Department of Health & Human Services
Centers for Medicare & Medicaid Services

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525358	A. Building B. Wing	08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Florence Health Services	5778 Chapin St Florence, WI 54121

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30570 Based on interview and record review, the facility did not promptly notify and consult with a resident's physician when there was deterioration in a resident's clinical condition. This occurred for 1 of 3 residents (R) R1, reviewed for change in condition. R1 presented with symptoms of low blood pressure and weakness on 5/30/24 at 9:43 a.m. R1 had symptoms of vomiting and diarrhea from approximately 3:30-4:00 p.m. to 7:00 p.m. when R1 was transferred to the emergency room . R1's physician was not consulted between when episodes of vomiting and diarrhea occurred. Findings include: The facility policy, entitled Change of Condition of the Resident revision date 9/20/2022, states: Policy: Facility should . consult with the physician .when there is a .significant change in the resident's physical . status in either life-threatening condition or clinical complications. Policy Explanation and compliance Guidelines: When a resident presents with a possible change in condition .Notify the residents physician. Immediate notification: Immediate notification for any symptom, sign or apparent discomfort that is: ~Acute of sudden onset and: ~A marked change (i.e., more severe) in relation usual symptoms and signs or ~Unrelieved by measures already prescribed . R1 was admitted to the facility on [DATE] with diagnoses that included in part, malignant neoplasm of esophagus, dysphagia and encounter for attention gastrostomy. R1 was his own decision maker and had elected DNR (Do not resuscitate). R1's POLST (physician orders for life sustaining treatment) indicated: DNR (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Limited Additional Interventions: do not intubate Antibiotics: use aggressive antibiotic treatment Artificially Administered Nutrition/Hydration: long term nutrition/hydration Summary of goals: discussed with patient/resident The basis for these orders is patients/residents: request, known preference R1's nurse progress notes in part read: ~5/30/24 4:15 AM: CNA (Certified Nursing Assistant) reports resident doesn't seem like himself, when assisting to sit at bedside resident very rigid and difficult to move, felt warm to touch, phlegm noted on right side of his shirt, thick yellow phlegm, temp 98.2, BP: 78/48 58, assisted to standing at bedside with 2 assist and walker when ambulated to the bathroom, rechecked BP when resident back in bed 98/50, 114, will cont to monitor and update POA (Power of Attorney) in AM . ~5/30/24 8:08 AM: Zofran oral tablet 4 mg: give 4 mg via g-tube every 8 hours as needed for nausea, vomiting: given for nausea ~5/30/24 9:43 AM: Resident B/P 82/54, Pm 110, R 18, 02 96% RA. Resident is weak and was incontinent of bm. Residents daughter called at 8:30 am for update on low B/P's and resident not feeling well. Resident refuses to go to the hospital and stated What for resident is now lying in bed with his head elevated. Resident is coughing up yellow mucous, LSCTA (lung sounds clear to auscultation). Will monitor. On 8/15/24 at 7:30 a.m., Surveyor interviewed Nursing Home Administrator in training (NHA/DON) B who was the Director of Nursing on 5/30/24 about R1 and his change of condition. NHA/DON B was joined by [NAME] President of Success (VPS) C. NHA/DON B indicated on 5/30/24 the day shift nurse had informed her R1 was having low blood pressure. NHA/DON B expressed after the morning meeting around 9:30 a.m. she reviewed R1's nurses notes and called R1's physician who directed the facility to hold R1's blood pressure medications and to send R1 out to be evaluated. NHA/DON B expressed she spoke with R1 about the concern of low blood pressure and his physician consultation regarding going into the hospital to be evaluated but failed to document the consultation in R1's medical record. NHA/DON B further indicated R1 did not want to go into the hospital for evaluation. Nurses Progress notes continued: ~5/30/24 11:37 AM Zofran oral tablet 4 mg: PRN (as needed) administration was effective ~5/30/24 7:00 PM: resident has been vomiting and has had diarrhea at least 5-6 times so far this shift. Residents' daughter is here. She is asking for resident to be transferred to the hospital. Resident was asked if he wanted to go to the hospital earlier today, and he refused. He is now in agreement to go. DON (Director of Nursing) notified. Paperwork to be started. ~5/30/24 7:33 PM: called MMC-D and report on resident given to RN (Registered Nurse) in ED (Emergency Department). (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	~5/30/24 7:50 PM: resident left via ambulance to emergency room . On 8/15/24 at 7:30 a.m., Surveyor interviewed NHA/DON B about the above events. NHA/DON B stated on the p.m. shift R1 had vomiting and 5-6 bouts of diarrhea from start of shift at 2:00 p.m. to 7:00 p.m. At approximately 7:00 p.m., R1's daughter came into the facility and convinced R1 to go to the hospital at which point R1's physician was contacted, and an order was obtained to send R1 out for evaluation. NHA/DON expressed she did not make note of R1's physician consultation in R1's record when she consulted the physician about R1's low blood pressure on 5/30/24 at approximately 9:30 a.m. NHA/DON B further expressed R1's physician was not consulted again until R1 decided to be transferred to the hospital. Nursing staff should have consulted R1's physician after his symptoms of vomiting and diarrhea started. R1's physician should have been consulted as this was new onset of symptoms. On 8/15/24 at 10:28 a.m., Surveyor interviewed Licensed Practical Nurse (LPN) E who worked the p.m. shift of 5/30/24 about R1's change in condition. LPN E reported R1 did not have vomiting at start of the pm shift on 5/30/24. LPN E reported R1 kept having episodes of vomiting and diarrhea 5-6 times with staff having to take him to the bathroom. The vomiting and diarrhea started somewhere around med pass start time of 3:30-4:00 p.m. R1 stayed in bed and is usually up in his recliner. LPN E indicated she unhooked his g-tube feeding, listened to his bowel, checked his vitals and skin turgor. LPN E indicated she could not recall if she documented this but believed this was done around 4:00 p.m. LPN E expressed R1 didn't seem dehydrated but she did not conduct a formal hydration assessment. LPN E indicated R1 did not want to go into the hospital until his daughter came into visit at which time she called the physician and got an order to send R1 in. LPN E expressed she did not make any previous contact with R1's physician to consult about his symptoms until R1 decided to go into the hospital. On 8/20/24 at 12:23 p.m., Surveyor interviewed Physician/Medical Director (MD) F about the facility consultation regarding R1 on 5/30/24. MD F expressed the facility had notified him the morning of 5/30/24 on R1 having unstable blood pressures. The facility indicated R1 was his own decision maker, had elected DNR and was adamant about not going into the hospital for evaluation and treatment earlier in the day. MD F recalls the facility contacted MD F later that day; at some point informing him R1's daughter had convinced R1 to go into the hospital. MD F gave an order for transfer for evaluation and treatment at that point. MD F indicated the symptoms of repeated episodes of vomiting and diarrhea were not reported to him, until the call around 7:00 p.m.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30570 Based on record review, the facility did not ensure that a comprehensive person centered care plan was developed for 1 of 5 sampled residents (R) R1. R1 was admitted to the facility on [DATE] with diagnoses that included in part, malignant neoplasm of esophagus and was undergoing chemotherapy treatment. The facility did not develop a care plan to address R1's increased risk for infection, risk for dehydration or abnormal lab values with increased need for monitoring related to his diagnosis and chemotherapy treatments. This is evidenced by: Surveyor requested and received the facility policy titled Comprehensive Care Plan dated as most recently revised on 9/23/2022. The policy in part reads: Policy: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with residents rights, that includes measurable objectives and timeframes to meet resident's medical, nursing, and mental and psychosocial needs that are identified in the residents comprehensive assessment. Policy Explanation and Compliance Guidelines: ~The care planning process will include an assessment of the residents' strengths and needs and will incorporate the residents personal and cultural preferences in developing goals of care . ~The comprehensive care plan will describe in minimum: The services that are to be furnished to attain or maintain the residents highest practicable physical, mental, and psychosocial well-being. ~Resident specific interventions that reflect the residents needs and preferences. ~The comprehensive care plan will be prepared by an interdisciplinary team that includes but is not limited to: attending physician or non-practitioner designee .A registered nurse with responsibility for the resident, a nurse aide with responsibility for the resident, a member of the food and nutrition services staff, the resident and the residents representative, to the extent possible and other appropriate staff or professionals . Review of R1's record shows R1 was admitted to the facility on [DATE] with diagnoses that included in part, malignant neoplasm of esophagus. R1's record shows physician appointment, treatments and labs as follows: 5/15/24 Family Medicine: Currently under direction of physician with HSHS oncology. Received R-Chop a modified regime with first cycle on 4/22/24 .He is scheduled to receive his second cycle . Plan: Follow with HSHS oncology scheduled labs with them. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5/21/24 Consultation/Clinic Referral: Progress note .Proceed w/#2 cycle chemo, rchop given today (R-Chop is a chemotherapy regimen given to treat lymphoma). New orders with stop dates: RTC (return to clinic) in 3 weeks with labs and planned #3 cycle of chemo than scans. 5/21/24 After Visit Summary: CBC (complete blood count) shows: (WBC) [NAME] blood count 10.2 elevated with reference range of normal (3.90-9.90) (RBC) Red blood count low 3.02 with a reference range of normal (4.42-5.68) (HGB) Hemoglobin low 10.4 with a reference range of normal (13.7-16.7) (HCT) Hematocrit low 33.5 with a reference range of normal (40.5-49.2) (MCV) Mean Corpuscular Volume high 111.0 with a reference range of normal (80-96) (MCH) Mean Corpuscular Hemoglobin high 34.6 with a reference range of normal (27-33) (MCHC) Mean Corpuscular Hemoglobin concentration low 31.2 with a reference range of normal (32-36) (RDW) Red Cell Distribution high 14.9 with a reference range of normal (10.5-13.5) Lymphocytes low 9.4 with a reference range of normal (15-40) Monocytes high 13.3 with a reference range of normal (3.1-9.3) ABS Neutrophils high 7.51 with a reference range of normal (1.8-6.4) (BUN) blood urea nitrogen high 57 with a reference range of normal (7-18) Creatine high 1.31 with a reference range of normal (0.70-1.30) BUN Creatinine high 43.5 with a reference range of normal (10.0-20.0) Albumin low 2.7 with a reference range of normal (3.4-5.0) The lab values above have several results that are abnormal with either high or low findings. Surveyor reviewed R1's care plan. The care plan did not address his increased risk for infection, risk for dehydration or abnormal lab values with increased need for monitoring related to his chemotherapy treatments. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/20/24 at 9:46 am, Surveyor interviewed Nursing Home Administrator in training who was the Director of Nursing (NHA/DON) B about the facility's expectation related to the development of a care plans related to R1's cancer diagnosis and chemotherapy treatment. NHA/DON B expressed she would expect the facility to develop a care plan to direct nursing staff on the monitoring of R1's condition, including what to expect for signs and symptoms related to chemotherapy treatment, monitoring for infections and when to reach out to R1's physician or oncologist. R1 did not have a care plan developed for this and should have.

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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** 30570 Based on interview and record review, the facility did not comprehensively assess resident medical status with a change in resident's clinical condition. This occurred for 1 of 3 residents (R1) reviewed for change in condition. R1 presented with symptoms of low blood pressure and weakness on [DATE] at 9:43 a.m. R1 had new onset of vomiting and diarrhea noted on [DATE] on the p.m. shift without a comprehensive nursing assessment of his clinical condition from 9:43 a.m. until his time of transfer to the hospital at approximately 7:00 p.m. Findings include: The facility policy, entitled Change of Condition of the Resident revision date [DATE], states: Policy Explanation and compliance Guidelines: When a resident presents with a possible change in condition . noted changes in mental physical functioning: Assess/evaluate the resident. This assessment/evaluation could include; but is not limited to: ~Vital signs, oxygen saturation, blood glucose level ~Personality, behavioral and/or cognitive changes ~Alteration in level of consciousness, ability to respond ~Bowel and bladder control ~Sensory weakness or change ~Generalized or localized weakness ~Gait, posture or balance change ~Reflexes, response to stimuli, neurological signs Monitor the resident's condition frequently until stable or transported to a higher level of care if needed. R1 was admitted to the facility on [DATE] with diagnoses that included in part, malignant neoplasm of esophagus, dysphagia and encounter for attention gastrostomy. R1 was his own decision maker and had elected DNR (Do not resuscitate). R1's record shows physician appointment, treatments and labs as follows: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	[DATE] Family Medicine: Currently under direction of physician with HSHS oncology. Received R-Chop a modified regime with first cycle on [DATE] .He is scheduled to receive his second cycle . Plan: Follow with HSHS oncology scheduled labs with them. [DATE] Consultation/Clinic Referral: Progress note .Proceed w/#2 cycle chemo, rchop given today (R-Chop is a chemotherapy regimen given to treat lymphoma). New orders with stop dates: RTC (return to clinic) in 3 weeks with labs and planned #3 cycle of chemo than scans. R1's nurse progress notes in part read: ~[DATE] 4:15 AM: CNA (Certified Nursing Assistant) reports resident doesn't seem like himself, when assisting to sit at bedside resident very rigid and difficult to move, felt warm to touch, phlegm noted on right side of his shirt, thick yellow phlegm, temp 98.2, BP: ,d+[DATE] 58, assisted to standing at bedside with 2 assist and walker when ambulated to the bathroom, rechecked BP when resident back in bed , d+[DATE]-114, will cont to monitor and update POA (Power of Attorney) in AM. ~[DATE] 7:14 AM: Metoprolol Tratrate oral tablet 50 mg: Give 1 tablet via g-tube for HTN (hypertension) hold if SBP less than 100 or pulse less than 60. B/P below parameters. ~[DATE] 7:16 AM: Enalapril Maleate oral tablet 20 mg: give 1 tablet via g-tube two times a day of HTN: B/P low ~[DATE] 8:08 AM: Zofran oral tablet 4 mg: give 4 mg via g-tube every 8 hours as needed for nausea, vomiting: given for nausea ~[DATE] 9:43 AM: Resident B/P ,d+[DATE], Pm 110, R 18, 02 96% RA. Resident is weak and was incontinent of bm. Residents daughter called at 8:30 am for update on low B/P's and resident not feeling well. Resident refuses to go to the hospital and stated What for resident is now lying in bed with his head elevated. Resident is coughing up yellow mucous, LSCTA (lung sounds clear to auscultation). Will monitor. ~[DATE] 11:37 AM Zofran oral tablet 4 mg: PRN (as needed) administration was effective ~[DATE] 7:00 PM: resident has been vomiting and has had diarrhea at least ,d+[DATE] times so far this shift. Residents daughter is here. She is asking for resident to be transferred to the hospital. Resident was asked if he wanted to go to the hospital earlier today, and he refused. He is now in agreement to go. DON (Director of Nursing) notified. Paperwork to be started. ~[DATE] 7:33 PM: called MMC-D and report on resident given to RN (Registered Nurse) in ED (Emergency Department). ~[DATE] 7:50 PM: resident left via ambulance to emergency room . (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE], at 7:30 a.m. Surveyor interviewed Nursing Home Administrator in training (NHA/DON) B who was the Director of Nursing on [DATE] about R1's change of condition and expected nursing assessment of his clinical condition. NHA/DON B was joined by [NAME] President of Success (VPS) C. NHA/DON B indicated on [DATE] the day shift nurse had informed her R1 was having low blood pressure. NHA/DON B expressed after the morning meeting around 9:30 a.m. she reviewed R1's nurses notes and called R1's physician informing him of R1's low blood pressure. No other nursing assessment was conducted or provided to R1's physician. R1's physician directed the facility to hold R1's blood pressure medications and to send R1 out to be evaluated. The blood pressure medications were held, and she spoke with R1 about his need to go into the hospital but R1 did not want to go in. R1 was administered Zofran for nausea which was effective. NHA/DON B expressed on the p.m. shift R1 had vomiting and ,d+[DATE] bouts of diarrhea from start of shift at 2:00 p.m. to 7:00 p.m. At approximately 7:00 p.m. R1's daughter came into the facility and convinced R1 to go to the hospital at which point LPN E completed the SNF/NF transfer form with an assessment of R1's vitals. NHA/DON B expressed she would have expected nursing staff to have conducted a comprehensive nursing assessment every ,d+[DATE] hours to evaluate R1's bowels and hydration status; including looking at his mouth/mucous membranes and looking at his skin integrity and cognition for hydration status, vital signs, and sharing all assessment results with R1's physician after his second bout of diarrhea. Nursing did not complete a comprehensive assessment or hydration status assessment. Medical record shows vitals were taken after R1 decided to go into the hospital. Medical record had no assessment of R1's hydration status. R1 expired in the hospital the next day. NHA/DON B provided Surveyor with R1's SNF/NF to hospital transfer form and R1's vital signs. Surveyor requested the hospital records from time of R1's admission on [DATE] to the time he expired. R1's SNF/NF to Hospital Transfer Form in part read: Reason for transfer: other: vomit, diarrhea, lethargic Relevant diagnosis: cancer Vital signs: B/P: ,d+[DATE], HR: 103, R: 20, Temp: 97.9, 02: 96.0 Code Status: DNR (do not resuscitate) Usual Mental Status: Alert, oriented, follows instructions Date of transfer: [DATE] at 7:15PM R1's Vitals Summary Notes for [DATE]: Respirations: [DATE] 1910: 20 breaths/minute Blood Pressure: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	7:14 am: ,d+[DATE] 7:09 pm: ,d+[DATE] 7:55 pm: ,d+[DATE] Pulse: 7:14 am: 110 bpm (beats per minute): regular 7:10 pm: 103 bpm (irregular-new onset) 7:55 pm: 103 bpm (irregular-new onset) The above blood pressure and pulse are not within normal limits and would require repeat assessments of R1. On [DATE] at 9:40 a.m. Surveyor interviewed Licensed Practical Nurse (LPN) D who worked the a.m. shift on [DATE] about R1's change in condition and comprehensive nursing assessment of R1's clinical condition. LPN D expressed she had received report from night shift that R1 was weak and nauseated. LPN D did not see these symptoms as new or unusual as R1 was receiving chemotherapy. That morning LPN D checked R1's vitals and R1's blood pressure was low. R1 was weaker and stayed in bed which was not normal. LPN D informed R1 he could go into the hospital and be evaluated and he stated, What for. R1 was given Zofran for his nausea and LPN D informed NHA/DON B. NHA/DON B looked at R1 but did not conduct an assessment. On [DATE] at 10:28 a.m., Surveyor interviewed LPN E who worked the p.m. shift of [DATE] about R1's change in condition and comprehensive nursing assessment of his clinical condition. LPN E reported R1 did not have vomiting at start of the p.m. shift on [DATE]. LPN E reported R1 kept having episodes of vomiting and diarrhea ,d+[DATE] times with staff having to take him to the bathroom, starting somewhere around med pass time 3:,d+[DATE]:00 p.m. R1 stayed in bed and is usually up in his recliner. LPN E indicated she unhooked R1's g-tube feeding, listened to his bowel, checked his vitals and skin turgor but could not recall is she noted the information in R1's record. LPN E expressed R1 didn't seem dehydrated, but a formal hydration assessment was not conducted. LPN E indicated R1 did not want to go into the hospital until his daughter came into visit at which time she called the physician, got an order to send him and took a set of vitals which were documented on the transfer form. NHA/DON B provided Surveyor with R1's Dehydration Risk Screener which was conducted on admission. NHA/DON B informed Surveyor the assessment dated [DATE] was the only assessment of R1's hydration status conducted by the facility. The evaluation shows on [DATE] R1 was not at risk for dehydration. NHA/DON B indicated nursing staff should have conducted a Dehydration Risk Screener after R1's second bout of diarrhea on [DATE] to evaluate R1's hydration status as part of their comprehensive nursing assessment. Surveyor reviewed the assessment and noted the following Instructions and areas to be evaluated: Instructions: Complete on admission, significant change in condition . (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's record showed no assessments of R1's condition from 9:43 a.m. until R1 was sent to the hospital. On [DATE] at 12:23 p.m., Surveyor interviewed Physician/Medical Director (MD) F about R1's change of condition. MD F expressed the facility had notified him the morning of [DATE] on R1 having unstable blood pressures. The facility indicated R1 was his own decision maker, had elected DNR and was adamant about not going into the hospital for evaluation and treatment earlier in the day. MD F recalls the facility contacted MD F later that day; at some point informing him R1's daughter had convinced R1 to go into the hospital. MD F gave an order for transfer for evaluation and treatment at that point. MD F expressed that had R1 been assessed on the evening shift and notified him. MD F would not have been alarmed with vomiting and diarrhea with a resident undergoing chemotherapy for cancer. Surveyor reviewed R1's hospital record. R1 expired with primary diagnosis of neutropenic sepsis, secondary to chemotherapy and espophageal cancer. R1 had a white blood count of 1, and a Neutropil absolute level of 0.9. (These lab results mean R1 had no ability to fight any infection due to the side effects of chemotherapy treatment).