STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525350	A. Building B. Wing	10/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ocoee Colby Healthcare Center LLC	702 W Dolf St Colby, WI 54421

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** 39713 Based on interview and record review, the facility did not ensure that residents receive treatment and care in accordance with professional standards of practice, the Comprehensive Person-Centered Care Plan, and the residents' choices for 1 of 3 sampled residents (R2). R2 had 4 tarry red stools between 11:00 AM and 1:00 PM on 8/31/24. R2's vitals were not monitored. There is no documentation of red tarry stools or physician notification until R2 was sent to the emergency roiagnom on [DATE] at 1:58 AM. This is evidenced by: Facility policy titled, Acute Condition Changes - Clinical Protocol, last revised, 3/2018, states in part . 2. In addition, the nurse shall assess and document/report the following baseline information: a. vital signs. g. onset, duration, severity. 7. Before contacting a physician about someone with an acute change of condition, the nursing staff will collect pertinent details to report to the physician. 8. The nursing staff will contact the physician based on the urgency of the situation. For emergencies, they will call or page the physician and request a prompt response (within approximately one-half hour or less). 10. The nurse and physician will discuss and evaluate the situation. a. The physician should request information to clarify the situation; for example, vital signs, physical findings, and detailed sequence of events and descriptions of symptoms. Facility policy titled, Change of a Resident's Condition or Status, last revised 5/2017, states in part . Policy Statement: Our facility shall promptly notify the resident, his or her Attending Physician, and representative (sponsor) of changes in the resident's medical/mental condition and/or status. Policy Interpretation and Implementation: 1. The nurse will notify the resident's Attending Physician or physician on call where there has been a(an): d. significant change in the resident's physical/emotional/mental condition; i. specific instructions to notify the Physician of changes in the resident's condition. 2. A significant change of condition is a major decline or improvement in the resident's status that: a. Will not normally resolve itself without intervention by staff or by implementing standard disease related clinical interventions (is not self-harming); 5. Except in medical emergencies, notifications will be made within twenty-four (24) hours of a change occurring in the resident's medical/mental condition or status. 8. The nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interact Version 4.5 Tool for Change in Condition: When to report to the MD/NP/PA, states in part . Immediate Notification: Any symptom, sign or apparent discomfort that is: Acute or Sudden in onset, and: A Marked Change (i.e., more severe) in relation to usual symptoms and signs, or Unrelieved by measures already prescribed. Blood Pressure: Systolic BP (blood pressure) > (greater) 200 mmHg or < (less than) 90 mmHg. Diastolic BP >115 mmHg. Facility document titled, [Oak Medical] Onsite Physician Services, states in part . What should be placed in the binder: 1. non-urgent paperwork. 2. DNR (do not resuscitate) consents. 3. Discharge paperwork. 4. Therapy certs. 5. Pharmacy Recommendations. 6. Papers that need signed by MD (medical doctor) only. What should NOT be placed in the binder: 1. Anything urgent/stat. 2. Lab/Diagnostic results-these should be communicated through Hucu.ai (Hucu.ai provides facilities with HIPAA compliant instant messaging for internal facility use, but also allows facilities to securely communicate with network partners, patients, and approved patient's family members in one universal system. It also can be integrated into your EHR to further improve your staff's efficiencies. It comes with built-in capabilities that streamlines communication across different staff/collaborators working in different organizations but caring for the same patients.) 3. Controlled substance refills-these should be communicated through Hucu.ai. Send HUCU Message URGENTLY IF . Vitals: SBP (systolic blood pressure) >200 or <90; DBP (diastolic blood pressure) >120 or <50. Change of Condition: Symptoms that need immediate addressing. According to AMDA (American Medical Directors Association) Guidelines, acute change of condition, protocols for Physician Notification, states in part . Bleeding, rectal ((melena) - dark stools with or without blood)). Immediate Notification: Persistent, or accompanied by diaphoresis, tachycardia, significant orthostatic BP drop. Non-Immediate: Recent self-limited bleeding, tarry stool, or melena without change in vital signs. R2 was admitted to the facility on [DATE], with diagnoses, including, but not limited to, ankylosing spondylitis of thoracic region, dementia, polyp of stomach and duodenum, gastrointestinal hemorrhage, low back pain, and malaise. R2's most recent quarterly MDS (Minimum Data Set) with ARD (Assessment Reference Date) of 9/10/24 indicates R2 has moderate cognitive impairment with a BIMS (Brief Interview for Mental Status) score of 10 out of 15. R2's care plan states in part . Focus: Risk for Impaired Circulatory-orthostatic hypotension, CAD (coronary artery disease), hyperlipidemia, HTN (hypertension). Revision on: 8/12/24 Interventions: Encourage oral fluid intake, maintain hydration. Date Initiated: 8/08/24. Evaluate heart rate. Date Initiated: 8/08/24. Focus: The resident has anemia r/t (related to) GI (gastrointestinal) bleed, gastric polyps, duodenal polyn, HX (history) GI bleed. Date Initiated: 8/28/24. Revision on: 9/30/24. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interventions: Monitor/document/report PRN (as needed) following s (signs)/sx (symptoms) of anemia: Pallor, Fatigue, Dizziness, Syncope, Headache, Palpitations, Weakness, fell ing of cold, Low Hgb (hemaglobin)/hct (hematocrit), SOB (shortness of breath) on exertion, Sore tongue, Chest pain, Tinnitus, Headache, changes in condition. Date Initiated: 8/28/24. Note: Care plan does not include monitoring for bleeding. R2's eMAR (electronic medical record), states in part . ASA (Aspirin) 81 mg (milligrams). Give 1 tablet by mouth one time a day related to Atherosclerotic heart disease of native coronary artery w/o (without) angina pectoris. Start Date: 8/02/24. Facility document titled, Weights and Vitals Summary, Blood Pressure Summary states in part . 8/31/24 at 8:22 AM, Blood Pressure: 116/52 (sitting l (left)/arm) 8/31/24 at 2:23 PM, Blood Pressure: 116/57 (sitting r (right)/arm) 8/31/24 at 3:26 PM, Blood Pressure: 110/38 (sitting l/arm) 8/31/24 at 2:23 PM, O2 sats (saturation): 95% (percent) 8/31/24 at 2:23 PM, Pulse: 70 (regular) 8/31/24 at 2:23 PM, Respirations: 20 Breaths/min (minute) 8/31/24 at 2:23 PM, Temperature: 97.2 (Temporal Artery) Note: Blood pressure on 8/31/24 at 3:26 PM was outside of parameters and not reported to the physician. Nurses Note, dated 9/01/24 at 1:58 AM, states, Hello, resident with 4 tarry red stools earlier between 1100 (11:00 AM) - 1300 (1:00 PM) today. BP reading this morning 112/38. On assessment, writer took residents BP manually, getting readings of 118/>20, because the gauge stopped reading. She is very pale. Denies pain. Above information related to PA, who requests a stat H&H (hemoglobin and hematocrit). When informed we would be unable to do this in our facility, and this was discussed with [name], who does want evaluated in ED (emergency department). [Name] okay with this plan. 911 called; resident left facility via ambulance to [hospital name] at 2100 (9:00 PM). Report called to RN (registered nurse). Hospital Discharge Summary, dated 9/03/24, states in part . Discharge Diagnosis: Dark stools. Hospital Course/Treatment Rendered: [AGE] year-old female past medical history significant for upper GI bleed 2/2 gastric polyps, CAD (coronary artery disease), with pacemaker, HTN, dementia, orthostatic hypotension, HF (heart failure), gout, E.coli sepsis, liver cirrhosis, stomach and duodenal polyp, previous GI bleed history evaluated in the ED due to black stools. She was recently discharged on ,d+[DATE] after being evaluated for possible GI bleed. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/7/24 at 3:05 PM, Surveyor interviewed ADON C and NHA A. Surveyor asked ADON C what SOP (standard of practice) the facility for physician notification. ADON C stated, we use [Name] Onsite Physician Services. On 10/7/24 at 3:30 PM, Surveyor asked ADON C and UM (unit manager)/RN D (registered nurse) when notification would be appropriate for rectal bleeding or dark tarry stools. ADON C stated, I would update after a second episode, would look at the patient history. UM/RN D stated, I would have updated after the first red tarry stool. Surveyor asked UM/RN D about R2's blood pressure reading from 8/31/25 at 2:35 PM. UM/RN D stated, someone should have contacted the physician with that blood pressure reading. On 10/7/24 at 4:15 PM, Surveyor interviewed RN F. Surveyor asked RN F what the protocol was for a change of condition. RN F stated, we have a system called Hucu to talk with physician or NP (nurse practitioner) via message board on the computer. We would complete an assessment and send the information. Within 10 minutes we get an answer. If an emergency can call [doctor's name], he is everyone's physician. We have his cell number. We also have a binder and guidelines for Hucu and there is always a nurse manager on call. On 10/7/24 at 4:30 PM, Surveyor interviewed LPN E (licensed practical nurse). Surveyor asked LPN E what the protocol was notification for a change of condition. LPN E stated, notify the physician via Hucu message board. If a severe change of condition would call immediately. The facility failed to update the physician when R2 had 4 red tarry stools and blood pressure reading was outside parameters. The facility did not monitor R2's vital signs regular following her red tarry stools.