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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525335 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 08/29/2024 |
| NAME OF PROVIDER OR SUPPLIER Shawano Health Services | | STREET ADDRESS, CITY, STATE, ZIP CODE 1436 S Lincoln St Shawano, WI 54166 | |

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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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
| <p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38793</p> <p>Based on staff interview and record review, the facility did not ensure the appropriate parameters for administering a bowel medication were met and did not document bowel movements or abnormal blood pressures for 1 Resident (R) (R1) of 14 sampled residents.</p> <p>R1 was given Miralax (a laxative used to treat constipation) on 8/9/24 after two documented episodes of diarrhea. In addition, R1 had episodes of diarrhea and low blood pressure that were not documented in R1's medical record.</p> <p>Findings include:</p> <p>On 8/28/24, Surveyor reviewed R1's medical record. R1 was admitted to the facility on [DATE] with diagnoses of post operative care for kidney/ureter/bladder removal, kidney disease, type 2 diabetes, hypertension, and chroic obstructive pulmonary disease (COPD). R1's most recent Minimum Data Set (MDS) assessment, dated 8/20/24, stated R1's Brief Interview for Mental Status (BIMS) score was 15 out of 15 which indicated R1 had intact cognition. R1 was R1's own decision maker and discharged home on 8/24/24.</p> <p>Surveyor reviewed R1's progress notes, hospital notes, Medication Administration Record (MAR), and vital signs.</p> <p>R1's medical record indicated R1 was hospitalized from 8/1/24 to 8/8/24 for removal of a kidney and part of the bladder and ureter. R1 developed an ileus (inability of the intestine (bowel) to contract normally and move waste out of the body) while in the hospital; however, R1's bowels were functioning normally when R1 was discharged on [DATE]. R1 was admitted to the facility with an order for Miralax 17 grams by mouth as needed (PRN) to promote bowel movements.</p> <p>On 8/9/24, Certified Nursing Assistant (CNA) charting indicated R1 experienced two episodes of watery diarrhea at approximately 1:15 AM and 3:30 AM.</p> <p>On 8/9/24 at 1:50 PM, Licensed Practical Nurse (LPN)-C administered PRN Miralax and noted it was effective.</p> <p>On 8/9/24 at 4:08 PM, R1 was sent to the emergency room (ER) and admitted to the hospital for an upper gastrointestinal (GI) bleed.</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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>On 8/29/24 at 11:35 AM, Surveyor interviewed CNA-E regarding R1's change in condition on 8/9/24. CNA-D stated CNA-D went to see R1 before breakfast because R1 was a new resident. CNA-D assisted R1 with toileting and R1 had a bowel movement. CNA-E noted R1 was pale, checked R1's blood pressure which was in the 80's over 60's, and notified LPN-C. CNA-D stated R1 ate approximately 50% of breakfast and lunch and had another episode of low blood pressure before lunch. CNA-D verified the episodes of low blood pressure were not documented in R1's medical record.</p> <p>On 8/29/24 at 1:51 PM, Surveyor interviewed LPN-C regarding R1's change in condition. LPN-C stated LPN-C was not told in report that R1 had diarrhea/dark stools and did not recall being told of any concerns by CNA-D during the AM shift. LPN-C documented a Daily Skilled note at approximately 2:00 PM on 8/9/24 that indicated R1's vital signs were within normal limits. LPN-C stated LPN-C gave R1 Miralax at approximately 2:00 PM because R1 requested it. LPN-C did not check R1's bowel charting prior to administering the Miralax and stated LPN-C was under the impression from R1 and R1's family that R1 did not have a bowel movement since 8/1/24.</p> <p>On 8/29/24 at 2:16 PM, Surveyor interviewed Registered Nurse (RN)-E regarding R1's change in condition. RN-E stated during shift change on 8/9/24 at approximately 2:30 PM, R1's family member approached the nurses' station and reported concerns with R1's stool. RN-E assessed R1 and noted R1's brief contained a large amount of dark/foul smelling stool. RN-E asked a CNA to obtain a set of vital signs and noted R1's blood pressure was 80/65 mm Hg (millimeters of mercury). RN-E updated Nurse Practitioner (NP)-F and got an order to send R1 to the ER.</p> <p>On 8/29/24 at 2:35 PM, Surveyor interviewed Director of Nursing (DON)-B regarding R1's change in condition. DON-B verified R1's low blood pressures and dark/tarry/bloody stools required an immediate update to the Medical Doctor (MD) and should have been documented in R1's medical record. DON-B stated if a resident had diarrhea/loose stools, DON-B expected staff to hold bowel medications such as Miralax.</p> <p>On 8/29/24 at 2:49 PM, Surveyor interviewed R1 who stated R1 did not request Miralax on 8/9/24 because R1 did not need it. R1 verified R1 had dark/loose stools at the hospital and stated the dark/loose stools got worse when R1 was admitted to the facility.</p> <p>On 8/29/24 at 4:05 PM, Surveyor interviewed NP-F regarding R1's change in condition. NP-F stated NP-F was first notified of R1's low blood pressures and dark/loose stools just before 4:00 PM on 8/9/24. NP-F stated if NP-F had been notified earlier in the day (at approximately 8:00 AM), NP-F would have ordered lab work to be done at the facility. NP-F agreed that R1 may have been sent to the ER earlier, but indicated R1's outcome would have been the same. NP-F confirmed laxative medications should not be given if a resident is having loose stools due to the risk of worsening diarrhea and/or dehydration.</p> | | |