| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 525343 | A. Building<br>B. Wing | 09/16/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Evergreen Health Services | 1250 Evergreen St<br>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 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>(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 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff and resident interview, and record review, the facility did not ensure 8 residents (R) (R3, R10, R8, R9, R11, R14, R15, and R13) of 16 sampled residents received timely assistance for activities of daily living (ADLs)R3 and R10 experienced long call light response times and had to wait to be assisted to bed.R8 experienced long call light response times which caused increased incontinence and embarrassment. R9 experienced long call light response times which caused stress and difficulty completing ADLs so R9 could go to bed.R11, R14 and R15 experienced long call light response times which resulted in increased stress and incontinence.R13 experienced long call light response times which resulted in increased incontinence. In addition, R13 had to wait to be assisted to bed.Findings include: The facility's Call lights: Accessibility and Timely Response policy, revised 7/6/22, indicates: .2. All residents will be educated on how to call for help by using the resident call system .10. All staff members who see or hear an activated call light are responsible for responding. If the staff member cannot provide what the resident desires, the appropriate personnel should be notified. 11. Process for Responding to Call Lights: a. Turn off the signal light in the resident's room. b. Identify yourself and call the resident by name. c. Listen to the resident's request and respond accordingly. Inform the resident if you cannot meet the need and assure him/her that you will notify the appropriate personnel. d. Inform the appropriate personnel of the resident's need. e. Do not promise something you cannot deliver. f. If assistance is needed with a procedure, summon help by using the call light. Stay with the resident until help arrives.The facility's Activities of Daily Living (ADLs) policy, revised 7/26/22, indicates: The facility will, based on the resident's comprehensive assessment and consistent with the resident's needs and choices, ensure a resident's abilities in ADLs do not deteriorate unless deterioration is unavoidable. Care and services will be provided for the following activities of daily living: 1. Bathing, dressing, grooming and oral care; 2. Transfer and ambulation; 3. Toileting .2. The facility will provide a maintenance and restorative program as applicable to assist the resident in achieving and maintaining the highest practicable outcome based on the comprehensive assessment. 3. A resident who is unable to carry out ADLs will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene .1. On 9/8/25, Surveyor reviewed R3's medical record. R3 was admitted to the facility on [DATE] and had diagnoses including vascular dementia, chronic obstructive pulmonary disease (COPD) with acute exacerbation, chronic respiratory failure with hypoxia, low back pain, and obesity. R3's Minimum Data Set (MDS) assessment, dated 6/18/25, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R3 had intact cognition. The MDS assessment also indicated R3 was totally dependent on staff for bathing/showering, standing, toileting, and transfers. On 9/8/25 at 3:18 PM, Surveyor noted R3's call light was turned on. R3's call light was turned off at 3:53 PM after 35 minutes. On 9/8/25 at 4:27 PM, Surveyor interviewed R3 who indicated R3 often has to wait for staff to answer R3's call light. R3 indicated it is not always acceptable to wait that long because sometimes R3 has to go to the bathroom and doesn't feel that R3 can hold it. R3 also indicated R3 and R3's roommate had to wait until the night shift arrived last week to go to bed which was after 10:00 PM. During the interview, R3's roommate confirmed R3's statement. R3 indicated R3 wanted to go to bed around 8:00 PM and turned on the call light, however, R3 was told a staff had gone home and staff were not able to put R3 to bed until the next shift arrived. R3 indicated the facility is understaffed.2. On 9/8/25, Surveyor reviewed R10's medical record. R10 was admitted to the facility on [DATE] and had diagnoses including congestive heart failure (CHF), chronic kidney disease, and polyosteoarthritis. R10's MDS assessment, dated 6/18/25, had a BIMS score of 10 out of 15 which indicated R10 had moderately impaired cognition. The MDS assessment also indicated R10 was totally dependent on staff for bathing/showering, standing, toileting, and transfers. On 9/8/25 at 3:20 PM, Surveyor noted R10's call was turned on. R10's call light was turned off at 3:59 PM after 39 minutes. Surveyor noted R10's call light was turned on again at 6:25 PM. R10's call light was turned off at 6:40 PM after 15 minutes. On 9/8/25 at 6:52 PM, Surveyor interviewed R10 who indicated R10's needs are not being met and stated R10's call light was on and R10 had to wait a long time. When staff responded, R10 was told R10 couldn't go to bed at that time and had to wait until later. R10 indicated staff said they had other things to do and R10 had to wait R10's turn to be put to bed. R10 stated R10 gets upset and wishes R10 didn't have to wait so often but there is nothing R10 can do. On 9/8/25 at 7:08 PM, Surveyor interviewed Certified Nursing Assistant (CNA)-I who verified CNA-I turned off call lights in a few rooms on the A wing. CNA-I indicated R10 wanted to go to bed |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, and record review, the facility did not ensure adequate supervision was provided for 1 resident (R) (R1) of 5 residents reviewed for elopement.R1 was at risk for wandering and elopement. On 8/15/25, R1 exited the facility unsupervised and was found lying on the side of the road 0.3 miles from the facility. The facility failed to ensure all exit doors alarmed and did not have a system in place to ensure doors were secure and an audible alarm functioned.The facility's failure to provide adequate supervision for a resident assessed to be at risk for elopement and who exited the facility and was discovered laying on the side of a road and to ensure a properly functioning alarm system led to a finding of immediate jeopardy that began on 8/8/25. Nursing Home Administrator (NHA)-A was notified of the immediate jeopardy on 9/10/25 at 4:30 PM. The immediate jeopardy was removed on 9/10/25, however, the deficient practice continues at a scope/severity level D (potential for more than minimal harm/isolated) as the facility continues to implement its action plan.Findings include: The facility's Elopement and Unsafe Wandering policy, revised 8/9/22, indicates the facility will ensure residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents .Alarms are not a replacement for necessary supervision. Staff are to be vigilant in responding to alarms in a timely manner. On 9/8/25, Surveyor reviewed R1's medical record. R1 was admitted to the facility on [DATE] and had diagnoses including toxic encephalopathy, chronic kidney disease, dysphagia, type 2 diabetes, anxiety, and mood disorder. R1's most recent Minimum Data Set (MDS) assessment, dated 8/8/25, had a Brief Interview for Mental Status (BIMS) score of 0 out of 15 which indicated R1 had severely impaired cognition. The MDS assessment also indicated R1 required the assistance of one staff for transfers and used a wheelchair. R1 had an activated Power of Attorney for Healthcare (POAHC) and discharged from the facility on 8/15/25.A care plan, initiated 8/8/25, indicated R1 was at risk for wandering related to cognitive impairment. The care plan contained interventions to encourage rest throughout the day, check alert bracelet functioning per facility guidelines, check alert bracelet placement per facility guidelines, provide assistance in locating room, and redirect if attempting to go outdoors. R1's plan of care also indicated R1 was at risk for falls.The facility placed a WanderGuard bracelet (a security device that triggers an alarm if the wearer exits the facility) on R1's left ankle upon admission on [DATE].Daily skilled nursing notes indicated R1 required increased supervision related to impaired cognitive status. A skilled nursing note, dated 8/8/25 at 10:00 PM, indicated R1 attempted to open the D wing door (exit 10) and the alarm sounded. Staff were able to redirect R1 toward the nurses' station. The facility's investigation, dated 8/15/25, included a timeline of events that indicated: ~ At 8:30 PM, R1 was toileted by Certified Nursing Assistant (CNA)-E. ~ At 9:15 PM, R1 was last seen by CNA-H. ~ At approximately 9:52 PM, LPN-D observed R1's empty wheelchair at the nurses' station and asked CNA-E if CNA-E recently saw R1. CNA-E replied no, began to search for R1, and notified other staff in the building. ~ At 10:00 PM, Director of Nursing (DON)-B was notified and instructed staff to follow the facility's elopement protocol. Staff conducted a head count and searched the perimeter of the building.~ At 10:13 PM, DON-B called the police and reported R1 missing. The police informed DON-B that R1 was located and taken to the ED. ~ At approximately 10:50 PM, Director of Maintenance (DOM)-C arrived at the facility and checked all door alarms. DOM-C indicated exit door 5 did not alarm when opened even though the keypad indicated the door was alarmed. DOM-C indicated DOM-C checked the door alarms daily by visually observing the keypad (rather than sounding the alarm). DOM-C added a temporary magnetic strip alarm on all exit doors as a back up in case of another malfunction. ~ On 8/16/25, DON-B spoke with Family Member (FM)-K who stated R1 told FM-K that R1 walked until R1's legs were sore and sat down. ~ On 8/19/25, Service Technician (ST)-J inspected the facility's alarm system and indicated the keypad on exit door 5 was deprogrammed which could be due to a power issue. ST-J reprogrammed the keypad and tested the other doors with no concerns. The facility's investigation did not include resident or staff interviews regarding alarms that sounded/were turned off and did not contain a determination of the root cause of exit door 5's malfunction. The facility provided immediate education to DOM-C to check door alarms by setting them off rather than observing keypad lights. All staff were educated on the elopement/wandering policy and instructed that if an alarm sounds, staff need to know why. If unable to determine why, staff should complete a head count and document on the resident roster. The facility did not provide proof of staff education on how to ensure alarms are properly functioning/armed, including temporary magnetic strip alarms. A police report, dated 8/15/25 |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide and implement an infection prevention and control program.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Based on observation, staff interview, and record review, the facility did not establish and maintain an infection prevention and control program designed to prevent the transmission of communicable disease and infection. This practice had the potential to affect more than 4 of the 36 residents residing in the facility.The facility was following COVID-19 precautions due to staff exposure. During lunch and supper on 9/8/25, hand hygiene was not offered to residents prior to or after dining.Finding includes: The facility's Hand Hygiene policy, dated 11/2/22, indicates: All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors .Hand Hygiene Table indicates hand hygiene is to be performed before and after eating .References: Centers for Disease Control and Prevention (CDC).About Handwashing information from CDC.gov, dated 2/16/24, indicates: Many diseases and conditions are spread by not washing hands with soap and clean, running water. Hand washing with soap is one of the best ways to stay healthy. If soap and water are not readily available, use a hand sanitizer with at least 60% alcohol to clean your hands. Washing hands can keep you healthy and prevent the spread of respiratory and diarrheal infections. Germs can spread from person to person or from surface to person when you: Touch your eyes, nose, and mouth with unwashed hands; Prepare or eat food and drinks with unwashed hands; Touch surfaces or objects that have germs on them; Blow your nose, cough, or sneeze into hands and then touch other people's hands or common objects. You can keep yourself and your loved ones healthy by washing your hands often, especially during these key times when you are likely to get and spread germs: Before, during, after preparing food; Before and after eating food .On 9/8/25 at 10:00 AM, Surveyor entered the facility and was informed the facility was following COVID-19 precautions due to COVID-19 exposure to staff. On 9/8/25 at 12:00 PM, Surveyor began observing lunch in the main dining room. There were 11 residents in the dining room. Survey observed 8 additional residents arrive for a total of 19 residents. Surveyor noted the dining tables did not contain hand sanitizing wipes or bottles of hand sanitizer. Surveyor did not observe staff offer or complete hand hygiene for residents prior to eating their meal. At 12:08 PM, Surveyor observed Dietary Manager (DM)-Q and Dietary Aide (DA)-R begin plating and serving meals to residents in the dining room. No other staff initially assisted the residents or during the majority of the time the food was served. On 9/8/25 at 12:03 PM, Surveyor interviewed DM-Q who indicated Certified Nursing Assistants (CNAs) are supposed to help in the dining room, however, kitchen staff will assist residents with dining until CNAs arrive. On 9/8/25 at 12:27 PM, Surveyor interviewed DA-R who indicated staff should offer residents hand hygiene before meals but forgot to do so that day. When Surveyor asked how staff offer hand hygiene, DA-R retrieved a container of individually packaged hand sanitizing wipes that were near the sink in the dining room and stated staff can give residents a wipe. DA-R then put the container of wipes back and walked away. When Surveyor asked if staff should still offer residents a wipe even though they had started eating since the facility was in a COVID-19 outbreak, DA-R retrieved the wipes and said DA-R forgot. DA-R offered approximately 8 residents a wipe and then put the wipes away. Surveyor noted residents were not offered hand sanitizing wipes after they finished their meal and before they exited the dining room.On 9/8/25 at 4:44 PM, Surveyor observed [NAME] (CK)-L and CK-M plate and serve supper in the main dining room. CNA-I was also serving meals and assisting residents. Surveyor noted staff did not offer hand hygiene prior to dining to the 16 residents in the dining room. On 9/8/25 at 5:12 PM, Surveyor interviewed CK-L who was unsure if residents should be offered hand hygiene before meals.On 9/8/25 at 5:13 PM, Surveyor interviewed CK-M who indicated residents should be offered hand hygiene before meals and was unsure why hand hygiene was not offered. When Surveyor asked how staff offer hand hygiene, CK-M showed Surveyor a container of individually packaged hand sanitizing wipes that were near the sink. On 9/8/25 at 5:18 PM, Surveyor interviewed CNA-I who indicated residents should be offered hand hygiene before and after meals and was unsure why that didn't occur. CNA-I then offered a wipe to 3 residents in the dining room. On 9/9/25 at 1:46 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A who indicated staff were trained and should follow the facility's infection control and hand hygiene policies and procedures. NHA-A indicated residents should be offered hand hygiene in the dining room and should be provided hand sanitizing wipes on room trays for every meal. |