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	04/23/2025

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

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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	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** 43361 Based on staff interview and record review, the facility did not ensure an injury of unknown origin was reported to the State Agency (SA) for 1 resident (R) (R32) of 4 sampled residents. On 4/2/25, staff discovered a hematoma on R32's left forearm. Facility staff and Hospice staff were unsure how the injury occurred. The facility did not report the injury of unknown origin to the SA. Findings include: The facility's Abuse Prevention policy and procedure, updated 7/2024, indicates: 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. All alleged violations will be reported via phone or in writing within 2 hours to the State Licensing Agency. The facility shall follow up with the State Licensing Agency in writing the findings and results of the completion of the investigation within 5 days . From 4/21/25 to 4/23/25, Surveyor reviewed R32's medical record. R32 was admitted to the facility on [DATE] and had diagnoses including dementia, adult failure to thrive, and palliative care. R32's Admission Minimum Data Set (MDS) assessment, dated 2/5/25, had a Brief Interview for Mental Status (BIMS) score of 3 out of 15 which indicated R32 had severely impaired cognition. R32 had an activated Power of Attorney for Healthcare (POAHC). A progress note, dated 4/2/25 at 3:14 PM, indicated the writer was informed by staff that R32 had discoloration on the bilateral wrists. Upon assessment, the writer noted R32's wrists contained purplish, red/brown discoloration. R32 denied pain to the areas. The writer was informed by a Hospice Certified Nursing Assistant (CNA) that the discoloration had come and gone over the past few weeks and the Hospice nurse was aware. The Hospice nurse also verified the discoloration had come and gone over the past few weeks and and indicated the discoloration was senile purpura. R32 was interviewed and stated R32 felt safe. The note indicated staff would continue to monitor R32's arms due to R32 having increased negative behavior toward staff with cares. (continued on next page)

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 progress note, dated 4/3/25 at 2:30 PM, indicated Hospice staff were in R32's room doing AM cares when the writer was called into the room and shown R32's left arm that had previous bruising. A raised hematoma that measured 9 centimeters (cm) x 10 cm was noted on the left side of R32's outer forearm. R32 had no complaints of pain or discomfort. R32 refused ice and was combative with staff. The Director of Nursing (DON) was notified. The note indicated staff would notify R32's POAHC and physician. On 4/21/25, Surveyor reviewed a facility investigation for R32's injury of unknown origin. The facility contacted R32's Power POAHC who indicated R32 was combative during a visit on 4/2/25 and hit R32's arms on the bed. The investigation determined the injury occurred when R32 hit R32's arms on the bed during the visit. The injury of unknown origin was not reported to the SA. On 4/21/25 at 2:25 PM, Surveyor interviewed DON-B who indicated the facility completed an investigation for R32's injury of unknown origin. DON-B verified the facility did not report the injury of unknown origin to the SA.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43361 Based on staff interview and record review, the facility did not ensure an injury of unknown origin was thoroughly investigated for 1 resident (R) (R32) of 4 sampled residents. R32 had an injury of unknown origin that was discovered on 4/2/25. The facility did not interview other residents to rule out abuse during the investigation. Findings include: The facility's Abuse Prevention policy and procedure, updated 7/2024, indicates: 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. The investigation shall consist of: .6. Interviews with other residents to whom the accused employee provides care or services. From 4/21/25 to 4/23/25, Surveyor reviewed R32's medical record. R32 was admitted to the facility on [DATE] and had diagnoses including dementia, adult failure to thrive, and palliative care. R32's Admission Minimum Data Set (MDS) assessment, dated 2/5/25, had a Brief Interview for Mental Status (BIMS) score of 3 out of 15 which indicated R32 had severely impaired cognition. R32 had an activated Power of Attorney for Healthcare (POAHC). A progress note, dated 4/2/25 at 3:14 PM, indicated the writer was informed by staff that R32 had discoloration on the bilateral wrists. Upon assessment, the writer noted R32's wrists contained purplish, red/brown discoloration. R32 denied pain to the areas. The writer was informed by a Hospice Certified Nursing Assistant (CNA) that the discoloration had come and gone over the past few weeks and the Hospice nurse was aware. The Hospice nurse also verified the discoloration had come and gone over the past few weeks and indicated the discoloration was senile purpura. R32 was interviewed and stated R32 felt safe. The note indicated staff would continue to monitor R32's arms due to R32 having increased negative behavior toward staff with cares. A progress note, dated 4/3/25 at 2:30 PM, indicated Hospice staff were in R32's room doing AM cares when the writer was called into the room and shown R32's left arm which had previous bruising. A raised hematoma that measured 9 centimeters (cm) x 10 cm was noted on the left side of R32's outer forearm. R32 had no complaints of pain or discomfort. R32 refused ice and was combative with staff. The Director of Nursing (DON) was notified. On 4/3/25, the facility began an investigation for R32's injury of unknown origin. The facility interviewed R32 and all staff who worked with R32 on 4/2/25 and 4/3/25. The facility also contacted R32's POAHC who indicated R32 was combative during a visit on 4/2/25 and hit R32's arms on the bed. The facility contacted Hospice and discontinued R32's anticoagulant therapy (which can increase bruising). In addition, R32 was wearing geri-sleeves on each arm to protect R32's arms/skin. The investigation did not include interviews with other residents to rule out abuse. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/21/25 at 2:25 PM, Surveyor interviewed DON-B who indicated the facility completed an internal investigation for R32's injury of unknown origin. DON-B verified the facility did not interview other residents to rule out abuse.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43361 Based on staff interview and record review, the facility did not revise a care plans in accordance with current care needs for 1 resident (R) (R32) of 15 sampled residents. R32's care plan was not updated to include calling R32 by R32's preferred names. R32's care plan was also not updated when R32 incurred an injury of unknown origin and geri-sleeves were implemented to protect R32's skin. Findings include: From 4/21/25 to 4/23/25, Surveyor reviewed R32's medical record. R32 was admitted to the facility on [DATE] and had diagnoses including dementia, adult failure to thrive, and palliative care. R32's Admission Minimum Data Set (MDS) assessment, dated 2/5/25, had a Brief Interview for Mental Status (BIMS) score of 3 out of 15 which indicated R32 had severely impaired cognition. R32 had an activated Power of Attorney for Healthcare (POAHC). On 4/21/25 at 1:15 PM, Surveyor interviewed Certified Nursing Assistant (CNA)-C who indicated when R32 was first admitted , staff called R32 by a shortened version of R32's name. CNA-C indicated R32 also told staff to call R32 grandma which staff sometimes did. CNA-C indicated R32 could be behavioral during cares and sometimes calling R32 grandma helped calm R32. CNA-C indicated one of R32's family members heard CNA-C call R32 grandma when they visited. CNA-C indicated R32's family member stated staff should not call R32 grandma because R32 was not their grandma and R32 did not like that. CNA-C told Assistant Director of Nursing (ADON)-D and the Social Worker (SW) who were going to talk to R32's POAHC. CNA-C was not sure of the outcome of the conversation and indicated CNA-C no longer calls R32 grandma. On 4/21/25 at 2:23 PM, Surveyor interviewed ADON-D who indicated ADON-D was working on the evening that CNA-C called R32 grandma and R32's family member got upset. ADON-D indicated the facility contacted R32's POAHC to explain what happened and that it sometimes helps if staff call R32 grandma when R32 is having difficulty with cares. R32's POAHC gave approval for staff to call R32 grandma if it helped. R32's medial record indicated R32 had an injury of unknown origin that was discovered on 4/3/25. The facility completed an investigation for R32's injury. R32 was known to be combative at times. The investigation indicated R32 was combative, swung R32's arms, and hit R32's arms on the bed during a visit with R32's POAHC. The facility, in conjunction with Hospice staff, initiated geri-sleeves (sleeves worn to protect skin) to protect and prevent injury to R32's skin. On 4/21/25, Surveyor reviewed R32's plan of care and noted there were no care plan updates related to the preferred names staff should call R32 or that R32 should wear geri-sleeves on the bilateral upper extremities. On 4/21/25 at 2:23 PM, ADON-D indicated the facility had not yet care planned the information. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/21/25 at 2:25 PM, Surveyor interviewed Director of Nursing (DON)-B who confirmed R32's care plan was not updated to include the preferred names staff should call R32 or that R32 should wear geri-sleeves on both arms to protect R32's skin. DON-B confirmed R32's care plan should have been updated.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45943 Based on observation, staff interview, and record review, the facility did not ensure 3 residents (R) (R7, R12, and R186) of 17 sampled residents received assistance as needed to complete activities of daily living (ADLs). R7 did not receive assistance with positioning, toileting, and breakfast. R12 did not receive weekly showers. In addition, the facility did not address R12's request for more showers. R186 did not receive a shower while at the facility. Findings include: The facility's Activities of Daily Living (ADLs) policy, dated 12/2024, indicates: Care and services will be provided for the following ADLs: 1. Bathing, dressing, grooming, and oral care; 2. Transfer and ambulation; 3. Toileting; 4. Eating to include meals and snacks .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 .5. The facility will maintain individual objectives of the care plan. The facility's Resident Showers policy, dated 12/2024, indicates: It is the practice of this facility to assist residents with bathing to maintain proper hygiene, stimulate circulation, and help prevent skin issues as per current standards of practice .1. Residents will be provided showers per request or the facility's schedule protocol and based upon resident safety . 1. From 4/21/25 to 4/23/25, Surveyor reviewed R7's medical record. R7 was admitted to the facility on [DATE] and had diagnoses including Alzheimer's disease, dementia, diabetes, moderate protein calorie malnutrition, and dysphagia. R7 received Hospice services. R7's Minimum Data Set (MDS) assessment, dated 3/5/25, indicated R7 required staff assistance with eating set up, substantial/maximal assistance with rolling left and right, and substantial/maximal assistance with toileting. The MDS assessment also indicated R7 had a Brief Interview for Mental Status (BIMS) score of 6 out of 15 which indicated R7 had severe cognitive impairment. R7 had a Guardian for healthcare decisions. A care plan (initiated 5/5/22) indicated R7 had an ADL self care performance deficit related to immobility, overall decline, and decreased motivation. The care plan contained the following interventions: Bed mobility: Requires substantial/maximal assistance with lying to sitting on end of bed, sitting to lying, and rolling left and right; Eating: May have meals/snacks/drinks independently in room with frequent visual checks at mealtime to ensure safety; and Toilet use: Requires two-person assistance .and is dependent for toileting hygiene. A care plan (initiated 8/9/24) indicated R7 had the potential for pressure ulcer development related to incontinence and spending a lot of time in bed. The care plan contained an intervention for R7 to be repositioned every two hours while in bed as tolerated. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A care plan (initiated 5/5/22) indicated R7 was at high nutritional risk secondary to protein calorie malnutrition, Hospice care, Alzheimer's disease, kidney disease, and diabetes. The care plan contained an intervention to monitor/document/report to MD as needed for signs and symptoms of dysphagia: pocketing, choking, coughing, drooling, holding food in mouth, several attempts at swallowing, refusing to eat, and if appears concerned during meals. On 4/21/25 at 10:27 AM, Surveyor observed R7 in bed. Surveyor noted R7 was leaning to the right side and had slid to the bottom of the bed. R7 indicated R7 was not comfortable. On 4/23/25 at 8:30 AM, Surveyor observed R7 in bed with the head of the bed elevated 45 degrees. R7 was leaning to the right side. Surveyor noted R7's breakfast tray was not set up and was in front of R7 untouched. The tray contained a plate of food that was uncovered, however, R7's milk, orange juice, and cereal were still covered. On 4/23/25 at 9:31 AM, Surveyor observed R7 in bed with the head of the bed elevated 45 degrees. R7 was leaning to the right side with R7's head touching the right bed rail. R7's breakfast tray was still untouched and not set up for breakfast. On 4/23/25 at 9:36 AM, Surveyor interviewed Certified Nursing Assistant (CNA)-C who stated breakfast trays are usually delivered around 8:00 AM. CNA-C indicated dietary staff were supposed to bring in the tray and remove covers from the plate, liquids, and cereal. CNA-C indicated R7 liked to sleep in and usually did not touch R7's breakfast tray until between 9:30 and 10:00 AM. CNA-C also indicated R7 was repositioned every two hours by CNAs or Hospice staff. CNA-C was assigned to R7 that shift and indicated the AM shift started at 6:00 AM. CNA-C stated CNA-C had not yet turned, repositioned, or checked and changed R7 or checked to see if R7 was eating. On 4/23/25 at 9:43 AM, Surveyor interviewed Assistant Director of Nursing (ADON)-D who indicated ADON-D observed dietary staff pass by with trays approximately 30 minutes ago. ADON-D indicated dietary staff typically set up R7's tray. ADON-D indicated R7 had a history of non-compliance with eating in an upright position and a history of aspiration and recent pneumonia. ADON-D indicated R7 should be repositioned by facility CNAs or the Hospice aide. ADON-D had not observed Hospice with R7 yet that day. ADON-D reviewed orders (dated 9/26/24) that indicated R7 could eat meals and snacks in R7's room unsupervised (discussed with Guardian) and staff should frequently check on R7 during meals and snacks. ADON-D stated CNAs should have offered and/or done repositioning by that time. On 4/23/25 at 10:15 AM, Surveyor interviewed CNA-C who stated R7 was just repositioned and changed for the first time that shift. CNA-C indicated R7 was having difficult eating cereal so another staff was assisting R7 with eating. On 4/23/25 at 3:14 PM, Surveyor interviewed Director of Nursing (DON)-B who indicated staff should check, change, and reposition R7 every 2-3 hours. DON-B indicated most residents are checked, changed, and repositioned before and after meals and before shift change on the AM and PM shifts unless care planned for every 2 hours like R7. DON-B verified the AM shift starts at 6:00 AM and confirmed staff should have checked, changed, and repositioned R7 before 9:36 AM and set up R7's tray before 10:15 AM. DON-B indicated meal set up includes removing covers. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/23/25 at 3:24 PM, Surveyor interviewed Licensed Practical Nurse (LPN)-E who indicated LPN-E heard R7 call out at approximately 9:36 AM and checked on R7. With the assistance of Clinical Market Leader (CML)-G, LPN-E checked, changed, and repositioned R7 who was incontinent of a medium amount of urine and a smear of stool. LPN-E indicated R7's condom catheter was not in place. LPN-E reheated R7's plate of food and removed covers from R7's oatmeal and liquids. CML-G assisted R7 with eating oatmeal. LPN-E indicated R7 required assistance with eating at times due to confusion and a history of swallowing issues. R7's Guardian had signed a diet non-compliance form to liberalize R7's diet for comfort when R7 started Hospice services. LPN-E agreed with DON-B that R7 should have been checked, changed, repositioned, and set up, assisted, or frequently checked on during eating. 49010 2. From 4/21/25 to 4/23/25, Surveyor reviewed R12's medical record. R12 was readmitted to the facility on [DATE] and readmitted again on 4/2/25 after a three-day discharge. R12 had diagnoses including traumatic brain injury, urinary incontinence, urinary catheter, morbid obesity with alveolar hypoventilation, and urinary tract infection (UTI). R12's MDS assessment, dated 4/4/25, had a BIMS score of 15 out of 15 which indicated R12 was not cognitively impaired. The MDS assessment also indicated R12 required substantial/maximal assistance with showering/bathing, upper and lower body dressing, and putting on/taking off footwear. On 4/21/25 at 12:15 PM, Surveyor interviewed R12 who indicated R12 did not receive weekly showers and R12's scalp and hair were greasy. R12 indicated R12 would like to shower more than once weekly. R12 indicated R12 told staff that R12 needed to shower more than once per week but still did not receive regular showers. R12 indicated R12 was told staff have a lot of other residents to shower and were not able to give R12 a shower. On 4/22/25, Surveyor observed a grievance from R12, dated 1/6/25. The grievance indicated R12 wanted to shower two times per week. The grievance also indicated R12 wanted staff to wake R12 up and get R12 ready for breakfast daily. The action taken was listed as discussed with resident and staff. The summary of pertinent findings stated resident would like to be up for breakfast daily. The summary of the grievance did not mention R12's shower request. The corrective action taken was listed as Care plan and Kardex (an abbreviated care plan used by nursing staff) updated. Staff aware/updated. R12's plan of care (initiated 10/31/22) indicated R12 had an ADL self care performance deficit related to muscle weakness and fracture to right distal femur that was surgically repaired. The goal indicated R12 will maintain current level of function or improve in: bed mobility, transfers, eating, dressing, grooming, toilet use, and personal hygiene. The plan of care contained the following intervention: Bathing: R12 requires substantial/maximal assistance with shower transfer and requires substantial/maximal assistance with showering and bathing (initiated 1/10/23). Surveyor noted there was not an update to R12's care plan following the grievance request to shower twice per week. R12's Kardex also did not indicate R12 would like to shower twice weekly. On 4/23/25, Surveyor reviewed the facility's shower schedule which indicated R12 was scheduled for a shower on the Monday AM shift. The shower schedule was not updated for twice weekly showers. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/23/25 at 10:17 AM, Surveyor interviewed LPN-J who indicated LPN-J fills out a shower sheet for every resident shower. LPN-J indicated shower sheets need to be completed even if the resident refuses the shower and a nurse must still complete a skin check for the resident (which is documented on the shower sheet). LPN-J indicated shower sheets are given to DON-B. On 4/23/25 at 11:15 AM, Surveyor reviewed R12's shower sheets for 1/1/25 through 4/23/25. Surveyor noted 6 shower sheets dated 1/6/25, 1/13/25, 1/20/25, 3/10/25, 4/7/25, and 4/21/25. On 4/23/25 at 11:15 AM, Surveyor interviewed Nursing Home Administrator (NHA)-A who confirmed the 6 shower sheets received for R12 were the only shower sheets the facility had for R12 in 2025. On 4/23/25 at 1:14 PM, Surveyor interviewed DON-B who indicated residents should be offered showers at least once weekly. DON-B indicated staff need to fill out a shower sheet or a refusal sheet and a nurse needs to complete a skin check even if the resident did not receive a shower. DON-B indicated if a resident files a grievance indicating they would like two showers per week, the resident should be offered two showers per week. DON-B also indicated the shower schedule, care plan, and Kardex should be updated with the twice weekly schedule. Surveyor and DON-B discussed R12's shower request, grievance, and the 6 shower sheets for R12. When asked why there were only 6 showers for R12 and why R12's care plan and Kardex and shower schedule were not updated after R12 filed a grievance, DON-B indicated there was a break in the system. On 4/23/25 at 2:44 PM, Surveyor interviewed NHA-A who indicated residents should be offered weekly showers. NHA-A indicated R12's shower grievance should have been completed and R12 should have been offered twice weekly showers. NHA-A indicated R12's care plan, Kardex, and shower schedule should have been updated to twice weekly showers. NHA-A also indicated there should have been audits to ensure the grievance was addressed and R12's expectations were met. 3. From 4/21/25 to 4/23/25, Surveyor reviewed R186's medical record. R186 was readmitted to the facility on [DATE] and had diagnoses including methicillin-resistant Staphylococcus aureus (MRSA) infection, epilepsy, morbid obesity, above knee right leg amputation, urinary retention, and urinary tract infection. R186's MDS assessment, dated 4/10/25, indicated R186 required substantial/maximal assistance with showering/bathing, upper and lower body dressing, and putting on/taking off footwear. The MDS assessment had a BIMS score of 10 out of 15 which indicated R186 had moderately impaired cognition. On 4/21/25 at 12:53 PM, Surveyor interviewed R186 who indicated R186 would like a shower. R186 indicated R186 had not been offered a shower since R186 was admitted to the facility two weeks prior. R186's plan of care indicated R186 had an ADL self care performance deficit related to weakness, physical deconditioning, pain, and right above the knee amputation (initiated 4/8/25). The plan of care contained a goal that R186 will safely perform ADLs through the review date. The plan of care contained the following intervention: Bathing (Shower/Bath Self): The resident ranges from being independent to requiring partial/moderate assistance with personal hygiene (initiated 4/8/25). Surveyor noted R186's MDS assessment and plan of care contained conflicting information on the level of assistance R186 needed for showers/bathing. On 4/23/25, Surveyor reviewed the facility's shower schedule which indicated R186 was scheduled for a shower on the Monday PM shift. (continued on next page)

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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 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/23/25 at 10:17 AM, Surveyor interviewed LPN-J who indicated LPN-J fills out a shower sheet for every resident shower. LPN-J indicated shower sheets need to be completed even if the resident refuses the shower and a nurse must still complete a skin check for the resident (which is documented on the shower sheet). LPN-J indicated shower sheets are given to DON-B. On 4/23/25, Surveyor requested shower sheets for R186 since R186's admission on 4/8/25. On 4/23/25 at 11:15 AM, NHA-A indicated there were no shower sheets, refusals, or skin check sheets for R186. On 4/23/25 at 1:14 PM, Surveyor interviewed DON-B who indicated residents should be offered showers at least once weekly. DON-B indicated staff need to fill out a shower sheet or a refusal sheet and a nurse needs to complete a skin check even if the resident did not receive a shower. DON-B indicated a resident should be assigned a shower day upon admission. DON-B reviewed R186's medical record and confirmed there were no skin checks completed. DON-B indicated it was not acceptable that R186 had not received a shower since admission. On 4/23/25 at 2:44 PM, Surveyor interviewed NHA-A who indicated residents should be offered weekly showers.