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	11/13/2024

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 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** 45942 Based on staff interview and record review, the facility did not ensure injuries of unknown origin were reported to Nursing Home Administrator (NHA)-A or the State Agency (SA) for 1 resident (R) (R15) of 6 sampled residents. R15 was transferred to the hospital with a head injury following a fall from A Hoyer lift on 8/6/24. R15 was also hospitalized from 9/4/24 to 9/10/24 due to aspiration pneumonia. The facility did not report an injury of unknown origin to NHA-A or the SA after hospital staff notified the facility that R15 had a vaginal mucosa tear with dried blood. In addition, the facility did not report bruises on R15's legs and compression fractures to R15's mid and lower back that were documented on R15's hospital discharge summary to the SA. Findings include: The facility's Abuse, Neglect and Exploitation policy, revised 7/15/22, indicates: .1. The facility will develop and implement written policies and procedures that: a) Prohibit and prevent abuse, neglect, and exploitation of residents .2. The facility will designate a leadership position who is responsible for reporting allegations or suspected abuse, neglect, or exploitation to the State Survey Agency and other officials in accordance with state law .B. Possible indicators of abuse include, but are not limited to: .2. Physical marks such as bruises or patterned appearances .on a resident's body. 3. Physical injury of a resident, of unknown source .VII. Reporting/Response: A. The facility will have written procedures that include: 1. Reporting of all alleged violations to the Administrator, State Agency, Adult Protective Services and to all other required agencies (e. g., law enforcement when applicable) within specified timeframes) immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or b) Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury .B. The Administrator will follow up with government agencies to report the results of the investigation when final within 5 working days of the incident as required by state agencies. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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	From 11/11/24 to 11/13/24, Surveyor reviewed R15's medical record. R15 was admitted to the facility on [DATE] and had diagnoses including stroke, hemiplegia (paralysis) and hemiparesis (weakness) affecting the left side, dysphagia (difficult swallowing) following stroke, aphasia (inability to speak) following stroke, gastrostomy (creation of an artificial opening in the stomach for feeding tube placement) status, and osteoarthritis. R15's Minimum Data Set (MDS) assessment, dated 8/23/24, had a Brief Interview for Mental Status (BIMS) score of 9 out of 15 which indicated R15 had moderately impaired cognition. R15's medical record indicated R15 was sent to the hospital with a head injury after a fall from a Hoyer lift on 8/6/24 and was hospitalized from 9/4/24 to 9/10/24 due to aspiration pneumonia. A hospital admission history and physical note, dated 9/5/24, indicated R15 was admitted to the hospital on 9/4/24 at 10:52 PM for hypoxia (low oxygen). R15 had mild episodes of epistaxis (nosebleed) and a vaginal bleed. A bedside evaluation showed mild vaginal mucosa tears with dried blood. The note indicated R15 had multiple patches of ecchymosis (bruises) on the lower extremities and a computed tomography (CT) scan revealed age-indeterminate multilevel fractures in the thoracic (middle) and lumbar (lower) spine. On 11/13/24 at 8:07 AM, Surveyor interviewed Director of Nursing (DON)-B and asked if R15's injuries of unknown origin were reported to the SA. DON-B indicated the compression fractures were not reported because the discharge summary did not contain a discharge order specific to the compression fractures. DON-B reviewed R15's history and physical note and indicated the facility should have started an investigation to determine why R15 had compression fractures. DON-B indicated DON-B was not sure how to answer if DON-B suspected abuse regarding the fractures. DON-B indicated NHA-A and Administrator in Training (AIT)-C had no suspicion of abuse. DON-B indicated the facility should have gotten more details on how the fractures occurred. On 11/13/24 at 8:21 AM, DON-B indicated hospital staff notified Social Worker (SW)-D that R15 had a vaginal mucosa tear and dried blood. DON-B indicated staff should have read R15's history and physical/discharge summary thoroughly and the injuries should have been reported to the Interdisciplinary Team (IDT). DON-B indicated NHA-A should have been notified to determine if the injuries were reportable or not. On 11/13/24 at 10:42 AM, Surveyor interviewed NHA-A, DON-B, AIT-C and the facility's regional consultant. NHA-A stated R15's 8/6/24 fall was investigated and indicated R15 was sent to the hospital with no fractures. NHA-A also indicated the facility was not aware of R15's vaginal tear. When Surveyor asked NHA-A if the injuries of unknown origin should have been reported to the SA, NHA-A did not answer. When Surveyor asked if staff interviewed R15 regarding the injuries, DON-B indicated R15 could let staff know if there were any issues. (continued on next page)

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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	On 11/13/24 at 10:53 AM, Surveyor interviewed SW-D who verified SW-D received a call from a hospital nurse who stated when R15 was examined, R15 had a vaginal tear or scratch. When the nurse asked if the facility was aware of the injury, SW-D stated SW-D was not aware. The nurse indicated the injury was in a suspicious area and the hospital was looking into it. SW-D indicated the nurse spoke to R15's Power of Attorney (POA) regarding abuse issues or questions that may have occurred during the fall. After becoming aware of R15's vaginal tear, SW-D informed AIT-C and DON-B and stated hospital staff did not have any follow-up with the facility after the concern was reported. SW-D confirmed SW-D did not document the phone conversation with the nurse but should have documented the call and reported the injury to nursing staff. On 11/13/24 at 11:00 AM, Surveyor interviewed DON-B, AIT-C, and the facility's regional consultant. DON-B indicated DON-B and AIT-C talked about R15's injury. DON-B asked if the facility was responsible if something happened at the hospital and indicated DON-B was still learning and was not familiar with nursing home processes and regulations. AIT-C indicated the facility did not have a record of any skin injuries for R15 and completed a skin assessment on 9/4/24. AIT-C said the injury could have happened at the hospital and indicated sometimes vaginal tears occur when pubic hairs are pulled. The facility's regional consultant indicated R15 had an enema in the hospital which may have caused the tear. The regional consultant indicated when hospital staff called SW-D, the facility thought the hospital was already investigating. When Surveyor asked if any of the possible causes for the vaginal mucosa tear that were mentioned were investigated, Surveyor did not receive an answer. NHA-A indicated if the hospital suspected abuse, they would have notified the SA and the facility would have been investigated.

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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 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** 45942 Based on staff interview and record review, the facility did not ensure injuries of unknown origin were thoroughly investigated for 1 resident (R) (R15) of 6 sampled residents. R15 was transferred to the hospital on 8/6/24 with a head injury following a fall from a Hoyer lift. R15 was also hospitalized from 9/4/24 to 9/10/24 due to aspiration pneumonia. The facility did not investigate an injury of unknown origin after hospital staff notified the facility that R15 had a vaginal mucosa tear with dried blood. In addition, the facility did not investigate bruises on R15's legs and compression fractures to R15's mid and lower back that were documented on R15's hospital discharge summary. Findings include: The facility's Abuse, Neglect and Exploitation policy, revised 7/15/22, indicates: 1. The facility will develop and implement written policies and procedures that: a) Prohibit and prevent abuse, neglect, and exploitation of residents .b) Establish policies and procedures to investigate any such allegations .B. Possible indicators of abuse include, but are not limited to: .2. Physical marks such as bruises or patterned appearances .on a resident's body, 3. Physical injury of a resident, of unknown source .An immediate investigation is warranted when allegation or suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur. B. Written procedures for investigations include: 1) Identifying staff responsible for the investigation .3) Investigating different types of alleged violations; 4) Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegation(s); 5) Focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent, and cause; and 6) Providing complete and thorough documentation of the investigation. From 11/11/24 to 11/13/24, Surveyor reviewed R15's medical record. R15 was admitted to the facility on [DATE] and had diagnoses including stroke, hemiplegia (paralysis) and hemiparesis (weakness) affecting the left side, dysphagia (difficult swallowing) following stroke, aphasia (inability to speak) following stroke, gastrostomy (creation of an artificial opening in the stomach for feeding tube placement) status, and osteoarthritis. R15's Minimum Data Set (MDS) assessment, dated 8/23/24, had a Brief Interview for Mental Status (BIMS) score of 9 out of 15 which indicated R15 had moderately impaired cognition. R15's medical record indicated R15 was sent to the hospital on 8/6/24 with a head injury following a fall from a Hoyer lift. R15 was also hospitalized from 9/4/24 to 9/10/24 due to aspiration pneumonia. A hospital admission history and physical note, dated 9/5/24, indicated R15 was admitted to the hospital on 9/4/24 at 10:52 PM for hypoxia (low oxygen). R15 was noted to have mild episodes of epistaxis (nosebleed) and a vaginal bleed. A bedside evaluation showed mild vaginal mucosa tears with dried blood. R15's skin had multiple patches of ecchymosis (bruises) on the lower extremities. A computed tomography (CT) scan indicated R15 had age-indeterminate multilevel fractures in the thoracic (middle) and lumbar (lower) spine. (continued on next page)

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/13/24 at 8:07 AM, Surveyor interviewed Director of Nursing (DON)-B who indicated the facility did not investigate the compression fractures after R15 returned from the hospital on 9/10/24 because the discharge summary did not have a discharge order specific to compression fractures. DON-B reviewed R15's hospital note and indicated the facility should have started an investigation to determine why R15 had multilevel compression fractures. On 11/13/24 at 8:21 AM, Surveyor interviewed DON-B who indicated the hospital notified Social Worker (SW)-D of R15's vaginal mucosa tear and dried blood. When Surveyor asked if the vaginal mucosa tear and dried blood warranted an investigation, DON-B indicated there should have been an investigation. DON-B indicated staff should have read R15's hospital discharge summary thoroughly and brought the concerns to the Interdisciplinary Team (IDT). On 11/13/24 at 10:42 AM, Surveyor interviewed Nursing Home Administrator (NHA)-A, DON-B, Administrator in Training (AIT)-C, and the facility's regional consultant. NHA-A stated R15 had a fell from a Hoyer lift on 8/6/24 and the fall was investigated. NHA-A indicated R1 was sent to the hospital with no fractures and facility was not aware of R15's vaginal tear. When Surveyor asked NHA-A if the new injuries discovered after R15's 8/6/24 fall should be investigated, NHA-A did not answer. When Surveyor asked if staff interviewed R15 about the injuries, DON-B indicated R15 could let staff know if there were any issues. On 11/13/24 at 10:53 AM, Surveyor interviewed SW-D who verified SW-D received a call from a hospital nurse who stated R15 when R15 was examined, R15 had a vaginal tear or scratch. The nurse asked if the facility was aware of the injury. The nurse informed SW-D that the injury was in a suspicious area and the hospital was looking into it. SW-D indicated the nurse spoke with R15's POA regarding any abuse or questions that may have occurred during R15's fall. SW-D informed AIT-C and DON-B about R15's vaginal tear and stated the hospital did not provide any further follow-up with the facility. SW-D confirmed SW-D did not document the conversation with the hospital nurse but indicated SW-D should have documented the call and reported the injury to nursing staff. On 11/13/24 at 11:00 AM, Surveyor interviewed DON-B who indicated DON-B and AIT-C talked about the injury. DON-B asked if the facility was responsible if something happened at the hospital and indicated DON-B was still learning nursing home processes and regulations. AIT-C indicated the facility had no record of any skin injuries and completed a skin assessment on 9/4/24. AIT-C stated the injury could have happened at the hospital and indicated when pubic hairs are pulled they sometimes cause vaginal tears. The regional consultant indicated R15 had an enema in the hospital which may have caused the tear and indicated when the hospital called SW-D, the facility thought the hospital was already investigating. When Surveyor asked if any of the possible causes of a vaginal mucosa tear that were mentioned were investigated, Surveyor did not receive an answer. NHA-A indicated if the hospital suspected abuse, they would have notified the State Agency and the facility would have been investigated.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48794 Based on observation, staff interview, and record review, the facility did not maintain an infection prevention and control program designed to help prevent the development and transmission of communicable disease and infection. This practice had the potential to affect all 53 residents residing in the facility. The facility did not maintain thorough surveillance/tracking documentation for a COVID-19 outbreak in September 2024 and did not report the outbreak to the local health department in a timely manner. In addition, the facility did not maintain thorough surveillance/tracking for a Respiratory Syncytial Virus (RSV) outbreak between 3/19/24 and 3/21/24 and did not report the outbreak to the local health department in a timely manner. The facility did not ensure consistent symptom tracking and documentation was completed for 5 residents (R) (R2, R18, R28, R31, and R163) of 6 residents who tested positive for COVID-19 in September 2024. Infection Preventionist (IP)-F also worked as a floor nurse. IP-F was unable to maintain the facility's infection prevention and control program which resulted in incomplete and/or inaccurate infection control surveillance. R6 had a wound but did not have an order or a care plan for enhanced barrier precautions (EBP). R8 had a multidrug-resistant organism (MDRO) and was not on EBP. Findings include: The facility's COVID-19 Prevention, Response and Reporting policy, dated 5/18/23, indicates: It is the policy of the facility to ensure that appropriate interventions are implemented to prevent the spread of COVID-19 and promptly respond to any suspected or confirmed COVID-19 infections. COVID-19 information will be reported through the proper channels as per federal, state and/or local health authority guidance .26. Responding to a newly identified SARS-CoV-2 infected HCP or resident: a. The facility should defer to the recommendations of the jurisdiction's public health authority when performing an outbreak response. b. A single new case of SARS-CoV-2 infection in a healthcare provider (HCP) or resident should be evaluated to determine if others in the facility could have been exposed. c. The approach to an outbreak investigation could involve either contact tracing or a broad-based approach; however, a broad-based approach (e.g., unit, floor, or other specific area(s) of the facility) approach is preferred if all potential contact cannot be identified or managed with contact tracing or if contact tracing fails to halt transmission .27. The Infection Preventionist, or designee, will monitor and track COVID-19 related information including, but no limited to: a. The number of residents and staff who exhibit signs and symptoms of COVID-19. b. The number of residents and staff who have suspected or confirmed COVID-19 and date of confirmation. c. Staff and resident vaccination status .e. Employee compliance with standard and transmission-based precautions . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	According to the Wisconsin State Legislature, Chapter DHS 145, Appendix A, Communicable Diseases and Other Notifiable Conditions: The following diseases are of urgent public health importance and shall be reported by telephone to the patient's local health officer or to the local health officer's designee upon identification of a case or suspected case .In addition to the immediate report, complete and fax, mail, or electronically report an Acute and Communicable Disease Case Report (DHS F-44151) to the address on the form, or enter the data into the Wisconsin Electronic Disease Surveillance System, within 24 hours . Severe Acute Respiratory Syndrome-associated Coronavirus (SARS-CoV) . The facility's Infection Outbreak Response and Investigation Policy, with a review date of 2/26/23, indicates: . d. An outbreak will be reported to the local and/or state health department in accordance with the state's reportable diseases website. The facility's Infection Surveillance policy, revised on 3/8/23, indicates: .10. Employee, volunteer, and contract employee infections will be tracked, as appropriate, such as influenza or gastrointestinal infection outbreaks. The Wisconsin Department of Health Services' Nursing Homes Provider Resources webpage indicates under Outbreak Reporting Requirements: In Wisconsin, confirmed or suspected outbreaks of any disease in health care facilities, including long-term care facilities, are a Category I Disease, meaning they shall be reported immediately by telephone to the patient's local health officer, or to the local health officer's designee, upon identification. The Wisconsin Department of Health Services publication Prevention and Control Recommendation for Acute Gastroenteritis Outbreaks in Wisconsin Long-Term Care Facilities, dated December 2017, indicates: Staff should exclude themselves from resident care and food service duties at the onset of the symptoms, including nausea, vomiting, abdominal pain, and/or diarrhea .Such exclusions shall remain in effect until the employee is asymptomatic and free of diarrhea and vomiting for 48 hours .A log should be maintained to record ill staff symptoms, date when they became ill, date they became well, and date they returned to work. The facility's Infection Preventionist policy, dated 9/22/22, indicates: .7. The IP must have the time necessary to properly assess, develop, implement, monitor, and manage the infection prevention and control program for the facility .The policy also indicates the IP must: .b. Establish facility-wide systems for the prevention, identification, reporting, investigation, and control of infections and communicable diseases of residents, staff and visitors. The facility's Enhanced Barrier Precautions (EBP) policy, with a revised date of 8/8/24, indicates: It is the policy of this facility to implement EBP for the prevention of transmission of multidrug-resistant organisms (MDROs) .1c. The facility will have the discretion on how to communicate to staff which residents require the use of EBP as long as staff are aware of which residents require the use of EBP prior to providing high-contact care activities .2b. An order for EBP will be initiated for residents with any of the following: .i. Wounds (e.g. chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers) .ii. Infection or colonization with a CDC-targeted or novel MDRO when contact precautions do not otherwise apply .4. High-contact resident care activities include: Dressing; Bathing; Transferring; Providing hygiene; Changing linens; Changing briefs or assisting with toileting . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	1. From 11/11/24 through 11/13/24, Surveyor reviewed the facility's infection prevention and control program surveillance documents and noted the facility experienced a COVID-19 outbreak in September 2024. Documentation pertaining to the COVID-19 outbreak consisted of a Monthly Infection Control Log, dated September 2024. The log included 6 residents who were COVID-19 positive. The log documented where the residents resided, the date of onset, and the date resolved. No additional surveillance or tracking was noted. Surveyor reviewed the rest of the facility's infection prevention documents for the month of September 2024 and noted the following: ~ A staff and resident line list, dated September 2024, included sections for tracking symptoms, date and time of last symptom, well date, return to work date (staff), and date removed from precautions (resident). The line list included 18 entries. Surveyor noted the line list was incomplete and did not contain the date and time of the last symptom, well dates, return to works dates, and removed from precautions dates. Surveyor also noted the line list did not include the 6 residents identified as COVID-19 positive on the Monthly Infection Control Log. ~ A blank Surveillance Floor Map. ~ An Infection Summary, dated September 2024, was incomplete and only contained information the for infection type and unit. The Infection Summary did not include a section for tracking COVID-19 and did not include the 6 positive residents. The facility's September 2024 COVID-19 outbreak surveillance also did not include documentation for symptomology, testing, the facility's response to the outbreak, preventative actions, or dates of outbreak reporting. On 11/13/24 at 3:15 PM, Surveyor interviewed IP-F who confirmed IP-F was responsible for the facility's infection prevention and control program. IP-F confirmed the facility had a COVID-19 outbreak in September 2024. Surveyor reviewed with IP-F documentation from the outbreak. IP-F confirmed surveillance documents, including an infection summary, surveillance map, and infection control line list were incomplete and did not contain the necessary information to ensure adequate surveillance and tracking. 2. On 11/13/24, Surveyor reviewed the medical records of the 6 residents who were diagnosed as COVID-19 positive in September 2024 and noted 5 (R2, R18, R28, R31 and R163) of the 6 residents had contradicting documentation regarding their COVID-19 symptoms. R2 was admitted to the facility on [DATE]. R2 tested positive for COVID-19 on 9/9/24 and was placed on droplet/contact precautions. R2's nursing notes contained the following entries: ~On 9/9/24 at 10:51 AM, Licensed Practical Nurse (LPN)-K documented R2 had shortness of breath (SOB) with exertion or while lying flat and an occasional cough. ~On 9/9/24 at 6:24 PM, nursing staff documented R2 was asymptomatic. ~On 9/10/24 at 9:10 AM, Director of Nursing (DON)-B documented R2 stated R2's SOB with exertion was improving. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	~On 9/11/24 at 9:50 PM, nursing staff documented R2 was asymptomatic. ~On 9/12/24 at 12:30 PM, nursing staff documented R2 was asymptomatic. ~On 9/16/24 at 1:44 PM, Administrator in Training (AIT)-C documented R2 had SOB when lying flat. ~On 9/16/24 at 2:30 PM, nursing staff documented R2 had SOB. R2's medical record did not indicate whether R2's SOB resolved or when R2 was removed from droplet/contact precautions. R18 was admitted to the facility on [DATE]. R18 tested positive for COVID-19 on 9/7/24 and was placed on droplet/contact precautions. R18's nursing notes contained the following entries: ~On 9/7/24 at 3:22 PM, LPN-K documented R18 had SOB with exertion and while laying flat and a dry cough. ~On 9/7/24 at 9:33 PM, nursing staff documented R18 had no SOB and was asymptomatic. ~On 9/9/24 at 8:20 AM, nursing staff documented R18 was asymptomatic. ~On 9/12/24 at 12:31 PM, nursing staff documented R18 was asymptomatic. R18's medical record did not indicate when R18's symptoms resolved or when R18 was removed from droplet/contact precautions. R28 was admitted to the facility on [DATE]. R28 tested positive for COVID-19 on 9/13/24 and was placed on droplet/contact precautions. R28's nursing notes contained the following entries: ~On 9/13/24 at 11:08 AM, LPN-K documented R28's lungs were diminished and R28 had an occasional cough and SOB while lying flat and with exertion. ~On 9/13/24 at 11:47 AM, IP-F documented R28 had no symptoms and noted R28's respirations were regular and unlabored. ~On 9/13/24 at 12:43 PM, IP-F documented R28 was asymptomatic. R28's medical record did not indicate when R28's symptoms resolved or when R28 was removed from droplet/contact precautions. R31 was admitted to the facility on [DATE]. R31 tested positive for COVID-19 on 9/9/24 and was placed on droplet/contact precautions. R31's nursing notes contained the following entries: ~On 9/9/24 at 10:54 AM, LPN-K documented R31 had SOB with exertion or while lying flat and an occasional dry cough. ~On 9/9/24 at 6:17 PM, nursing staff documented R31 was asymptomatic. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	~On 9/10/24 at 8:40 AM, DON-B documented R31's SOB with exertion was improving. ~On 9/11/24 at 9:48 PM, nursing staff documented R31 was asymptomatic. ~On 9/12/24 at 12:29 PM, nursing staff documented R31 was asymptomatic. ~On 9/16/24 at 1:50 PM, AIT-C documented R31 had SOB when laying flat and with exertion. R31's medical record did not indicate when R31's symptoms resolved or when R31 was removed from droplet/contact precautions. R163 was admitted to the facility on [DATE]. R163 tested positive for COVID-19 on 9/5/24 and was placed on droplet/contact precautions. R163's nursing notes contained the following entries: ~On 9/5/24 at 7:33 PM, LPN-K documented R163 had a cough, chills, and congestion. R163 also had SOB at rest, while lying flat, and with exertion. ~On 9/6/24 at 9:14 AM, DON-B documented R163 had a cough and congestion. ~On 9/7/24 at 9:30 PM, nursing staff documented R163 was asymptomatic. R163's medical record did not indicate when R163's symptoms resolved or when R163 was removed from droplet/contact precautions. On 11/13/24 at 3:15 PM, Surveyor interviewed IP-F who indicated IP-F was not sure why the charting was inconsistent for 5 of the 6 residents who tested positive for COVID-19. IP-F stated none of the residents who tested positive were symptomatic. IP-F confirmed resident's symptoms were not documented as part of the IP surveillance. IP-F indicated symptoms were only monitored through charting and nurse-to-nurse communication. IP-F stated LPN-K assisted IP-F with the infection prevention and control program until October 2024 and was responsible for the line list and resident testing. On 11/13/24 at 3:50 PM, Surveyor interviewed LPN-K who stated resident symptoms were tracked on one line list. LPN-K indicated if residents were diagnosed and prescribed an antibiotic, they were placed on the Monthly Infection Control Log. LPN-K stated some of the residents who tested positive for COVID-19 were symptomatic. LPN-K stated LPN-K did not know why there were discrepancies in the charting on whether a resident had symptoms or not. LPN-K stated LPN-K charted based on LPN-K's assessment of the resident. 3. From 11/11/24 through 11/13/24, Surveyor reviewed the facility's September 2024 COVID-19 outbreak surveillance documents which indicated the first staff member tested positive on 9/4/24 and the first resident tested positive on 9/5/24. The documents did not indicate the facility reported the outbreak to the local health department. On 11/13/24 at 3:40 PM, Surveyor interviewed AIT-C who indicated AIT-C reported the outbreak to the local health department. AIT-C provided an e-mail, dated 9/12/24, that contained communication with the health department, but not the date the outbreak was reported. AIT-C stated AIT-C initially reported the outbreak via phone to the health department. AIT-C was not certain of the date and did not have documentation of the date the outbreak was reported. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 11/14/24 at 10:38 AM, Surveyor interviewed Public Health Nurse (PHN)-J who stated the facility reported the COVID-19 outbreak via phone on 9/11/24 which was 7 days after the first individual tested positive. 51043 4. On 11/12/24 at 4:07 PM, Surveyor interviewed IP-F who provided an incomplete staff line list titled Employee Infection Line List/Log. The log did not have a date in the space provided at the top left side of the form but listed 8 dates next to the 8 staff listed on the form. The dates listed were 5/7, 6/5, 6/4, 6/5, 6/11, 7/7, 7/15, and 7/27. The form listed the unit where each staff worked and their symptoms. The form contained columns that were not filled out for any of the staff including Seen by Physician Y/N, Confirmed Infection (MD or Lab), Number of Hours with No Symptoms, and Return to Work Date. The Date/Time of Onset of Symptoms column contained two dates listed for two of the staff. When Surveyor asked IP-F about return to work dates for staff with complaints of nausea, emesis (vomiting), and diarrhea to ensure staff did not infect residents or other staff upon their return to work, IP-F indicated return to work dates depended on symptoms and were usually 24 hours after symptoms subsided. IP-F stated the facility calls and asks staff if they are able to return for their next shift. For COVID-19, IP-F indicated IP-F would have staff test and return to work 24 hours after their symptoms resolved and 1 negative test unless the policy stated otherwise. For nausea and diarrhea, IP-F indicated staff can return to work 24 hours after their symptoms subside. IP-F indicated IP-F had no further information regarding the dates and times of staffs' last illness symptoms and when staff returned to work. Per the Wisconsin Department of Health Services, staff should not return to work until at least 48 hours after their last episode of diarrhea or vomiting. On 11/13/24 at 10:33 AM, Surveyor interviewed IP-F and requested a completed Surveillance Map since the only Surveillance Map located in the facility's Infection Control binder to track resident infections was blank. IP-F verified IP-F had not been completing Surveillance Maps. On 11/13/24 at 2:42 PM, Surveyor reviewed the March 2024 Monthly Resident Infection Control Log which indicated 6 residents were Respiratory Syncytial Virus (RSV) positive between 3/19/24 and 3/21/24 which constituted an outbreak per the Wisconsin Department of Health Services and should have been reported within 24 hours. On 11/14/24 at 10:38 AM, Surveyor interviewed PHN-J who indicated the RSV outbreak was reported via phone and e-mail on 3/26/24. 5. On 11/13/24 at 3:33 PM, Surveyor interviewed IP-F who indicated IP-F did not have enough time to maintain the facility's infection prevention and control program and indicated it should be a designated 40-hour per week position. When Surveyor asked IP-F how many hours IP-F currently devoted to the position, IP-F stated maybe 2 hours a week and indicated IP-F also worked as a floor nurse. 49010 6. On 11/11/24, Surveyor reviewed R6's medical record. R6 was admitted to the facility on [DATE] and had diagnoses including type two diabetes mellitus with diabetic neuropathy, congestive heart failure (CHF), and dementia. R6's Minimum Data Set (MDS) assessment, dated 10/09/24, had a Brief Interview for Mental Status (BIMS) score of 12 out of 15 which indicated R6 had moderately impaired cognition. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	R6's medical record indicated R6 had a diabetic ulcer on the ball of the right foot. R6's plan of care did not indicate R6 was on EBP. On 11/11/24 at 12:37 PM, Surveyor observed R6's room entrance and noted there was no EBP sign on or near the door. On 11/11/24 at 12:51 PM, Surveyor interviewed DON-B who stated there should be an EBP sign outside R6's room since R6 was on EBP due to an active foot wound. DON-B posted an EBP sign near R6's room entrance. On 11/12/24, Surveyor reviewed R6's physician orders. R6 had a wound care order, dated 10/4/24, for the diabetic ulcer on R6's right foot. R6 did not have an order for EBP. Surveyor reviewed R6's diagnoses list which did not contain R6's right diabetic foot ulcer. On 11/13/24 at 8:49 AM, Surveyor interviewed R6 who indicated R6 had an open foot wound that nursing staff cleaned and dressed regularly. Surveyor observed a bandage on R6's right foot that was dated 11/11/24. On 11/13/24 at 8:50 AM, Surveyor interviewed Certified Nursing Assistant (CNA)-L who indicated CNA-L used EBP for R6 due to R6's foot wound. On 11/13/24 at 8:56 AM, Surveyor interviewed CNA-M who indicated CNA-M used EBP for R6 due to R6's foot wound. On 11/13/24 at 1:50 PM, Surveyor interviewed IP-F who stated R6 was on EBP for a foot wound and should have an order in R6's medical record. IP-F indicated R6 used to have an EBP order, however, the EBP order wasn't reinitiated after R6 went to the hospital in September 2024. IP-F indicated IP-F and others involved with admissions should have ensured an order for EBP was in R6's medical record upon readmission. On 11/13/24 at 2:54 PM, Surveyor interviewed DON-B who confirmed R6's EBP order should have already been in place since staff were implementing EBP. DON-B indicated R6 should also have a care plan for EBP and indicated R6's foot wound should be listed on R6's diagnoses list. 7. On 11/11/24, Surveyor reviewed R8's medical record. R8 was admitted to the facility on [DATE] and had diagnoses including congestive heart failure (CHF), bipolar disorder, excoriation (skin picking) disorder, and anxiety. R8's MDS assessment, dated 9/17/24, had a BIMS score of 13 out of 15 which indicated R8 was not cognitively impaired. R8's medical record indicated R8 had an order for EBP due to an MDRO. A care plan, dated 10/28/24, indicated R8 was on EBP due to an MDRO and for wounds due to skin picking. R8 had a physician order for EBP, dated 10/30/24, due to MDROs. R8's diagnoses list did not contain an MDROs. On 11/11/24 at 12:37 PM, Surveyor observed R8's room entrance and noted there was no EBP sign on or near R8's door. (R6 and R8 were roommates) On 11/11/24 at 12:51 PM, Surveyor interviewed DON-B who stated R8 was not on EBP. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 11/13/24 at 8:50 AM, Surveyor interviewed CNA-L who indicated R8 was not on EBP and CNA-L did not know of any reason why R8 would be on EBP. CNA-L indicated EBP was for R8's roommate (R6). On 11/13/24 at 8:56 AM, Surveyor interviewed CNA-M who indicated CNA-M did not use EBP for R8. CNA-M indicated EBP was for R8's roommate (R6) only. On 11/13/24 at 9:53 AM, Surveyor interviewed DON-B. When Surveyor asked why R8 had an order and a care plan for EBP but staff did not use EBP for R8, DON-B stated DON-B was wrong and staff should use EBP for R8 if R8 had an EBP order. When Surveyor asked why R8 had a care plan for MDROs and an EBP order for MDROs but did not have an MDRO diagnosis in R8's diagnoses list, DON-B stated DON-B would look into it. On 11/13/24 at 10:14 AM, Surveyor interviewed DON-B who indicated DON-B spoke with AIT-C and confirmed R8 had a history of an MDRO. DON-B indicated R8's diagnoses list would be updated and DON-B would ensure staff used EBP for R8. On 11/13/24 at 1:50 PM, Surveyor interviewed IP-F who stated IP-F was not aware R8 had an EBP order or why EBP would be used for R8 just for an MDRO. When Surveyor asked if an MDRO should be listed in a resident's diagnoses list, IP-F indicated IP-F was unsure. On 11/13/24 at 2:54 PM, Surveyor interviewed DON-B who confirmed R8 had a history of an MDRO and indicated extended-spectrum beta lactamase (ESBL) resistance was added to R8's active diagnoses list. DON-B confirmed the orders should have already been in place and EBP should have been ongoing. DON-B indicated R8 was now on the EBP list and staff would use EBP with R8 going forward.

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. 48794 Based on staff interview and record review, the facility did not ensure the Infection Preventionist (IP) dedicated a minimum number of part-time hours to adequately manage the facility's infection prevention and control program. This had the ability to affect all 53 residents residing in the facility. Licensed Practical Nurse (LPN)-F was designated as the facility's IP. LPN-F also worked as a full-time floor nurse which resulted in LPN-F's inability to adequately maintain the facility's infection prevention and control program. Findings include: The facility's Infection Preventionist policy, dated 9/22/22, indicates: The facility will employ one or more qualified individuals with responsibility for implementing the facility's infection prevention and control program .1. The facility will designate a qualified individual as Infection Preventionist (IP) whose role is to coordinate and be actively accountable for the facility's infection prevention and control program including the antibiotic stewardship program .6. The IP must be employed at least part-time. Designated IP hours per week may vary based on the facility and its resident population .7. The IP must have the time necessary to properly assess, develop, implement, monitor, and manage the infection prevention and control program for the facility, address training requirements, and participate in required committees .11. The responsibilities of the IP include but are not limited to: a. Develop and implement an ongoing infection prevention and control program to prevent, recognize, and control the onset and spread of infections b. Establish facility-wide systems for the prevention, identification, reporting, investigation, and control of infections and communicable diseases of residents, staff, and visitors. c. Develop and implement written policies and procedures in accordance with current standards of practice and recognized guidelines for infection prevention and control. d. Oversight of and ensuring the requirements are met for the facility's antibiotic stewardship program. e. Oversight of resident care activities (i.e., use and care of urinary catheters, wound care, incontinence care, skin care, medication administration, etc.). g. Review/revise and approve infection prevention and control training topics and content and ensure staff are trained on the facility's infection prevention and control program. On 11/13/24, Surveyor reviewed the Facility Assessment, dated 8/7/24, which listed a position for Infection Preventionist and indicated the IP work at least part-time at the facility. There were no designated hours or number of hours noted. (continued on next page)

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 11/13/24 at 3:15 PM, Surveyor interviewed LPN-F who confirmed LPN-F was the facility's IP and had been for four years. LPN-F stated another nurse assisted with the line lists until September 2024, however, LPN-F was responsible for the infection prevention and control program. LPN-F stated LPN-F designated maybe 2 hours a week to infection prevention and control because LPN-F also worked as a floor nurse. LPN-F stated LPN-F did not feel that was enough time for the infection prevention and control program and indicated it should be a designated 40 hour per week position. Director of Nursing (DON)-B and Administrator in Training (AIT)-C were present during the interview with LPN-F. Neither DON-B or AIT-C disputed LPN-F's statement that LPN-F was only able to designate 2 hours per week as the IP or LPN-F's statement that it was not sufficient time to complete IP responsibilities. From 11/11/24 to 11/13/24, the survey team noted the facility did not have a thorough infection prevention and control program as evidenced by incomplete line lists, lack of symptom tracking, lack of follow through on vaccinations, and an incomplete antibiotic stewardship program. (See F880, F881, F883, and F887 for additional information.)