</p> <p>This is evidenced by:</p> <p>The Facilities Elopement/Unsafe Wandering Policy and Procedure dated 1/4/24 does not speak to monitoring the function of the elopement device.</p> <p>R2 is short-term resident of the facility. R2 has the following diagnoses: cerebral infarction, nontraumatic intracerebral hemorrhage in cerebellum, psychosis not due to a substance or known physiological condition, mood disorder, alcohol dependence with unspecified alcohol-induced disorder, psychoactive substance abuse, anxiety disorder, personality disorder, and encephalopathy (disease in which the functioning of the brain is affected by some agent or condition).</p> <p>R2's Physician Orders include:</p> <p>Wander Device, Check placement and location on right ankle dated 4/28/25.</p> <p>It is important to note that R2's TAR (treatment authorization request) does not include to check the function of his wander device.</p> <p>On 5/5/25 at 3:11 PM, Surveyor interviewed RN M (Registered Nurse). Surveyor asked RN M how she checks placement of the wander device, RN M said a visual check. Surveyor asked RN M how she checks the function of the wander device, RN M stated she hasn't done that yet. Surveyor asked RN M what she meant by she hasn't done that yet, RN M explained that she is new and hasn't learned how to check the function of the wander device yet. Surveyor asked RN M if there was anything she was going to do regarding checking the function of wander devices today, RN M said I'm going to ask someone how to do that.</p> <p>On 5/7/25 at 11:32 AM, Surveyor interviewed DON B (Director of Nursing). Surveyor asked DON B how often should the function of the wander devices be checked, DON B stated every shift. Surveyor asked DON B how the function of the wander device is checked, DON B explained that there is a box that you point at the device, green light means its functioning, red light means it's not functioning. Surveyor asked DON B if all nurses should know how to check the function of the wander device, DON B stated yes.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Middleton Village Nursing and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 6201 Elmwood Ave Middleton, WI 53562	
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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 5/5/25 at 12:00 PM, Surveyor interviewed LPN N (Licensed Practical Nurse). Surveyor asked LPN N how the function of the wander guard is checked, LPN N replied she takes the resident for a walk in the hall to the door and gets close enough for the alarm to go off. She also reports that you can use the brown box and check, but she doesn't like to use that so much. Surveyor asked LPN N how often the wander guard should be checked, LPN N replied every day.</p> <p>On 5/6/25 at 9:20 AM, Surveyor interviewed RN R (Registered Nurse). Surveyor asked RN R how the function of the wander guard is checked, RN R replied that she didn't know, she was just an agency nurse and hadn't done that yet. Surveyor asked RN R how often the wander guard should be checked. RN R replied she didn't know and would have to check. RN R returned and replied that it should be checked every shift, but she also had not done that yet.</p> <p>On 5/6/25 at 11:05 AM, Surveyor interviewed LPN S. Surveyor asked LPN S how the function of the wander guard is checked, LPN S replied that she uses the brown box that is at the nurses' station, she holds it to the wander guard and if it beeps and turns green it is working. LPN S showed Surveyor the brown box at the nurses' station. Surveyor asked LPN S how often the wander guard should be checked, LPN S replied every shift.</p> <p>On 5/6/25 at 11:46 AM, Surveyor interviewed IP P (Infection Preventionist). Surveyor asked IP P how the function of the wander guard checked, IP P replied that there is a grey box at the nurses' station to check the wander guard, or you can take the resident up to a door and see if the alarm sounds. Surveyor asked IP P how often the function of the wander guard should be checked, IP P replied on the NOC shift.</p> <p>On 5/6/25 at 3:15 PM, Surveyor interviewed RN T. Surveyor asked RN T how the function of the wander guard is checked, RN T replied when the resident gets too close to the receptionist it should go off. Surveyor asked RN T if there was any equipment used to check the function, RN T replied she didn't know of any equipment to use. Surveyor asked RN T how often the wander guard should be checked, RN T replied she did not know how often.</p> <p>On 5/7/25 at 4:03 PM, DON B handed Surveyor Elopement/Unsafe Wandering Policy and Procedure and said that this doesn't speak directly to checking function of the device but protocol here is to check every shift.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>38725</p> <p>Based on interview and record review, the facility did not ensure that they provided pharmaceutical services (including procedures that assures the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. This affected 1 (R2) of 6 residents reviewed for medication administration.</p> <p>R2 had 2 dates in May 2025 that were blank for his thyroid medication.</p> <p>This is evidenced by:</p> <p>The Facilities Administering Medications Policy and Procedure dated 12/24 documents, in part: .3. Medications must be administered in accordance with the orders, including any required time frame .19. The individual administering the medication must initial the resident's MAR (Medication Administration Record) on the appropriate line after giving each medication and before administering the next ones .</p> <p>R2 is short term resident of the facility. R2 has the following diagnoses: cerebral infarction, nontraumatic intracerebral hemorrhage in cerebellum, psychosis not due to a substance or known physiological condition, hypothyroidism (thyroid gland doesn't produce enough thyroid hormone), mood disorder, alcohol dependence with unspecified alcohol-induced disorder, psychoactive substance abuse, anxiety disorder, personality disorder, and encephalopathy (disease in which the functioning of the brain is affected by some agent or condition).</p> <p>R2's Physician Order include:</p> <p>Levothyroxine Sodium Oral Tablet 100 mcg (micrograms) (Levothyroxine Sodium) Give 1 tablet by mouth one time a day related to Hypothyroidism.</p> <p>R2's MAR (Medication Administration Record) includes:</p> <p>Levothyroxine Sodium Oral Tablet 100 mcg (micrograms) (Levothyroxine Sodium) Give 1 tablet by mouth one time a day related to Hypothyroidism is scheduled at 0600 (6:00 AM). R2's medication was not signed out on 5/2/25 and 5/3/25.</p> <p>On 5/7/25 at 11:32 AM, Surveyor interviewed DON B (Director of Nursing). Surveyor asked DON B if there is a blank box in the MAR was the medication given, DON B explained it could indicate that it was not checked and saved. Surveyor asked DON B if there is any way to know if the medication was given if the box is blank, DON B replied that it can't be verified, no. Surveyor asked DON B would you expect all medications to be given as ordered, DON B stated yes.</p> <p>On 5/6/25 at 11:48 AM, Surveyor interviewed IP P (Infection Preventionist). Surveyor asked IP P what a blank box on the MAR (Medication Administration Record) would indicate, IP P replied she couldn't answer that now, she would have to find out who worked to figure out why it was blank.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 5/6/25 at 1:12 PM, Surveyor interviewed LPN S (Licensed Practical Nurse). Surveyor asked LPN S what a blank box on the MAR would indicate, LPN S replied that they might not have given the med, or sometimes people give the med but forget to mark it off.</p> <p>On 5/7/25 at 3:20 PM, Surveyor interviewed LPN T. Surveyor asked LPN T what a blank box on the MAR would indicate? LPN T replied that she had not seen a MAR before, it didn't look like that on her screen. Surveyor asked LPN T to bring up the MAR on her computer. After seeing the MAR, LPN T replied that someone didn't sign or give a code.</p> <p>On 5/6/25 at 3:25 PM, Surveyor interviewed LPN Q. Surveyor asked LPN Q what a blank box on the MAR would indicate, LPN Q replied nothing was done.</p> <p>The facility submitted additional documentation. This documentation was reviewed but does not change the citation.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>50698</p> <p>Based on observation, interview, and record review, the facility did not ensure the preparation, storage, and serving of food in a clean and sanitary environment. This has the potential to affect all 67 residents in the facility.</p> <p>Surveyor observed partially eaten meal trays from the previous meal sitting on tables in the dining room while residents were eating breakfast.</p> <p>Surveyor observed 3 wall dispensers of hand sanitizer in the dining room to not be in working order.</p> <p>Surveyor observed a table in the dish room to be covered with stacked boxes mixed with a tray of glasses, a dirty towel, dirty coffee pots, and a fleece jacket laying on top of a metal pot which was inside of a box of white aprons.</p> <p>Surveyor observed a microwave in the kitchen which was covered with multi-colored splatters all over the inside walls.</p> <p>Surveyor observed an opened package of butter with half of the wrapper removed and butter was sitting on a cart by the stove exposed to air, not covered.</p> <p>Surveyor observed multi-colored stains on the wall to the right and left of the dish room entrance and stains on the curtain by the garbage.</p> <p>Evidenced by:</p> <p>Facility policy, entitled Safe Storage of Food, revised 1/1/25, states in part: .All foods will be stored wrapped or in covered containers, labeled and dated, and arranged in a manner to prevent cross contamination . Storage areas will be neat, arranged for easy identification .</p> <p>Example - Dirty meal trays on tables in dining room</p> <p>On 5/5/25 at 8:25 AM, Surveyor was in dining room observing breakfast. Surveyor observed 4 meal trays with dirty plates, bowls, and cups on the table under the wall clock in the dining room. Surveyor observed a scoop of rice on one of the plates, dried piece of tomato on another plate, melted Jello with strawberry pieces and oranges in 3 of the bowls, and some coffee in 2 of the cups. Surveyor checked the menu from Sunday 5/4/25; the supper menu was Salisbury steak, rice pilaf, seasoned squash, and mandarin orange gelatin.</p> <p>Example - Empty hand sanitizer dispensers</p> <p>On 5/5/25 at 8:40 AM, Surveyor tested the hand sanitizer dispensers outside and inside of the main dining room. All 3 of the dispensers on the inside of the dining room were not working.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Example - Dish room table</p> <p>Facility policy, entitled Safe Storage of Food, revised 1/1/25, states in part: .All foods will be stored wrapped or in covered containers, labeled and dated, and arranged in a manner to prevent cross contamination . Storage areas will be neat, arranged for easy identification .</p> <p>Facility Kitchen AM Dietary Aide Cleaning Schedule states, in part: .Thursday - Move tables and drying rack in dish room. Sweep and mop underneath. Pickup any kitchen ware; cups, silverware, bowls, lids, etc.</p> <p>On 5/5/25 at 8:45 AM, Surveyor and DM E (Dietary Manager) observed a metal table in the dish room to have stacks of cardboard boxes, a tray of clear plastic glasses to be sitting on top of a cardboard box, a metal basket sitting on top of a cardboard box containing a soiled towel and 2 coffee pots with brown residue in them, a large black tub was sitting on top of the metal basket, a fleece jacket was laying on top of a metal pot which was sitting on a opened cardboard box containing white aprons.</p> <p>Surveyor interviewed DM E about these items. DM E indicated she needed to take those items to storage and hasn't gotten them to the basement yet, said she would take care of it.</p> <p>Example - Microwave</p> <p>Facility Kitchen AM [NAME] Cleaning Schedule states, in part: .Thursday - Wipe down inside and outside of microwave .</p> <p>On 5/5/25 at 9:55 AM, Surveyor and DM E observed the inside of the microwave. On all walls on the inside, there were several multi-colored splatters dried on the surfaces. Surveyor interviewed DM E about the cleaning of the microwave and DM E indicated the microwave should be getting wiped out after every meal and stated she would have someone clean it.</p> <p>Example - Opened package of butter</p> <p>Facility policy, entitled Safe Storage of Food, revised 1/1/25, states in part: .All foods will be stored wrapped or in covered containers, labeled and dated, and arranged in a manner to prevent cross contamination . Storage areas will be neat, arranged for easy identification .</p> <p>On 5/5/25 at 9:55 AM, Surveyor and DM E observed an opened package of butter sitting on a cart by the stove in the kitchen. The wrapper was half torn off and the butter wasn't covered, wrapped or dated. DM E indicated the butter should be covered, labeled and put away.</p> <p>Example - Splatters on the wall</p> <p>On 5/6/25 at 12:32 PM, Surveyor, DA F (Dietary Aide), and DM E observed several multi-colored dried on splatters on the wall to the right and left of dish room entrance and observed dried on splatters on the curtain in the dining room by the garbage.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Surveyor interviewed DA F and DM E who both indicated the PM kitchen staff are supposed to be cleaning the walls daily. DM E stated she would have someone clean the walls and find out who should be cleaning the curtains.</p> <p>On 5/7/25 at 4:04 PM, Surveyor interviewed NHA A (Nursing Home Administrator) who indicated she would expect kitchen staff to follow their policies and procedures and cleaning schedules.</p>		