STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525343	A. Building B. Wing	05/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Evergreen Health Services	1250 Evergreen 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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40342 Based on staff interview and record review, the facility did not ensure appropriate care and treatment were provided for 1 resident (R) (R29) of 1 resident reviewed for cardiac monitoring. The facility did not assess R29's ability to follow cardiac monitoring instructions or provide monitoring assessments for R29's cardiac monitor. Findings include: On 5/27/25, Surveyor reviewed R29's medical record. R29 was admitted to the facility on [DATE] and had diagnoses including hemiplegia (weakness on one side of the body) and hemiparesis (paralysis on one side of the body) following cerebral infarction (also known as stroke) affecting the left non-dominant side, congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), emphysema, and atrial fibrillation. R29's Minimum Data Set (MDS) assessment, dated 4/9/25, had a Brief Interview for Mental Status (BIMS) score of 10 out of 15 which indicated R29 had moderate cognitive impairment. R29 was responsible for R29's healthcare decisions. R29 was transferred to the hospital on 5/24/25 and remained hospitalized during the survey. R29's medical record contained a physician's order that indicated staff should not apply lotion to R29's skin on the morning of 3/24/25 in preparation for cardiac monitor placement scheduled that day. A note, dated 3/24/25 at 12:29 PM, indicated R29 had a cardiology appointment. No new orders were initiated. A note, dated 3/25/25 at 1:12 PM, indicated a [NAME] monitor (a type of cardiac monitor) was set up and working properly. On 5/27/25 at 9:57 AM, Surveyor interviewed Close Friend (CF)-F via phone who indicated CF-F had been helping R29 since R29's spouse passed away several years ago. CF-F verified CF-F was R29's emergency contact. CF-F indicated CF-F tried to attend appointments with R29 but had to miss occasionally due to work. CF-F indicated the cardiac monitor should be in place for fourteen days. CF-F could not attend the appointment when the monitor was placed and stated, I know (R29's) moods. (R29) will sometimes tell them (healthcare professionals) about things, sometimes not. (continued on next page)

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

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/28/25 at 10:10 AM, Surveyor interviewed Licensed Practical Nurse (LPN)-G who verified LPN-G wrote the above notes in R29's medical record. LPN-G indicated a folder sent to R29's cardiac monitor appointment was empty when R29 returned. LPN-G indicated if a resident comes back without papers, a nurse typically calls the clinic to get papers faxed to the facility. LPN-G reviewed R29's medical record and indicated LPN-G could not find any paperwork from R29's cardiac monitor appointment, however, R29 returned to the facility on [DATE] with a cardiac monitor in place. LPN-G indicated the monitor would have come with a phone which blue-toothed with the monitoring device. LPN-G indicated staff were to report any signs or symptoms experienced by a resident wearing the device on the phone after the button was pushed on the device. LPN-G indicated the device's batteries also needed to be checked. LPN-G verified there was no documentation in R29's medical record regarding how long the cardiac monitor was on, how frequently R29 was assessed for symptoms during use, or how frequently the device was checked for correct placement and battery function. LPN-G indicated LPN-G should have called the clinic to get orders since there was no paperwork in R29's folder. LPN-G verified LPN-G did not call the clinic and probably passed the task onto the next shift. When asked about R29's mentation and attending the appointment alone, LPN-G indicated R29 was for the most part alert and oriented with occasional confusion regarding historical questions and timelines of events. LPN-G indicated R29 knew why R29 needed care at the facility. LPN-G indicated if R29 was at an appointment, R29 could tell transportation or clinic staff where R29 needed to be when R29 was at baseline. On 5/28/25 at 2:20 PM, Surveyor interviewed Respiratory Therapist (RT)-H via phone who verified RT-H applied R29's cardiac monitor on 3/24/25. After application of the device, RT-H indicated a box containing a phone and an instruction booklet was sent to the facility with R29. RT-H indicated R29 was able to answer questions but the answers were not always appropriate. RT-H indicated R29 was unable to clearly express understanding of how to use the device. On 5/28/25 at 3:02 PM, Surveyor interviewed Director of Nursing (DON)-B, Nursing Home Administrator (NHA)-A, and [NAME] President of Success (VPS)-I. DON-B verified there was no documentation in R29's medical record to indicate follow-up occurred at the facility for R29's cardiac monitor. DON-B indicated the booklet probably went back to the clinic with the monitor. VPS-I verified assessment and monitoring related to cardiac monitor use should have been part of R29's plan of care.