STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525335	A. Building B. Wing	11/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shawano Health Services	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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40342 Based on staff and resident interview and record review, the facility failed to implement policies and procedures for ensuring the reporting of a reasonable suspicion of a crime in accordance with section 1150B of the Act for 1 resident (R) (R1) of 4 sampled residents. On 10/19/24, the facility discovered missing doses of narcotic medication for R1 which raised concerns of potential drug diversion and possible exploitation. The facility did not report the suspected crime to the State Agency (SA) or local law enforcement. Findings include: The facility's Reporting Abuse to Facility Management policy, with a revision date of December 2013, indicates: It is the responsibility of our employees, facility consultants, attending physicians, family members, visitors, etc., to promptly report any incident or suspected incident of neglect or resident abuse, including injuries of unknown source, and theft or misappropriation of resident property to facility management .1. Our facility does not condone resident abuse by anyone, including staff members, physicians, consultants, volunteers, staff of other agencies serving the resident, family members, legal guardians, sponsors, other residents, friends, or other individuals. 2. To help with recognition of incidents of abuse, the following definitions of abuse are provided: .j. Exploitation means taking advantage of a resident for personal gain through the use of manipulation, intimidation, threats, or coercion .6. Any staff member or person affiliated with this facility who has witnessed or who believes that a resident has been a victim of mistreatment, abuse, neglect, or any other criminal offense shall immediately report, or cause a report to be made of, the mistreatment or offense .7. Staff members and persons affiliated with this facility shall not knowingly: a. Attempt, with or without threats or promises of benefit, to induce another to fail to report an incident of mistreatment or other offense; b. Fail to report an incident of mistreatment or other offense. (continued on next page)

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

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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Report Reasonable Suspicion of a Crime policy, with an implementation date of 9/1/22, indicates: It is the policy of this center, pursuant to Section 1150B of the Social Security Act, to report any reasonable suspicion of a crime committed against a resident of this facility .1. The facility will coordinate with state and local law enforcement entities to determine what actions are considered crimes in the facility's political subdivision and will work with law enforcement to determine which crimes are reported. Examples of situations that would be considered crimes in all subdivisions include, but are not limited, to: .g. Drug diversion for personal use or gain .i. Certain cases of abuse, neglect, and exploitation .3. Any covered individual can report any reasonable suspicion of a crime without fear of retaliation. On 11/4/24, Surveyor reviewed R1's medical record. R1 was admitted to the facility on [DATE] with diagnoses including after-care from surgical amputation of right lower leg below knee, cognitive communication deficit, and diabetes mellitus. R1's Minimum Data Set (MDS) assessment, dated 10/21/24, stated R1's Brief Interview for Mental Status (BIMS) score was 15 out of 15 which indicated R1 was not cognitively impaired. R1's medical record indicated R1 was responsible for R1's healthcare decisions. R1's medical record contained notes, dated 10/19/24, that indicated R1 was seen at a clinic for a surgical follow-up visit on 10/18/24. A prescription for 60 tablets of hydrocodone/acetaminophen (also known as Norco) 7.5 mg/325 mg (milligrams) (a controlled substance narcotic used to treat moderate to severe pain) was sent to a local pharmacy. The notes indicated the facility did not have any Norco to administer to R1 and R1's spouse picked up the prescription from the pharmacy. R1 told staff that R1 was unable to get in touch with R1's spouse because R1's spouse's phone was accidentally left with R1. R1 refused staff's offer to call law enforcement to obtain the medication from R1's spouse and indicated R1's adult child would try to get in touch with R1's spouse. The notes indicated R1's spouse went to the facility on [DATE] at 11:45 AM. R1 and facility staff informed R1's spouse the medication needed to be brought to the facility for nursing staff to lock up and administer to R1 as needed. R1's spouse expressed understanding. On the afternoon of 10/19/24, R1 told a Certified Nursing Assistant (CNA) to give a bag with a local pharmacy emblem to the nurse. The bag contained two bottles of medication, one of which was a bottle of Norco 7.5 mg/325 mg with the label partially ripped off. Two nurses counted 14 pills in the bottle. When a nurse asked R1 about the other 46 pills, R1 indicated R1 owed them to other people. The nurse immediately reported the information to the Director of Nursing (DON). On 11/4/24 at 9:31 AM, Surveyor interviewed R1 who indicated R1 did not have any stored medication in R1's room. R1 indicated the physician would no longer prescribe narcotic pain medication to R1 since R1 got it all screwed up. R1 indicated at R1's clinic appointment, R1 had Norco refilled at a local pharmacy like R1 did when R1 was at home. R1 would not provide any further details. R1 was satisfied with pain management provided by the facility and had no care concerns. On 11/4/24 at 10:45 AM, Surveyor observed law enforcement at the facility for an event with residents. Surveyor interviewed Police Officer (PO)-D who indicated the facility should report to law enforcement any crime committed against a resident. PO-D verified if a resident was suspected of selling their narcotic medication, it was considered a reportable crime. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/4/24 at 11:11 AM, Surveyor interviewed Nursing Home Administrator (NHA)-A and DON-B. NHA-A indicated the facility was never in possession of the medication. DON-B indicated R1 had an appointment and the physician prescribed 60 Norco tablets. The facility thought the order was sent from the clinic to the facility's pharmacy. DON-B indicated R1 called the clinic after the appointment and requested the order be sent to a different pharmacy for R1's spouse to pick up. DON-B indicated when the facility became aware, staff were unable to get in touch with R1's spouse. DON-B indicated R1's spouse came to the facility and provided 14 Norco tablets. When R1's spouse was asked about the rest of the tablets, R1's spouse did not answer. DON-B indicated R1's physician then discontinued R1's narcotic orders. DON-B again indicated the facility did not have possession of the missing narcotic medication and verified staff were mandatory reporters of suspected crime. NHA-A indicated corporate management informed NHA-A the situation was not reportable to the SA or local law enforcement since the facility never had possession of the missing narcotics. When asked what the facility suspected happened to the missing narcotics, NHA-A indicated it was thought that R1's spouse kept the medication. Following a discussion of R1's nursing note on 10/19/24 that indicated R1 stated R1 owed the missing pills to everyone else, NHA-A and DON-B indicated they were unaware of the wording of the note. When asked what NHA-A and DON-B would have done if they were aware of the wording, NHA-A indicated they would have questioned R1 more as to what R1 meant by that. On 11/4/24 at 12:04 PM, Surveyor interviewed Licensed Practical Nurse (LPN)-E via phone. LPN-E verified LPN-E worked the 10/19/24 AM shift on R1's unit and documented the above notes. LPN-E indicated LPN-E placed a note in the paperwork sent to the clinic on the day of R1's surgical follow-up appointment to let the physician know R1 was out of Norco and needed a prescription sent to the facility's pharmacy. When LPN-E reported to work on the morning of 10/19/24, LPN-E asked the previous shift nurse if R1's Norco had arrived. The previous shift nurse indicated it had not. LPN-E reviewed R1's clinic notes which indicated 60 tablets of Norco were prescribed, but the prescription had gone to a local pharmacy instead of the facility's pharmacy. LPN-E recalled that before R1 returned from the appointment, the facility received a call from R1's physician group and instructed staff to give the surgical clinic phone number to R1 because R1 had called the physician group by mistake and wanted the phone number for the surgical clinic. LPN-E indicated LPN-E assumed R1 had intercepted the prescription and changed the pharmacy because LPN-E did not know how else the prescription was sent to the other pharmacy. On 10/19/24, R1 told LPN-E that R1's spouse was supposed to pick up the medication from the pharmacy and stated, (R1's spouse) is a user and I can guarantee there won't be 60 of them when (R1's spouse) brings them. LPN-E immediately reported the incident to DON-B. When asked if LPN-E informed DON-B of the specific wording used by R1, LPN-E indicated yes. When asked if the facility asked LPN-E to provide a written statement, LPN-E indicated LPN-E provided a written statement. LPN-E indicated R1 stated R1's spouse left their phone at the facility and R1's adult child found R1's spouse asleep in a car. LPN-E indicated R1's spouse came to the facility and gave LPN-E a funny look when LPN-E asked for the Norco. LPN-E was unsure when R1's spouse left the facility and indicated a person came to the desk a short time later and asked for a room number on a different unit. The person then returned to the desk and told LPN-E they were looking for R1 and were given the wrong room number. LPN-E directed the person to R1's room where they stayed for approximately 4 minutes and then left the facility. A CNA gave LPN-E a bag that contained a bottle of Norco from R1's room. LPN-E and another nurse counted 14 tablets in the bottle. When LPN-E asked R1 about the missing medication, R1 indicated R1 owed them to people. When LPN-E asked if R1 owed pills to the person who had just visited, R1 indicated yes. LPN-E then contacted DON-B. LPN-E indicated when R1's covering physician and surgical physician were notified of what happened, R1's narcotic medication was discontinued. LPN-E indicated staff monitored R1 for indications of pain, however, R1 had not exhibited signs of pain. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/4/24 at 12:43 PM, Surveyor interviewed DON-B who provided Surveyor with copies of written staff statements. DON-B indicated the facility did not have any other investigative documentation. On 11/4/24, Surveyor reviewed a typed and hand-signed statement from LPN-E, dated 10/19/24, that stated, . There were 14 pills in the bottle. Writer went and questioned the resident. Writer asked 'where did the other 46 pills go?' Resident responded (R1) 'owed them to everyone else'. Writer asked resident is that what that (person) was doing in your room? Resident responded 'yes'. I asked how many pills (R1) gave the (person) and (R1) replied 8. Writer asked what about all the others? Resident stated they went to everyone else (R1) owed . On 11/4/24 at 1:31 PM, Surveyor interviewed NHA-A. Following a discussion that the facility should have notified law enforcement of the suspected crimes of drug diversion and possible exploitation, NHA-A indicated NHA-A was instructed by corporate staff not to.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40342 Based on observation, staff and resident interview, and record review, the facility did not ensure accurate and safe administration of pharmaceuticals for 3 residents (R) (R2, R1, and R3) of 4 sampled residents. On 11/4/24, multiple oral medications and an inhaler were left unattended by staff in R2's room. R2 was not assessed as able to self-administer medication. On 11/4/24, R1 indicated nurses sometimes left 2 Tylenol (used to treat mild to moderate pain) at R1's bedside for R1 to take if R1 had pain during the night. R1 was not assessed as able to self-administer medication. On 11/4/24, medication was left unattended by staff in R3's room for R3 to self-administer. R3 was not assessed as able to self-administer medication. Findings include: The facility's Medication Administration policy, dated 1/23, indicates: To administer oral medications in an organized, accurate, and safe manner .10. Administer medication and remain with the resident while medication is swallowed. Do not leave medication in a resident's room without orders to do so along with documentation of self-administration. Use caution with residents who have difficulty swallowing. 1. On 11/4/24, Surveyor reviewed R2's medical record. R2 was admitted to the facility on [DATE] with diagnoses including pneumonia and diabetes mellitus. R2's Minimum Data Set (MDS) assessment, dated 11/4/24, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R2 had no cognitive impairment. R2's medical record indicated R2 was responsible for R2's healthcare decisions. On 11/4/24 at 9:19 AM, Surveyor observed R2 (through an open door from the hallway) sitting upright in a recliner, tying R2's shoes, and talking to a housekeeper who was cleaning R2's room. Surveyor observed an inhaler and medication cup with several oral medications on a table near R2. There was no food on the table. On 11/4/24 at 9:20 AM, Surveyor observed R2 put some of the medications in R2's hand and swallow the pills one by one while taking sips of liquid from a cup with a straw. Surveyor noted the medication cup still contained several medications. On 11/4/24 at 9:25 AM, Surveyor interviewed R2 who indicated a nurse left the medications a short time ago and stated, I have to work at it. There are so many. R2 indicated the inhaler was the same type of inhaler R2 used at home and was left in R2's room at all times. R2 indicated the nurses only left AM medications with R2 to take unattended. R2 indicated R2 received less medication at other times of the day and took those medications in front of the nurse. R2 did not have a roommate. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Self-Administration of Medication Approval form that was signed and dated by R2 on 10/31/24 indicated R2 wished to have medication administered to R2. On 11/4/24 at 9:39 AM, Surveyor observed R2 put more medications in R2's hand and swallow the pills one by one while taking sips of liquid from a cup with a straw. Surveyor noted the medication cup still contained medication. Surveyor reviewed R2's November 2024 Medication Administration Record (MAR) which indicated R2's AM medications on 11/4/24 included the following: ~ Aspirin (used to prevent blood clots) oral tablet Give 81 milligrams (mg) once daily .take with food ~ Calcium plus Vitamin D (used as a supplement) 600-200 mg 1 tablet once daily ~ Fexofenadine HCl (hydrochloride) (used to treat seasonal allergies) oral tablet Give 180 mg once daily ~ Metoprolol Succinate ER (extended release) (used to treat high blood pressure) oral tablet 25 mg Give 1 tablet by mouth once daily ~ Multivitamin with Minerals (used as a supplement) Give 1 tablet once daily ~ Omega-3 (used to treat high cholesterol) oral capsule Give 3000 mg once daily ~ Polyethylene Glycol 3350 (to promote bowel movement) powder Give 17 grams by mouth once daily .mix with 6-8 ounces (oz) of fluid ~ Spironolactone (used to treat high blood pressure) oral tablet Give 25 mg once daily ~ Vitamin C (used as a supplement) oral tablet Give 500 mg once daily ~ Vitamin D (used as a supplement) oral tablet Give 2000 units once daily ~ Vitamin E (used as a supplement) oral capsule Give 180 mg once daily ~ Acidophilus (used to prevent loose stools) oral capsule Give 1 capsule two times daily ~ Cefuroxime Axetil (used to treat infection) oral tablet 500 mg Give 1 tablet two times daily ~ Fluticasone-Salmeterol (used to treat asthma) Inhalation Aerosol Powder Breath Activated 250-50 mcg/act (micrograms per activation) 1 inhalation two times daily On 11/4/24 at 10:27 AM, Surveyor noted the medication cup and inhaler were no longer on R2's bedside table and observed R2 sitting on the edge of the bed with the bedside table close by. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/4/24 at 10:55 AM, Surveyor interviewed Registered Nurse (RN)-C who indicated if a resident was assessed as able to self-administer medication, the medication would be locked in the resident's room for the resident to self-administer. RN-C indicated the facility did not have any residents who were assessed as able to self-administer medication. Following a discussion of the above observations, RN-C indicated R2 told RN-C to leave the room when RN-C delivered R2's AM medication. RN-C verified RN-C should not have left the medication with R2. RN-C indicated RN-C usually worked a different unit and did not know whether or not R2 could self-administer medication. 2. On 11/4/24, Surveyor reviewed R1's medical record. R1 was admitted to the facility on [DATE] with diagnoses including after-care from surgical amputation of right lower leg below knee, cognitive communication deficit, and diabetes mellitus. R1's MDS assessment, dated 10/21/24, stated R1's BIMS score was 15 out of 15 which indicated R1 had no cognitive impairment. R1's medical record indicated R1 was responsible for R1's healthcare decisions. On 11/4/24 at 9:31 AM, Surveyor interviewed R1 in R1's room. Surveyor did not observe medication in the room. R1 indicated R1 did not store medication in the room but stated, Sometimes the nurse will give me two Tylenol and leave them in my room in case I need them at night. R1 indicated it depended on which nurse was working. R1 did not have a roommate. Surveyor reviewed R1's November 2024 MAR which included a physician order for acetaminophen (Tylenol) 325 mg Give 2 tablets every 4 hours as needed (PRN) for pain/fever. The MAR indicated R1 received doses of PRN Tylenol on 11/1/24 at 7:05 AM, on 11/2/24 at 11:09 AM and 8:00 PM, and on 11/3/24 at 8:03 AM and 8:35 PM. All doses were documented as effective. Surveyor reviewed two Self-Administration of Medication Approval forms in R1's medical record, signed and dated by R1 on 9/19/24 and 10/14/24, that indicated R1 wished to have medication administered to R1. On 11/4/24 at 11:11 AM, Surveyor interviewed Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B. NHA-A indicated residents were asked to sign a form upon admission regarding whether or not they wished to self-administer medication. NHA-A indicated if a resident wanted to self-administer an inhaler, the resident would first be assessed by staff for the capability to self-administer the inhaler. NHA-A indicated the facility provided a locked box at the bedside of any resident able who self-administered medication and indicated there were no residents who were assessed as able to self-administer medication. Following a discussion of the above observations and interviews, NHA-A and DON-B indicated they were unaware staff left medication at the bedside and verified the practice was against the facility's policy. 51043 3. On 11/4/24, Surveyor reviewed R3's medical record. R3 was admitted to the facility on [DATE] with diagnoses including chronic respiratory failure, chronic obstructive pulmonary disease (COPD), chronic pain, and arthropathic pain. R3's MDS assessment, dated 10/21/24, had a BIMS score of 15 out of 15 which indicated R3 had no cognitive impairment. On 11/4/24 at 9:18 AM, Surveyor observed 2 capsules in a medication cup on R3's beside table which were later identified by R3 as Tylenol (used for pain). R3 indicated staff gave R3 the capsules but R3 fell asleep and did not take them. R3 had a roommate (R4). (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R3's November 2024 MAR indicated R3 was administered PRN Tylenol at 4:28 AM. On 11/4/24 at 10:40 AM, Surveyor interviewed Licensed Practical Nurse (LPN)-F who provided a Self-Administration of Medication Approval form from R3's medical record that was signed and dated by R3 on 4/28/24. The form indicated R3 wished to have R3's medications administered to R3. LPN-F indicated LPN-F did not see medication at R3's bedside, but stated, I know the night shift nurse said she gave it (referring to Tylenol) around 4:30 AM. On 11/4/24, Surveyor reviewed R4's medical record. R4 had diagnoses including Parkinson's disease, cognitive communication deficit, and dysphagia (difficulty or discomfort in swallowing). R4's MDS assessment, dated 10/21/24, had a BIMS score of 14 out of 15 which indicated R4 had no cognitive impairment. On 11/4/24, Surveyor interviewed RN-C. When asked about the Tylenol at R3's bedside, RN-C indicated R3 stated R3 was going to take the Tylenol, however, RN-C didn't see R3 take it. RN-C indicated the facility's medication administration process included making sure residents took their medication. On 11/4/24 at 12:01 PM, Surveyor interviewed DON-B. When asked if any residents self-administered medication, DON-B indicated there were no residents who self-administered medication. When asked DON-B's expectations regarding medication administration, DON-B indicated DON-B expected staff to stay with residents to ensure they took the meds, didn't drop the meds, and swallowed the meds safely.