STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525348	A. Building B. Wing	09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greentree Health and Rehabilitation Center	70 Greentree Rd Clintonville, WI 54929

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** 49563 Based on staff interview and record review, the facility did not ensure an allegation of neglect was reported to the State Agency (SA) for 1 resident (R) (R1) of 3 sampled residents. On 7/18/24, R1 had a fall with major injury. R1's care plan contained an intervention for a sensor alarm on R1's bed. The facility's fall investigation indicated a sensor alarm was not on R1's bed at the time of the fall. The facility did not report the potential neglect to the SA. Findings include: The facility's Abuse Prevention policy, with a revision date of July 2024, indicates: It is the policy of this facility that each resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation .Identification of Abuse - Identify events, such as but not limited to, suspicious bruising of residents, occurrences, patterns, and trends that may constitute abuse; and to determine the direction of the investigation. 1. Bruises, skin tears and injuries of unknown source will be investigated to rule out abuse . Investigation - All identified events are reported to the Administrator/Designee immediately and will be thoroughly investigated .The investigation shall consist of: .5. An interview with staff members (on all shifts) having contact with the resident(s) during the period of the alleged incident; .Reporting/Response - All alleged violations will be reported via phone or in writing within 2 hours to the State Licensing Agency. The facility shall follow-up to the State Licensing Agency in writing the findings and results of the completion of the investigation within 5 days .Definitions - Neglect is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress . On 9/11/24, Surveyor reviewed R1's medical record. R1 was admitted to the facility on [DATE] and had diagnoses including dementia, left humerus fracture, and hypertension. R1's Minimum Data Set (MDS) assessment, dated 6/14/24, stated R1's Brief Interview for Mental Status (BIMS) score was 2 out of 15 which indicated R1 had severe cognitive impairment. R1's medical record indicated R1 had an activated Power of Attorney for Healthcare (POAHC). (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	A fall investigation indicated R1 had an unwitnessed fall in R1's room on 7/18/24 at approximately 3:45 AM. R1 was found on R1's back on the floor. R1's bed was in the lowest position and a floor mat was in place. When asked what happened, R1 stated, I was trying to walk. An assessment indicated R1's vital signs, neurological checks, and range of motion to left upper and lower extremities were at baseline. R1 complained of right upper extremity and right hip/lower extremity pain with movement. A Hoyer lift was used to assist R1 into bed. A Hospice nurse arrived to assess R1 and discussed R1's condition with R1's POAHC. The Hospice nurse and R1's POAHC decided to have staff monitor R1 throughout the day to determine if further measures should be taken. Pain medication was administered to ensure comfort for any complaints or signs of pain. Due to R1 guarding R1's right hip and upper right thigh, an order was received at approximately 3:00 PM to obtain an X-ray of R1's right hip. An X-ray was obtained at the facility on 7/18/24 at approximately 5:20 PM. Per the guidance of the Hospice nurse and R1's POAHC, the facility continued previously ordered Hospice comfort medication and repositioning to ensure comfort. The X-ray report, dated 7/19/24, indicated R1 had an acute basil cervical right femoral neck fracture. Following Hospice, Medical Doctor (MD), and POAHC notification, a decision was made to keep R1 comfortable with appropriate pain management in the facility. On 7/19/24 at 10:10 AM, R1 passed away. The fall investigation indicated 20 staff were interviewed regarding the use of a sensor alarm on R1's bed. Approximately half of the staff remembered a bed alarm in use for R1 and the other half did not remember ever seeing a bed alarm in use for R1. On 9/11/24 at 12:30 PM, Surveyor interviewed Certified Nursing Assistant (CNA)-D via telephone. CNA-D indicated CNA-D observed R1 lying sideways on the floor following R1's fall on 7/18/24. R1's bed was in a low position and a fall mat was on the floor. CNA-D indicated there was not a sensor alarm on R1's bed. On 9/11/24 at 2:30 PM, Surveyor interviewed Regional Administrator (RA)-C who indicated the facility initiated an investigation on 7/19/24 and did not have a clear picture of the circumstances surrounding the fall at that time. RA-C indicated the facility identified on 7/22/24 that staffs' use of R1's bed alarm was inconsistent with R1's care plan. RA-C verified R1's fall with injury was not reported to the SA. RA-C indicated the facility didn't think the fall would be considered or classified as neglect.

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49563 Based on staff interview and record review, the facility did not ensure the provision of an assistive device to prevent accidents for 1 resident (R) (R1) of 3 sampled residents. R1's plan of care contained an intervention for a sensor alarm on R1's bed. On 7/18/24 at 3:45 AM, R1 sustained a fall with injury. The sensor alarm was not in place at the time of the fall. Findings include: The facility's Falls Program policy, revised 9/2024, indicates: It is the policy of this facility to reduce the number and severity of falls and to identify high risk residents and take precautionary measures .Falls Interdisciplinary Team (IDT): .2. When a fall occurs, the Falls IDT will meet the next business day to discuss the fall, interventions, and review risk management. A Fall IDT note will be made regarding the fall. Risk Management will be left open for 7 days with the IDT to re-evaluate effectiveness of interventions. A closing Fall IDT note will be completed after 7 days. The Director of Nursing (DON) and the Nursing Home Administrator (NHA) will sign a Risk Management and Lock Assessment. The facility's Fall Program policy also indicates: It is the policy of this facility to develop an acute care plan post-fall. Purpose: To implement interventions that assure maximum resident safety . On 9/11/24, Surveyor reviewed R1's medical record. R1 was admitted to the facility on [DATE] with diagnoses including dementia, left humerus fracture, and hypertension. R1's Minimum Data Set (MDS) assessment, dated 6/14/24, stated R1's Brief Interview for Mental Status (BIMS) score was 2 out of 15 which indicated R1 had severe cognitive impairment. R1's medical record indicated R1 had an activated Power of Attorney for Healthcare (POAHC). R1's care plan, dated 8/5/21, indicated R1 was at risk for falls related to a history of falls. The care plan contained a goal that R1 would not sustain serious injury through the review date. The care plan contained the following interventions: ~ Bed in the lowest position (initiated 6/7/24) ~ Sensor alarm on bed (initiated 5/7/24) ~ Floor mats at bedside when sleeping (initiated 4/22/24) A nursing progress note, dated 5/10/24 at 3:56 PM, indicated R1 fell on [DATE] and obtained a skin tear. An alarm was placed as an immediate intervention due to R1's continued attempts to self-transfer. R1's POAHC and the IDT were in agreement with the intervention. Surveyor reviewed R1's fall history. R1 had numerous falls within the past year, including 3 falls in July of 2024 (76/24, 7/14/24, and 7/18/24). On 7/18/24 at 3:45 AM, R1 had an unwitnessed fall in R1's room. At the time of the incident on 7/18/24, R1 was found on the floor with R1's bed in the lowest position and a floor mat in place; however, there was no sensor alarm on R1's bed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/11/24 at 12:30 PM, Surveyor interviewed Certified Nursing Assistant (CNA)-D via telephone. CNA-D indicated during rounds on 7/18/24, CNA-D heard R1 call for help and yell louder as CNA-D approached R1's room. CNA-D indicated R1 was lying sideways behind R1's wheelchair. R1's bed was in a low position and a fall mat was on the floor. CNA-D indicated there was not a sensor alarm on R1's bed and R1 usually didn't have a bed alarm. CNA-D notified the nurse and an assessment was completed. Surveyor reviewed a fall investigation for R1's fall on 7/18/24. The investigation indicated 20 staff were interviewed regarding the use of a sensor alarm on R1's bed. Approximately half of the staff remembered a bed alarm and the other half did not remember ever seeing a bed alarm in use for R1. On 9/11/24 at 2:33 PM, Surveyor interviewed Regional Administrator (RA)-C who verified a sensor alarm was not in place at the time of R1's fall on 7/18/24. RA-C verified R1's care plan included an intervention for a sensor alarm on R1's bed and indicated the sensor alarm should have been in place.