STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525362	A. Building B. Wing	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lafayette Manor	719 E Catherine St Box 167 Darlington, WI 53530

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41788 Based on interview and record review, the facility did not ensure that residents were free from abuse, perpertrated by a Certified Nusing Assistant (CNA) for 1 of 17 sampled residents (R40). R40 had voiced to a CNA to stop during cares as the CNA was hurting him. The CNA continued providing care despite the residents request and voicing discomfort. Addtionally, staff who overheard the interaction did not intervene to protect R40. Evidenced by: The facility policy entitled, Abuse, Neglect and Exploitation, dated [DATE], states, in part: . Policy: It is the policy of this facility to provide protection for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. Definitions: Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish, which can include staff to resident abuse . III. Prevention of Abuse, Neglect and Exploitation The facility will implement policies and procedures to prevent and prohibit all types of abuse, neglect, misappropriation of resident property, and exploitation that achieves: . B. Identifying, correcting and intervening in situations in which abuse, neglect, exploitation, and/or misappropriation of resident property is more likely to occur with the deployment of trained and qualified, registered, licensed, and certified staff . E. Ensuring the health and safety of each resident . (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: 525362	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/12/2024
NAME OF PROVIDER OR SUPPLIER Lafayette Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 719 E Catherine St Box 167 Darlington, WI 53530	

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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 0600 Level of Harm - Actual harm Residents Affected - Few	R40 was admitted to the facility on [DATE] and has diagnoses that include, malignant neoplasm of unspecified part of left bronchus or lung (a cancerous tumor that has developed in the left bronchus, one of the large airways in the lungs) and nontraumatic intracranial hemorrhage (bleeding in the brain that occurs without trauma or surgery). R40 admitted to hospice [DATE] and expired [DATE]. A Facility Self Report dated [DATE], at 11:14:22 AM, states, in part: . Summary of Incident: Allegation Type: Abuse: Hitting, slapping, threats of harm, assault, humiliation. Name-Affected Person: R40 Name-Accused Person: CNA D . Date occurred: [DATE]. Time occurred: 06:15 AM . Date discovered: [DATE] . Briefly describe the incident . R40 recently admitted to the facility. It was reported that resident was reporting pain during cares when CNA D was assisting. CNA D continued cares after resident stated to stop . Explain what steps the entity took upon learning of the incident to protect the affected person and others from further potential misconduct: Upon learning of the incident, investigation was started; CNA D was put on leave. Residents interviewed to determine if they feel their rights are being upheld by CNA D and other staff . R40's progress note written by LPN E (Licensed Practical Nurse) dated [DATE], 6:15 AM, states: Went in to give R40 pain med and Ativan which R40 refused. R40 also refused to have brief changed and lidocaine patch applied. I told the two CNAs that were trying to change his brief to just leave him alone because R40 was getting irate and was verbally abusive to CNAs and I. CNA D came up to this floor went down to R40's room and told him he was going to be changed, he did not have a choice in the matter. CNA D told R40 to suck it up buttercup. R40 screamed the whole time CNA D was in there . Resident Interviews conducted by SW G (Social Worker) during investigation, dated [DATE], shows 3 residents voiced CNA D does not respect their wishes and 3 residents indicate CNA D has disregarded their wishes. 2 of those 3 residents voiced they do not feel safe when CNA D works with them. Written statement by LPN E, dated [DATE], states, in part: . (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	CNA C, CNA F, and I went in R40's room to check him and administer his medications- I attempted to give R40 his meds and he refused. So, I was going to wait for CNA C and CNA F to give R40's cares and try again. R40 started grabbing at CNA F and CNA C at which time R40 was told that he was not to do that because it was unacceptable behavior. CNA C and CNA F started to try and check R40 again and he would not stop screaming saying Leave me alone! R40 said he wanted a male to care for him. I told CNA C and CNA F R40 is screaming and saying no so just leave him alone and we would come back later, Then I saw CNA D go past the nursing station door. I got up to see what CNA D was doing, and she was going into his room. R40 started screaming and I heard CNA D say, Suck it up buttercup because we are fixing to change you. I walked down to the room because R40 was continually screaming, I said just leave him alone and check back later. CNA D said just send me some help in here and a pad. CNA C took a pad to her, she cleaned him up, came by the office and said he had a large BM (bowel movement) tell CNA C to mark it. CNA D then went back downstairs R40 screamed during the whole process. CNA C's statement, dated [DATE], at 1:41 PM, states: CNA C was on 3rd floor and CNA D was on 2nd floor. CNA F was a float between the two floors. CNA C heard resident say, Stop you are hurting me and CNA D asked CNA C to get a Chux and wipes and said, Some help would be nice. CNA D stated,Yelling isn't doing you justice at all CNA D replied. CNA D asked R40 if he thinks it is. R40 responded Obviously not. CNA D was yelling at R40, and CNA D was being mean and rough to R40. R40 continued to tell CNA D to stop, and she continued to keep going. CNA D did not give R40 the option to not get changed and CNA C and CNA F offered to change R40 and educated him on having a wet brief on and R40 still said no he did not want to be changed. CNA C and CNA F told him okay and that they would have day shift try to change him. CNA D came upstairs after CNA F went back down to 2nd floor. CNA D asked what the resident's name was and what room he was in. CNA C told CNA D the room number and R40's name. SW G's interview with R40, dated [DATE], states, in part: . Spoke with R40 regarding situation where nursing staff reported hearing CNA speaking harshly to R40 and allegedly completing cares against his will. R40 stated in his interview that he sort of remembered the situation, but his pain was bad . Education on Resident Rights, Professionalism- Customer Service, and Abuse, Neglect and Exploitation are dated [DATE] by CNA D. It should be noted CNA D has received previous disciplinary action regarding resident rights/self-determination, dignity/respect and insubordination as listed below: Action Plan for Incident [DATE] CNA D and R40 shows: Care Plan for R40 updated to address pain management: -Breathing - Stress Balls during Care (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 0600 Level of Harm - Actual harm Residents Affected - Few	- Medications for Pain scheduled instead of PRN (as needed) Discussion between CNA D and Interim NHA A (Nursing Home Administrator) related to resident rights and customer service. Inservice for all staff -Resident rights/self-determination Continue touch bases with R40 to determine if needs are being met. CNA D's Disciplinary Action Report dated [DATE], states, in part: . Rules Violated: Resident dignity- respectful treatment of residents . Nature of Incident: A resident felt threatened and demeaned . CNA D's Disciplinary Action Report dated [DATE], states, in part: . Rules Violated: 1. Insubordination . 3. Departmental policies of safety rules and regulations. Nature of Incident: 1. CNA does not follow directions given by nurse on duty and must be reminded multiple times of required tasks of job description . 3. It has been reported on [DATE] that a resident was calling out from their room, and it was noted that CNA was standing at the medication cart conversing with the nurse and not responding to resident . On [DATE], at 7:30 AM, Surveyor interviewed CNA C and asked CNA C to talk about the incident that occurred on [DATE] with R40. CNA C indicated her and CNA F were in R40's room with LPN E between 5:00 AM and 6:00 AM and asked R40 if we could check to see if he was incontinent which he was. R40 said Please don't touch me, so we left him alone and stated we would come back later to try again. CNA C stated we went back to try again and R40 stated, No, leave me alone. We left the room. When CNA F and CNA C went back downstairs, CNA D yelled at CNA F stating Where the hell have you been? We explained we were in with R40, and he was refusing to be changed. CNA D asked what the resident's name was and room number. CNA C indicated she told CNA D and CNA D went upstairs to R40's room. CNA C indicated she followed CNA D upstairs and as CNA C was walking toward R40's room she heard R40 saying to CNA D, Please leave me alone. Please stop, you are hurting me! CNA C indicated she heard CNA D yell at R40 Screaming isn't doing you justice; it isn't doing you no good! When CNA C reached the room, CNA D asked CNA C to go get a blue chux and stated, some help would be nice. CNA C indicated LPN E was standing outside the room. CNA C went in R40's room and handed CNA D the items requested and suggested with R40 screaming, we should leave R40 alone and come back later. CNA D continued with cares even though R40 was screaming. Surveyor asked CNA C if R40 was screaming due to pain and CNA C indicated yes. CNA C indicated by the sounds R40 was making, R40 was in a lot of pain. CNA D would not listen to me and kept going with providing the cares. I reported it to NHA A (Nursing Home Administrator) that morning. Surveyor asked when the incident happened, and CNA C indicated between 5:00 AM and 6:00 AM. (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 0600 Level of Harm - Actual harm Residents Affected - Few	On [DATE] at 7:45 AM, Surveyor interviewed CNA F and asked her to tell Surveyor about the incident on [DATE] with R40. CNA F indicated she was floating that night and had gone upstairs to assist CNA C. Between 5 and 5:30 AM, we went in by R40. R40 was refusing to be changed. LPN E was in room with us. CNA F indicated it took all three of us to convince R40 to take his AM medications. R40 indicated he wanted a male caregiver because us women were ganging up on him. CNA F indicated they left the room. CNA F went back downstairs, and CNA D asked what took so long and CNA F informed CNA D that R40 was refusing to be changed. CNA D offered to go up and attempt, so CNA F indicated she gave CNA D the room number and resident name. CNA F indicated she was not up in R40's room when incident occurred, but CNA D came back downstairs and indicated she had completed care for R40 with no problems. CNA F indicated she was informed by CNA C and LPN E that CNA D went in R40's room by herself and R40 refused, and CNA D rolled him anyway. CNA F indicated she had told CNA D residents have the right to refuse and CNA D indicated that staff can't leave a resident soiled because they will break down. On [DATE] at 7:55 AM, Surveyor interviewed CNA D and asked her to tell Surveyor about the incident on [DATE] with R40. CNA D indicated she was scheduled on the lower floor. CNA F indicated they had a hard time with R40, and he was refusing to be changed. CNA D offered to attempt cares with R40 and went upstairs to R40's room. CNA D indicated telling R40 he needed to be cleaned up because he was full of BM (bowel movement). R40 didn't say anything but made a few noises AH, AH. CNA D indicated R40 was full of BM and staff could not leave a resident like that because they will break down. CNA D indicated she was trying to break the ice and told R40 to suck it up buttercup, we are going for a ride. Surveyor asked CNA D how R40 replied to that, and CNA D indicated R40 did not say a whole lot but did not say what R40 said specifically. CNA D told R40 he was going to roll on his side towards the wall and CNA D began cleaning R40 up with wipes. R40 was pushing up against the wall with his hands trying to roll back over as CNA D was cleaning him. CNA D indicated R40 was bracing himself. Surveyor asked if R40 was in pain and CNA D indicated R40 might have said Ow! Surveyor asked CNA D if R40 was scared. CNA D stated he could have been because I was rolling him towards the wall. CNA D indicated she was not aware R40 had brain cancer. Surveyor asked CNA D if R40 ever told CNA D to stop and CNA D indicated R40 might have said Stop. CNA D indicated she was aware R40 did not want his bottom cleaned. Surveyor asked if R40 told her that and CNA D indicated no R40 was just fidgety. On [DATE] at 3:16 PM, Surveyor interviewed NHA A (Nursing Home Administrator). Surveyor asked NHA A regarding the Facility Self Report dated [DATE] regarding R40 and CNA D. Surveyor asked NHA A if CNA D is still employed at facility. NHA A indicated yes. Surveyor asked what education CNA D has received and NHA A indicated resident rights, customer service and abuse. NHA A provided copies to Surveyor. Surveyor asked NHA A if this incident would be considered abuse and NHA A indicated yes, that is why we did a self-report on it. Surveyor asked NHA A to help Surveyor understand why CNA D was educated but not all of nursing staff. NHA A indicated the nursing staff was educated on resident rights at the inservice. Surveyor asked if nursing staff was educated on abuse and NHA A indicated no. NHA A indicated no explanation to why the facility did not educate all nursing staff on abuse after the incident. Surveyor asked if all staff should have been educated on abuse and NHA A indicated yes. Surveyor asked NHA A what facility has put into place to ensure residents safety from CNA D and NHA A indicated the Social Worker does touch base meetings with residents that had concerns regarding CNA D. Surveyor asked NHA A how often these touch base meeting occured and requested documentation. NHA A indicated she would check with the Social Worker. Surveyor asked NHA A how CNA D is monitored and how CNA D's interactions with residents are monitored and NHA A indicated through charting and touch base with residents for new concerns and following up if new concerns are brought forward. Surveyor asked if any new concerns regarding CNA D have come forward and NHA A indicated not to her knowledge. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Lafayette Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 719 E Catherine St Box 167 Darlington, WI 53530	

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On [DATE] at 3:30 PM, Surveyor interviewed NHA A and SW G. Surveyor asked SW G if she did touch bases with residents and SW G indicated yes and she would look for them and get them to Surveyor. Surveyor asked what facility did to ensure residents safety when CNA D returned to work. SW G indicated the touch bases with residents and CNA D had someone with her the first night she returned to work on [DATE]. SW G indicated she interviewed all residents and followed up with the residents that had voiced concerns regarding CNA D. SW G indicated she also would ask residents in normal conversations during the day but did not document these conversations. SW G indicated she does walk bys and asks residents how they are doing but has not charted those. SW G indicated she asks residents if they feel safe and asks if they have any concerns when she completes BIMS (Brief Interview of Mental Status) and PHQ (Patient Health Questionnaire) quarterly and when needed for mood change. On [DATE] at 9:16 AM, Surveyor interviewed NHA A. Surveyor asked NHA A to help me understand if the facility considered the incident abuse should all staff have been educated on abuse. NHA A indicated she has no answer. With resident interviews, residents didn't voice concerns with other staff. It was handled as an isolated incident. Surveyor asked NHA A what her expectation is for staff if they observe abuse by another staff member towards a resident. NHA A indicated she would expect them to take over and ask that staff to leave. Surveyor asked with that being said, was that the case in this incident and NHA A indicated no, all staff should have been educated. Surveyor asked NHA A what time the incident was reported to the NHA, and NHA A indicated it should have been between 7:00 AM and 7:30 AM. NHA A indicated LPN E reported it to her, but NHA A did not have the time documented. Surveyor showed NHA A the Facility Self Report time with a reported time of 6:15 AM and it shows it was reported to the State Agency at 11:14 AM. Surveyor asked when it should be reported to the State and NHA A indicated within 2 hours. Surveyor asked if it was reported within the 2 hours, NHA A indicated no. Surveyor asked when should staff report abuse to the facility and NHA A indicated immediately. Surveyor asked NHA A how the facility ensured safety to all nonverbal residents and NHA A indicated by monitoring for bruises and injuries of unknown origin, watch for more agitation. Surveyor asked NHA A if skin assessments had been completed at the time of the investigation and NHA A indicated not at the time, but they are completed weekly. NHA A indicated the facility should have completed additional skin assessments with nonverbal residents at the time of the investigation. Surveyor asked NHA A if this was a complete investigation and NHA A indicated no, it should have included all staff education on abuse and skin assessments on nonverbal residents.

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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** 41788 Based on interview and record review, the facility did not ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment, are reported immediately to the administrator of the facility and to other officials, including the State Survey Agency, in accordance with State law though established procedures for 1 of 17 abuse investigations reviewed involving (R40). Facility became aware of an abuse allegation on [DATE] at 6:15 AM and did not report it to the State Agency until [DATE] at 11:14 AM. Evidenced by: The facility policy, entitled Abuse, Neglect and Exploitation, dated [DATE], states, in part: . Policy: It is the policy of this facility to provide protection for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property . V1I. 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: a. 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 . R40 was admitted to the facility on [DATE] and has diagnoses that include, malignant neoplasm of unspecified part of left bronchus or lung (a cancerous tumor that has developed in the left bronchus, one of the large airways in the lungs) and nontraumatic intracranial hemorrhage (bleeding in the brain that occurs without trauma or surgery). R40 admitted to hospice [DATE] and expired [DATE]. Facility Self Report dated [DATE], at 11:14:22 AM, states, in part: . Summary of Incident: Allegation Type: Abuse: Hitting, slapping, threats of harm, assault, humiliation. Name-Affected Person: R40 Name-Accused Person: CNA D (Certified Nursing Assistant) . (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	Date occurred: [DATE]. Time occurred: 06:15 AM . Date discovered: [DATE] . Briefly Describe the incident . R40 recently admitted to the facility. It was reported that resident was reporting pain during cares when CNA D was assisting. CNA D continued cares after resident stated to stop . Explain what steps the entity took upon learning of the incident to protect the affected person and others from further potential misconduct: Upon learning of the incident, investigation was started; CNA D was put on leave. Residents interviewed to determine if they feel their rights are being upheld by CNA D and other staff . On [DATE] at 9:16 AM, Surveyor interviewed NHA A (Nursing Home Administrator). Surveyor asked NHA A what time the incident was reported to you, and NHA A indicated it should have been between 7:00 AM and 7:30 AM. NHA A indicated LPN E (Licensed Practical Nurse) reported it to her, but NHA A did not have the time documented. Surveyor showed NHA A the Facility Self Report time reported was 6:15 AM and it shows it was reported to the State Agency at 11:14 AM. Surveyor asked when the self-report should have been reported to the State Agency and NHA A indicated within 2 hours. Surveyor asked if it was reported to the State Agency within 2 hours and NHA A indicated no. Surveyor asked the NHA A when should staff report abuse to the facility, NHA A indicated immediately.

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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** 41788 Based on interview and record review, the facility failed to thoroughly investigate an accusation of physical abuse for 1 of 17 residents (R40) reviewed for abuse. Facility became aware of an abuse allegation on [DATE] and did not complete a thorough investigation. Evidenced by: The facility policy, entitled Abuse, Neglect and Exploitation, dated [DATE], states, in part: . Policy: It is the policy of this facility to provide protection for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property . Definitions: Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish, which can include staff to resident abuse . V. Investigation of Alleged Abuse, Neglect and Exploitation A. An immediate investigation is warranted when 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. 2. Exercising caution in handling evidence that could be used in a criminal investigation (e.g. not tampering or destroying evidence). 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 allegations. 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. VI. Protection of Resident (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility will make efforts to ensure all residents are protected from physical and psychosocial harm, as well as additional abuse, during and after the investigation. Examples include but are not limited to: . A. Responding immediately to protect the alleged victim and integrity of the investigation; . C. Increased supervision of the alleged victim and residents . VII. Reporting/Response . 5. Taking all necessary actions as a result if the investigation, which may include, but are not limited to the following: a. Analyzing the occurrence(s) to determine why abuse, neglect, misappropriation of resident property or exploitation occurred, and what changes are needed to prevent further occurrences. b. Defining how care provisions will be changed and/or improved to protect residents receiving services. c. Training of staff on changes made and demonstration of staff competency after training is implemented. d. Identification of staff responsible for implementation of corrective actions. e. The expected date for implementation; and f. Identification of staff responsible for monitoring the implementation of the plan . R40 was admitted to the facility on [DATE] and has diagnoses that include, malignant neoplasm of unspecified part of left bronchus or lung (a cancerous tumor that has developed in the left bronchus, one of the large airways in the lungs) and nontraumatic intracranial hemorrhage (bleeding in the brain that occurs without trauma or surgery). R40 admitted to hospice [DATE] and expired [DATE]. Facility Self Report dated [DATE], at 11:14:22 AM, states, in part: . Summary of Incident: Allegation Type: Abuse: Hitting, slapping, threats of harm, assault, humiliation. Name-Affected Person: R40 Name-Accused Person: CNA D (Certified Nursing Assistant) . Date occurred: [DATE]. Time occurred: 06:15 AM . (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Date discovered: [DATE] . Briefly Describe the incident . R40 recently admitted to the facility. It was reported that resident was reporting pain during cares when CNA D was assisting. CNA D continued cares after resident stated to stop . Explain what steps the entity took upon learning of the incident to protect the affected person and others from further potential misconduct: Upon learning of the incident, investigation was started; CNA D was put on leave. Residents interviewed to determine if they feel their rights are being upheld by CNA D and other staff . Resident Interviews conducted by SW G (Social Worker) during investigation, dated [DATE], shows 3 residents voiced CNA D does not respect their wishes and 3 indicate CNA D has disregarded their wishes. 2 of those 3 residents voiced they do not feel safe when CNA D works with them. On [DATE] at 3:30 PM, Surveyor interviewed NHA A (Nursing Home Administrator) and SW G (Social Worker). Surveyor asked SW G if she did touch bases with residents and SW G indicated yes and she would look for them and get them to Surveyor. Surveyor asked what facility has done to ensure residents safety when CNA D returned to work, and SW G indicated the touch bases with residents and CNA D had someone with her the first night she returned to work on [DATE]. SW G indicated she interviewed all residents and followed up with the residents that had voiced concerns regarding CNA D. SW G indicated she also would ask residents in normal conversations during the day but did not document these conversations. SW G indicated she walks by a resident room and asks residents how they are doing but has not charted those. SW G indicates she asks residents if they feel safe and ask if they have any concerns when she completes BIMS (Brief Interview of Mental Status) and PHQ (Patient Health Questionnaire) quarterly and when needed for mood changes. On [DATE] at 9:16 AM, Surveyor interviewed NHA A. Surveyor asked NHA A how the facility ensured safety to all nonverbal residents and NHA A indicated by monitoring for bruises and injuries of unknown origin, watch for more agitation. Surveyor asked NHA A if skin assessments had been completed at time of investigation and NHA A indicated not at time, but they are completed weekly. NHA A indicated the facility should have completed additional skin assessments with nonverbal residents at the time of investigation. Surveyor asked NHA A if this was a complete investigation and NHA A indicated no, it should have included all staff education on abuse and skin assessments on nonverbal residents.

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36253 Based on observation, interview, and record review, the facility did not ensure that a resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing for 1 of 3 residents reviewed for pressure injuries (R8). R8 developed a pressure injury, and the facility did not transcribe orders, did not ensure orders were being carried out, and did not put interventions in place to help improve and heal R8's pressure injury. Findings include. The facility's policy, Pressure Injury Prevention and Management, states: *After completing a thorough assessment/evaluation, the interdisciplinary team shall develop a relevant care plan that includes measurable goals for prevention and management of pressure injuries with appropriate interventions. *Interventions will be based on specific factors identified in their risk assessment, skin assessment, and any pressure injury assessment (e.ge., moisture management, impaired mobility, nutritional deficit, staging, wound characteristics). *Evidence-based interventions for prevention will be implemented for all residents who are assessed at risk or who have a pressure injury present period basic or routine care interventions could include comma but are not limited to: i.) Redistribute pressure such as repositioning, protecting and/or offloading heels, etc.); ii.) Minimize exposure to moisture and keep skin clean; iii.) Provide appropriate, pressure-redistributing, support surfaces, iv.) Provide non-irritating surfaces; and v.) Maintain or improve nutrition and hydration status, where feasible. *Interventions will be documented in the care plan and communicated to all relevant staff. R8 was admitted to the facility on [DATE] and has diagnoses that include dementia and hemiplegia (paralysis of one side of the body) affecting left non-dominant side. Her most recent Minimum Data Set (MDS), dated [DATE] includes a Brief Interview for Mental Status (BIMS) score 00, indicating R8 is severely cognitively impaired. R8 was admitted with a stage 2 pressure injury on her left elbow. R8's 9/21/24 Braden (scale for predicting pressure ulcer risk), reveals a score of 12, indicating R8 is at high risk for pressure ulcer development. R8's care plan states, Focus: Alteration in skin integrity with potential for additional areas of skin breakdown related to dementia, left hemiparesis, weakness, functional urinary and bowel incontinence (date initiated: 11/7/23) .Goal: Management of pressure ulcer (date initiated 11/7/23), prevention of future pressure ulcers (date initiated 11/7/23). The interventions for R8's skin integrity focus, all dated 11/7/23, are: *Evaluate skin for areas of blanching or redness (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	*Evaluate ulcer characteristics *Keep skin clean and well lubricated *Monitor bony prominences for redness *Monitor ulcer for signs of progression or declination *Notify family of new onset finding *Provide wound care per treatment order R8's Kardex (Certified Nursing Assistant care plan) does not address any guidance for CNAs on how to address and manage R8's pressure injuries (positioning, cares, etc.) R8's nutritional orders include Magic Cup (protein supplement) one time a day (ordered 3/24/24), Liquacel (protein supplement) at supper for wound healing (ordered 12/28/23), and Breeze (protein supplement) three times a day with all meals (ordered 12/21/23). The facility documented the following progress note on 11/8/24 at 2:31 PM: CNA reported that resident had a hole in her L foot. Upon assessment this writer noted a round open area measuring 15mm x 10mm x 2mm with slough tissue to the wound bed. Some necrotic tissue noted to wound bed as well. No drainage noted at this time. Peri wound skin red and blanchable. No tunneling noted. Wound edges red and moist in appearance. Dry flakey skin noted beyond peri wound area. Cleaned with NS (normal saline) and bordered foam dressing applied. DON (Director of Nursing) updated. Doctor updated via fax. R8's physician directed staff to continue to monitor and continue with the border foam dressing. The facility's weekly wound observation, dated 11/11/24, states that R8's pressure injury to the left heel measures 10 mm x 10 mm x 2 mm (length x width x depth) with 100% slough, no drainage or odor, with a peri-wound description of red and blanchable and wound edges described as red and moist. Additionally, this observation documents border foam as the current treatment plan. No documentation was provided showing that R8's border foam dressing was being completed, nor the details of the order (frequency, timing, etc.). On 11/13/24 at 2:11 PM, LPN I (Licensed Practical Nurse) documented the following progress note for R8 Resident's left foot wound looks infected at this time and has an odor to it. Inside of wound does appear to be tunneling and yellow drainage is present. LPN I notified R8's physician, who then requested the NP (Nurse Practitioner) see R8 quickly, as he (R8's physician) was unable to get to the facility until 11/25/24. The 11/19/24 weekly wound observation noted the left heel to be worsening with measurements of 7mm x 9mm x 5 mm, tunneling all around the perimeter of the wound, deepest at 6:00 at 0.4 cm. The wound was also described as red and blanchable, with non-attached wound edges. The wound was noted to be unstageable at this point. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The NP's note from her wound visit with R8 dated 11/19/24 states, Having pain upon assessment of wound today. Pulling her foot away from provider and kicking with the right foot .patient is severely contracted . swelling of soft tissues .pressure ulcer of left leg, unspecified pressure ulcer stage. The NP's post visit summary states, The optimal goal for wound care will be to relieve pressure, keep the wound clean, and attempt to prevent infection. Cleanse wound with wound cleanser. Patient to have plain packing gauze impregnated with Santyl and lightly fluffed into wound bed. Cover with small nonstick pad and Band-Aid or Tegaderm. Change daily. This order was placed on 11/19/24 with a start date of 11/19/24. The NP order for Santyl external ointment 250 unit/gram applied daily to left heel was not started until 11/22/24. Additionally, according to R8's Medication Administration Record (MAR), R8's Santyl treatment was not done on 11/24/24 and 11/25/24. Of note, the facility experienced an environmental emergency beginning 11/27/24 which required transfer of all residents to other local facilities. The facility sent its own staff to these neighboring facilities and continued caring for their own residents. Residents returned to the facility on [DATE]. During this hiatus from the facility, R8's MAR indicates all her medications and treatments were conducted with exception of the Santyl treatment to her left heel. From 11/28/24 up to and including 12/6/24, no documentation was made that these treatments were carried out at the temporary facility. Subsequent weekly wound observations on 11/28/24 and 12/5/24 indicate the wound was unchanged with measurements and description of the wound matching that of the 11/19/24 assessment. On 12/12/24 at 10:11 AM, Surveyor observed RN H (Registered Nurse) conduct R8's daily Santyl treatment. R8 was lying in bed on her right side. Of note, R8 does not have an air mattress. When RN H lifted the blanket off R8, her left foot was observed directly on the mattress. The wound, which had been described as left heel was observed to be on the ball of R8's large toe. This area appeared to be directly on the mattress as R8's foot appeared to naturally turn down to the mattress. R8 was lying on her right side with her knees together and the left foot draped over her right so that the underside of her left foot's large toe presses directly on the mattress. After the treatment, RN H put a fleece blanket between R8's knees. When asked if R8's foot should have been offloaded from the mattress prior to the treatment, RN H stated, Yes, and indicated that R8 had blue boots (a boot to offload pressure) in the past but would kick them off. RN H indicated that R8 can be repositioned on her left side, although she (R8) prefers to lay on her right side. On 12/12/24 at 1:52 PM, Surveyor interviewed LPN I who stated that on 11/13/24 she was told by the night shift nurse that she had smelled an odor coming from R8's left foot wound. LPN I stated that this night nurse did not contact the doctor and indicated that this night nurse had been aware of this odor from R8's foot for a few days. LPN I stated that she went and looked at the wound and it had an odor and it was tunneling. LPN I stated that she then contacted the doctor. LPN I stated that she was unaware of any pressure relieving devices for R8 and had not seen anything specifically care planned for her and staff to follow for pressure relief. Additionally, on 12/12/24, Surveyor interviewed CNA O (2:24 PM) and CNA P (2:29 PM), both of whom stated that they did not know of any interventions to prevent pressure and/or offload R8's foot nor were they doing anything specific as there was nothing care planned. CNA O indicated that she doesn't position R8 on her left side as that is her weak side and prefers not to lie on that side. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	It should be noted that R8 does not have a specialty pressure-relieving/reducing mattress, but rather the standard mattress that all residents use. The facility was unable to provide any information on the standard mattress and its pressure relieving capabilities. On 12/12/24 at 5:25 PM, Surveyor interviewed NHA A (Nursing Home Administrator). NHA A is the interim NHA at the facility and was DON before her interim NHA status. When asked to review R8's MAR from 12/1-12/6, NHA A indicated she would expect it to be signed out and to have been completed for those dates. NHA A is unable to say it was completed based on MAR not being signed out. Surveyor asked if this would be documented any other place as completed, NHA A indicated she would look. Additionally, NHA A indicated there was an order for border foam for the initial treatment of R8's left foot wound, but the order was never put into the system. NHA A indicated she was unaware how many times it was done or if the treatment was conducted regularly. NHA A was unable to find any historical or current interventions for R8 to offload and/or relieve pressure from her left foot wound. The facility became aware of R8's left foot wound on 11/8/24, which was assessed to be a stage 2 pressure injury, and had orders to apply border foam, however, this order was not put into the facility's system. It is unknown the extent of its application. Additionally, on 11/13/24, R8's wound was noted to have worsened, having become odiferous with draining and tunneling observed. The wound was assessed at this time and noted to be unstageable. R8 was seen by the NP on 11/19/24, who confirmed the wound to be unstageable, with orders changed to Santyl daily, which was not started until 11/22/24 with treatments on 11/24/24 and 11/26/24 not documented. Additional treatments were not documented to have been done between 11/28/24 to 12/6/24 when R8 was at a neighboring facility due to the facility having an environmental emergency. On 12/12/24, Surveyor observed R8's foot directly on her mattress. The facility did not put any interventions in place at any time on or after 11/8/24 to offload and/or reduce pressure on R8's foot.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39849 Based on observation, interview, and record review, the facility did not ensure adequate supervision and safety to prevent accidents from occurring for 3 of 4 residents (R16, R31, and R142) reviewed for falls. R142 sustained a fall on 11/27/24 and the facility failed to find a root cause or implement a new intervention. R31 had several falls, and the facility failed to complete a root cause analysis or implement interventions to prevent additional falls. R16 had several falls, and the facility failed to complete a root cause analysis or implement interventions to prevent additional falls. Findings include: The facility policy, Fall Policy and Procedure, updated 11/2024, indicates, in part: Policy: Staff shall assess for risk, provide preventative measures, and address falls in a safe and professional manner. Procedure: .Fall incident: .7) Documentation: a. Fall note .e. Update fall care plan of immediate intervention . Fall Team Meeting: .2) Fall team is to meet within 72 hours of fall to review fall data and documentation to ensure completion and to review intervention for appropriateness .4) Nurses note is to be completed following the meeting to including: a. Members present b. Root cause c. Intervention: Including all possible interventions noted and reasons for negating or approving of interventions. Example 1 R142 was admitted to the facility on [DATE] with diagnoses that include, in part: Hemiplegia and Hemiparesis (weakness and paralysis on one side of body), Muscle Weakness, Unsteadiness on Feet, and Repeated Falls. R142's admission Minimum Data Set (MDS) dated [DATE] indicates a Brief Interview for Mental Status (BIMS) of 2, indicating R142 has a severe cognitive impairment. R142's care plan includes, in part: --Focus: Potential for falls related to CVA (Cerebral Vascular Accident - Stroke) with right sided weakness, cognitive deficit, communication deficit, functional urinary and bowel incontinence, medications received, intermittent pain, h/o (history of) falls. Date Initiated: 12/4/24. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	--Goal: The resident will be free of minor injury through the review date. Date Initiated: 12/4/24. --Interventions/Tasks (all indicate date initiated 12/4/24): Anticipate and meet the resident's needs. Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance. Ensure that the resident is wearing appropriate footwear mobilizing in w/c. Follow facility fall policy. Pt evaluate and treat as ordered or PRN (as needed) The resident uses bed and chair alarm. Ensure the device is in place as needed. --Focus: The resident has limited physical mobility related to CVA (Cerebral Vascular Accident/stroke) with right sided weakness, balance deficit, cognitive impairment. Date initiated 12/4/24. --Goal: The resident will increase level of mobility by [sic] through the next review date. Date initiated: 12/4/24. Revision on 12/10/24. --Interventions/Tasks, in part: .Assistive devices: Hoyer, wheelchair. Date initiated: 12/9/24 . Of note, no interventions indicated a date initiated of 11/27/24, the date R142 sustained a fall, or within 72 hours of the fall. A fall document, dated 11/27/24 at 1:30 PM, titled, #169 Un-witnessed Fall, includes, in part: Nursing description: Resident found on floor next to bed, alarm sounding, resident lying on right side facing bed, no apparent injuries noted. Resident description: Resident Unable to give Description . Injury Type: No Injuries observed at time of incident. Mobility: Wheelchair bound. Of note, there is no information on the document regarding a root cause analysis or the implementation of a new individualized fall intervention(s). A nurse's note, dated 11/27/24 1:35 PM includes the following: Resident found on floor next to bed, alarm sounding, Admin/DON (Director of Nursing), MD, and family aware, no new injuries noted. Resident unable to recall incident. VSS (Vital Signs Stable), will monitor. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/12/24 at 7:20 AM, Surveyor observed R142 in bed with her bed in low position. On 12/12/24 at 2:38 PM, Surveyor interviewed CNA T (Certified Nursing Assistant) who indicated she can look at the resident Kardex or in the electronic record to see what fall interventions are in place for a resident. CNA T indicated that for R142, when she is in bed, she has a bed alarm and they keep her bed in low position. When R142 is in the common area, they keep her by staff. CNA T opened the Kardex for R142 on the computer and was not able to locate these interventions. On 12/12/24, Surveyor interviewed NHA A (Nursing Home Administrator). NHA A is the interim NHA at the facility and was the DON (Director of Nursing) before her interim NHA status. NHA A indicated that a root cause should be completed for falls and a new intervention put into place and was not. 36253 Example 2 R16 was admitted to the facility on [DATE] and has diagnoses that include malignant neoplasm of brain (cancer in the brain) and seizures. Her care plan states, Focus: Potential for falls related to lung cancer with brain metastasis, history of CVA (Cerebrovascular Accident/Stroke), limitations to lower extremities, weakness, balance deficit, intermittent urinary and bowel incontinence, recent history of falls, visual deficit . Goal: resident will be free of falls .Interventions: 1) Assist resident with ambulation and transfers, utilizing therapy recommendations (dated 10/1/24), 2) Determine residents ability to transfer (dated 10/1/24), 3) If fall occurs, alert provider (dated 10/1/24) 4) If resident is a fall risk, initiate fall risk precautions (dated 10/1/24). Recent fall risk assessments conducted on 12/7/24 and 12/10/24 show a score of 16, indicating R16 is at high risk for falls (10 or greater indicates high risk). R16 experienced the following falls: 9/30/24 at 11:10 PM: Unwitnessed in resident room/bathroom 10/25/24 at 5:45 PM: Unwitnessed, found on floor in room near bathroom. 10/31/24 at 11:53 AM: Witnessed near therapy room slide out of her wheelchair. 10/31/24 at 8:46 PM: Witnessed in room sliding out of chair. 11/2/24 at 5:45 PM: Witnessed trying to self-reposition in her wheelchair in the hallway. 12/6/24 at 7:55 PM: Unwitnessed, found on floor sitting near her bed. None of these falls resulted in significant or major injuries. Additionally, a progress note dated 11/6/24 at 5:56 PM states, Resident's alarm started going off ran into room to find resident sitting on the foot part of recliner, she had scooted to the end and was going to try to get up. She did not fall. She continually is getting up unassisted. She takes her alarm off, and we have caught her several times tonight get up without assist. (continued on next page)

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F 0689

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

The fall reports for these falls do not include any interventions, immediate or otherwise. The facility was unable to provide documentation or record of Interdisciplinary Team (IDT) meetings or documentation detailing a root cause analysis, how the facility will help address R16's unique needs and her continued falls. Additionally, Fall risk precautions, as mentioned in R16's care plan, are not detailed.

Example 3

R31 was admitted to the facility on [DATE] and has diagnoses that include dementia. His care plan states, Potential for falls related to dementia, self-care deficit, weakness, balance deficit, recent history of falls, incontinence, intermittent pain .Goal: will be free of falls (dated 5/21/24) .Interventions: 1) Assist resident with ambulation and transfers, utilizing therapy recommendations (dated 5/21/24), 2) Determine residents ability to transfer (dated 5/21/24), 3) Ensure bed is kept in lowest position (dated 6/21/24), 4) Ensure call light is available to resident (dated 6/12/24), 5) Evaluate fall risk on admission and PRN (as needed) (dated 5/21/24), 6) If fall occurs, alert provider (dated 5/21/24), 7) If fall occurs, initiate frequent neuro (neurological) and bleeding evaluation per facility protocol (dated 5/21/24), 8) If resident is a fall risk, initiate fall risk precautions (dated 5/21/24), 9) Utilize devices as appropriate to ensure safety (dated 6/12/24).

On 12/10/24 at 10:07 AM, Surveyor interviewed R31, who was laying in his bed, which was low to the floor with fall mat next the bed. Across the fall mat, R31's wheelchair was facing him. R31 stated that he had, had recent falls but could not remember exactly when. He stated that he sometimes trips over the mat on the floor and that he recently fell from tripping on it.

The facility documented the following falls for R31:

*10/29/24 at 7:46 PM: Resident had an unwitnessed fall at 1545 (3:45 PM) today in his bathroom. Resident was found sitting on the floor on his buttocks in his bathroom with his back up against the wall. Resident denied hitting his head when he was asked today by this writer. No immediate signs of injury were noted by this writer today. Resident said that the staff could get him up when he was asked by this writer. Resident said he got up by himself and tripped on the fall mat on the floor and slid. Water was on the floor, resident's water mug got knocked over and water got spilled on the floor. Family and DON (Director of Nursing) was updated.

*10/31/24 at 6:30 AM: The night shift and day shift were in hall doing walking rounds and resident was resting on bed. At 0635 CNA's went past his room and found resident laying on the floor supine by the closet and sink. He was alert but had blood on floor under his head. Night nurse and this writer went to assess and found a hematoma (collection of blood) on the occipital area (back of head) of head and no laceration, but hematoma had bleeding. Resident was able to speak clearly and was able to state he was walking to get his underwear to change it. {sic}

R31 was sent to the hospital after the 10/31 fall, but no significant or major injuries were identified.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The fall reports for the 10/29 and 10/31 falls does not include any interventions, root cause analysis, immediate or otherwise. The facility was unable to provide documentation or record of Interdisciplinary Team (IDT) meetings or documentation detailing how the facility will help address R31's unique needs and his continued falls. Additionally, Fall risk precautions, as mentioned in R31's care plan, are not detailed. No documented root cause analysis was sought or identified, nor any resident specific interventions or approaches have been care planned for R31. On 12/12/24 at 5:45 PM, Surveyor interviewed NHA A (Nursing Home Administrator). NHA A is the interim NHA at the facility and was DON before her interim NHA status. NHA A stated that the facility talks about falls at standup but does not document those interactions. NHA A stated that they did not look at any root-cause analysis. When asked how they plan to address R16's falls, NHA A stated, She keeps sliding out of her chair, that is the cause. When Surveyor told NHA A that R31 had stated that he trips on his fall mat, NHA A indicated that the specific fall mat in R31's room can be slippery.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39849 Based on interview and record review, the facility did not ensure residents maintain acceptable parameters of nutritional status, such as usual body weight or desirable body weight range, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise for 2 of 2 residents (R35 and R17) reviewed for nutrition. R35's weights were obtained using different methods and therefore it is unclear if they are accurate. R35's physician was not updated on weight gain/loss based on these weights. R17's physician was not updated on a 21 pound weight loss and there was no documentation of trialing supplements with R17. Findings Include: The facility policy, titled, Weight Monitoring, date reviewed 11/2024, indicates, in part: Policy: Based on the resident's comprehensive assessment, the facility will ensure that all residents maintain acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise. Compliance Guidelines: .1. The facility will utilize a systemic approach to optimize a resident's nutritional status. This process includes: .c. Developing and consistently implementing pertinent approaches. d. Monitoring the effectiveness of interventions and revising them as necessary .4. Interventions will be identified, implemented, monitored and modified (as appropriate), consistent with the resident's assessed needs, choices, preferences, goals and current professional standards to maintain acceptable parameters of nutritional status .6. Weight Analysis: The newly recorded resident weight should be compared to the previous recorded weight. A significant change in weight is defined as: a. 5% change in weight in 1 month (30 days) b. 7.5% change in weight in 3 months (90 days) c. 10% change in weight in 6 months (180) days .7. Documentation: a. The physician should be informed of a significant change in weight .f. Observations pertinent to the resident's weight status should be recorded in the medical record as appropriate . Example 1 R35 was admitted to the facility on [DATE] with diagnoses that include, in part: Alzheimer's Disease, Hypertension, and Gastro-Esophageal Reflux (stomach contents goes up into the food pipe causing irritation). R35's Facility recorded weights include, in part: 12/8/24: 166 lbs (wheelchair) (this is a 5 pound loss) 11/1/24: 171.0 lbs (wheelchair) (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Lafayette Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 719 E Catherine St Box 167 Darlington, WI 53530	

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10/1/24: 167.4 (Standing) 9/1/24: 171.6 (Standing) (this is a 10.8 pound loss) 8/6/24: 182.4 (wheelchair) 8/1/24: 180.6 (wheelchair) (this is a 13.4 pound or 7.41% gain) 7/1/24: 167.2 lbs (wheelchair) 6/1/24: 169 lbs (Standing) (this is a 8 pound gain) 3/14/24: 161.2 (Standing) . Review of R35's Physician Orders do not reference a weight gain or loss parameter for notification. A 9/15/24 Nutrition/Dietary Note indicates, in part: .On 8/1/24 and 8/6/24 he (R35) had weights documented approximately 180-182#, which was a approximate 13-15# wt gain from the previous month (9/1/24) weight was approximately 171.6#. Writer questioning accuracy of 8/24/24 weights, if accurate though writer unsure of cause of weight gain. Not concerned at this time with weigh [sic] variations as po (oral) intake remains good, fairly stable compared to previous assessment with (outside of 8/24/24 weights) primarily ranging approximately 165-171# since 5/1/24 .No recommended changes to nutritional care plan . On 12/12/24 at 2:47 PM, Surveyor interviewed CNA S (Certified Nursing Assistant) a who indicated the facility electronic health record indicates how a resident should be weighed. CNA S indicated the majority of the residents on the floor (where R35 resides) are wheelchair weights. CNA S showed surveyor a list of residents who are weighed via wheelchair that also includes the weight of the wheelchair that should be subtracted after the weight is obtained. CNA S indicated that the wheelchair weight includes all equipment such as pressure relieving cushions, foot petals, etc. CNA S indicated if a resident's chair changes then the CNAs are to update the list. CNA S indicated the nurse will tell them if they need to complete a re-weight and that either the CNA or the nurse can document the weight in the record. On 12/12/24 at 2:52 PM, Surveyor interviewed RN H (Registered Nurse) who indicated the CNAs bring her the resident weights and if something is funky a re-weight is completed and if it is still funky then it is compared to prior months. If after this anything is still funky then the information goes to the dietician and if it is a major weight loss/gain they are to update the doctor. Surveyor reviewed R35's weights with RN H and asked how you could tell if there was a re-weight. RN H indicated they do not keep the paper that re-weights are documented on. RN H also reviewed R35's orders and did not find an order for when to contact the provider for weight gain/loss. RN H indicated with no order she would contact the physician with a 5 lb. change in resident weight. RN H was unsure if there was a facility policy regarding this. RN H indicated that residents should be weighed consistently by the same method and that R35 is on the list of residents who should be weighed in their wheelchair, and she would expect him to be weighed in his wheelchair. RN H indicated she would have expected a provider notification on 9/1/24 when R35's weight went from 182.4 lb (Wheelchair) on 8/6/24 to 171.6 (Standing) on 9/1/24. (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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/12/24 at 3:39 PM, Surveyor interviewed NHA A (Nursing Home Administrator). NHA A is the interim NHA at the facility and was the DON (Director of Nursing) before her interim NHA status. NHA A indicated resident's weights should be obtained at the beginning of the month and that they need to be weighed the same way. If they are going to use a wheelchair then they need to do that every month. If they are going to use the shower chair, then use that every month. Otherwise, there can be discrepancies. Surveyor reviewed R35's weights with NHA A. NHA A indicated there is no way to know if the weights are accurate given the different methods the weights were obtained by. NHA A indicated she would expect re-weights to be documented. NHA A indicated she was unsure of the exact facility policy on when to call the physician if an order for weight changes is not given and would check on this. (Please see policy information above that was later provided to surveyor). NHA A indicated she would have expected the physician to have been called, based on the following weight changes: 8/6/24: 182.4 lbs to 9/1/24: 171.6 lbs (Loss of 10.8 lbs. or 5.9%) 7/1/24: 167.2 lbs to 8/1/24: 180.6 lbs (Gain of 13.4 lbs. or 8.0%) 11/1/24: 171 lbs to 12/8/24: 166 lbs (Loss of 5 lbs. or 2.9%) No further documentation or provider notification for these weights was provided by the facility. 36253 Example 2: R17 was admitted to the facility on [DATE] and has diagnoses that include unspecified dementia without behavioral disturbance. Her most recent Minimum Data Set (MDS), dated [DATE], includes a Brief Interview for Mental Status (BIMS) score of 01, indicating R17 is severely cognitively impaired. The facility documented the following weights for R17: 10/9/2024 19:05 (7:05 PM) 179.2 Lbs 10/19/2024 20:01 (10:01 PM) 179.6 Lbs 11/1/2024 12:48 (12:48 PM) 158.4 Lbs 11/6/2024 11:03 (11:03 AM) 161.1 Lbs 12/8/2024 10:18 (10:18 AM) 158.0 Lbs Additionally, on 10/6/2024 at 4:36 PM, the facility's dietician notes R17's hospital weight, prior to discharge to the facility, to be 171.2 lbs. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The dietician also noted for R17 on 10/24/24 at 5:21 PM, Resident had been started on Ensure 4oz (TID w/ meals) on 10/8/24, it was discontinued on 10/23 and boost breeze was started in its place. Documentation notes she didn't care for ensure. Documentation does show she has refused frequently for breakfast and lunch, however it also shows she has consumed ~100% of supper ensure. Questioning accuracy. Since starting boost breeze she has averaged ~70% (based on x5 offerings). Meal intakes over the last ~14 days: ~0-25%: x17; ~26-50%: x12; ~51-75%:x8; ~76-100%: x3. 10/19/24 wt 179.6#; 10/9/24 179.2#. Weight has held ~179# since admitting. A nutrition note, entered by DM Q (Dietary Manager), dated 11/6/24 at 12:52 PM states, Resident is not eating well. Trial of Magic cup at noon and supper meals. Pudding cup at all meals. Still getting the wildberry breeze three times daily. Facility was unable to provide any documentation of this trial of R17's Magic Cup. On 12/12/24 at 3:59 PM, Surveyor interviewed DM Q (Dietary Manager) who stated that, although she is not a dietician, the facility's contracted dietician, who is not in the building often, would give her permission to trial nutritional supplements for up to three days. DM Q stated that she remembers the trial for R17 but the dietary department does not track how often they go out or if the supplement was actually consumed. DM Q stated it would be the CNAs (Certified Nursing Assistants) that would track the consumption of the supplements. On 12/12/24 at 4:15 PM, Surveyor interviewed NHA A (Nursing Home Administrator). NHA A is the interim NHA at the facility and was the DON before her interim NHA status. When asked who tracks supplement intake, NHA A stated nursing staff should be documenting, even if it is a trial. When asked if there was documentation of R17's three day trial of the Magic Cup, NHA A stated she was unable to find any documentation of it. Additionally, when asked if R17's physician was made aware of her 21 lb weight loss, NHA A indicated she was unable to find communication of the weight loss. NHA A indicated if the weights are that different back to back, nursing staff should be re-weighing to ensure accuracy, but then the weight loss should be communicated with the physician.

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F 0755

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 39849

Based on interview and record review, the facility did not provide pharmaceutical services including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals to meet the needs of each resident for 1 of 1 residents (R142) reviewed.

R142 did not receive her scheduled Dupilumab (Dupixent) Subcutaneous (under the skin) Solution Auto-Injector 300mg/2ml on 12/6/24.

Findings include:

The facility policy titled, Medication Errors, date reviewed 11/2024, includes, in part:

Policy: It is the policy of this facility to provide protections for the health, welfare, and right of each resident by ensuring residents receive care and services safely in an environment free of significant medication errors .

Policy Explanation and Compliance Guidelines:

1. The facility shall ensure medications will be administered as follows: a. According to physician orders .4. The facility will consider factors indicating errors in medication administration, including, but not limited to, the following: a. Medication administered not in accordance with the prescriber's order. Examples include, but not limited to: ii. Medication omission .

R142 was admitted to the facility on [DATE] with diagnoses that include, in part: Other Seasonal Allergic Rhinitis, Hemiplegia and Hemiparesis.

R142's admission Minimum Data Set (MDS) dated [DATE] indicates a Brief Interview for Mental Status (BIMS) of 2, indicating R142 has a severe cognitive impairment.

On 12/10/24 at 11:19 AM, Surveyor contacted R142's Power of Attorney for Health Care (POAHC) due to R142's cognitive status. R142's POAHC indicated that R142 was not receiving her injections of Dupilumab for her eczema since being at the facility and she feels her skin is getting worse and that she is itching her arms again. R142's POAHC indicated that she has talked to the facility about it and they were looking into it but has not been given a definitive answer yet.

R142's December Medication Administration Record (MAR) indicates the following, in part:

Dupilumab Subcutaneous Solution Auto-Injector 300mg/2ml (Dupilumab) Inject 2ml subcutaneously one time a day every 14 day(s) related to Other Seasonal Allergic Rhinitis with a start date of 12/6/24 AM. (of note: this medication is a biological medication, which are used for inflammatory conditions)

Of note, the next dose would not be scheduled for administration until 12/20/24.

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Lafayette Manor	719 E Catherine St Box 167 Darlington, WI 53530

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R142's Physician Orders indicate an order date for the Dupilumab of 11/22/24 and a start date of 12/6/24. On 12/6/24 there is a circled M and N/A written for the 12/6/24 administration time for R142's Dupilumab. It is important to note that the facility had an environmental emergency where residents were relocated to other local facility's from 11/27/24 returning to the facility 12/6/24. Facility staff did provide cares to residents at the other facilitys. On 12/12/24 at 2:41 PM, Surveyor interviewed CNA T (Certified Nursing Assistant) who indicated that R142 does itch her arms a lot. CNA T indicated that R142's daughter said that she was on a medication for it but she (CNA T) was unsure if R142 was on it now and that she thought the facility was checking into it. CNA T indicated that they will let the nurse know and sometimes they will put lotion on but that it doesn't help for long. On 12/12/24 at 3:29 PM, Surveyor interviewed NHA A (Nursing Home Administrator). NHA A is the interim NHA at the facility and was the DON (Director of Nursing) before her interim NHA status. According to the physician order audit details, NHA A entered the Dupilumab order into the facility electronic record. NHA A indicated that if she remembers correctly R142 does have eczema. NHA A indicated the reason the order was put in on 11/22/24 with a start date of 12/6/24 was because she spoke to the hospital, and they said that they gave it the day she left the hospital on 11/22/24. NHA A indicated that when the residents were out of the building their medications were sent with them to the other facility's. Surveyor reviewed R142's MAR with NHA A for the 12/6/24 dose of Dupilumab. NHA A indicated agreement that this was not given based on the documentation. NHA A indicated the missed medication was not reported to her. NHA A indicated someone should have reviewed the MARs when residents returned to know if anything was missed and contacted the provider so that it could be rescheduled sooner than the next scheduled dose of 12/20/24.

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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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36253 Based on interview and record review, the facility did not ensure residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record for 2 of 5 residents reviewed for unnecessary medications (R17 and R30). R17 was taking an antipsychotic medication without appropriate diagnoses and indications for its use. R30's comprehensive care plan and documentation did not indicate what side effects of antipsychotic, benzodiazepine, or antidepressive medication that R30 should be monitored for, nor was there any documentation to indicate that R30's side effects were being monitored by staff. Findings include The facility policy titled, Use of Psychotropic Medication, states, in part: *The indications for initiating, withdrawing, or withholding medications, as well as the use of non-pharmacological approaches, will be determined by: a) Assessing the residents underlying condition, current signs, symptoms, expressions, and preferences and goals for treatment, b) Identification of underlying causes, when possible. *New admissions: the facility shall identify the indication for use, as possible, using preadmission screening and other preadmission data. The physician in collaboration with the consultant pharmacist shall reevaluate the use of the medication and consider whether or not the medication can be reduced or discontinued upon admission or soon after admission. * the effects of the psychotropic medications on a resident's physical, mental, and psychosocial well-being will be evaluated on an ongoing basis, such as: a) upon physician evaluation (routine and as needed), b) during the pharmacist's monthly medication regimen review, c) during MDS review (quarterly, annually, significant change), and d) in accordance with nurse assessments and medication monitoring parameters consistent with clinical standards of practice, manufacturer's specifications, and the residents comprehensive plan of care. * The resident's response to the medications, including progress towards goals and presence/absence of adverse consequences, shall be documented in the residence medical record. Example 1 R17 was admitted to the facility on [DATE] and has diagnoses that include unspecified dementia without behavioral disturbance, depression, and anxiety disorder. Admission medication orders for R17 included Quetiapine (seroquel) 25 mg (milligrams) three times daily for depression. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility has targeted behaviors for R17 as anxiety (as manifested by fidgeting, repetitive comments, worry, feelings of not knowing what to do), insomnia, and depression. The facility documents on these behaviors each shift. A pharmacy consultant note, dated 10/21/24 at 11:09 AM reads, .noted Seroquel diagnosis is depression . Nursing recommendation to update diagnosis on Quetiapine . A facility progress note for R17, 10/22/24 at 1:42 PM, states, Residents son here to visit over the noon hour. Resident has been eating poorly at meals as she gets distracted very easily and then will state she doesn't care for a lot of the food choices. Has been refusing her supplements as well. Will update provider and she if he wants to order anything for appetite. Will have kitchen send a few different types of supplements to see what she likes. On 10/22/24 at 4:52 PM, R17's physician made an electronic note regarding R17's nutritional status, writing, Omeprazole was started and also Quetiapine was increased, hopefully between these 2 her appetite will be stimulated. An additional progress note made for R17 on 10/23/24 at 8:53 AM reads Received a response from the provider as he was updated on resident's heartburn last week and of her having anxiety episodes intermittently throughout all shifts and at times to the point of making her hyperventilate or get nauseated . Provider did order resident to start on Omeprazole 20mg P.O. daily for GERD (gastroesophageal reflux disease; a digestive disorder that causes heartburn and indigestion), and wants to increase the Seroquel to give 25mg P.O. 3 times daily and 50 mg at night. A pharmacist note to R17's physician, dated 11/25/24, states, Resident had a quetiapine dose increase on 10/23/24 to 25 mg 3 times daily and 50 mg at bedtime. The diagnosis in this order is listed as dementia with behaviors. Per discussion with the psychotropic medication review committee resident does not display harmful behavior, and the quetiapine dose increase was due to increased anxiety symptoms. She does have diagnosis of both depression and anxiety on her chart. Could we have an updated diagnosis for the quetiapine please? The physician, on 12/4/24, responded with a new diagnoses of dementia with agitation and aggression. The facility was unable to provide any documentation that R17 was being monitored for agitation or aggression. On 12/12/24 at 2:16 PM, Surveyor interviewed SW G (Social Worker) who stated that she had not seen any aggression by R17. SW G also stated that, as far as her agitation, R17 gets a bit fidgety but that is specifically addressed in her behaviors being tracked for anxiety. On 12/12/24 at 4:25 PM, Surveyor interviewed NHA A (Nursing Home Administrator). NHA A is the interim NHA at the facility and was DON (Director of Nursing) before her interim NHA status. When asked if depression or dementia were appropriate diagnosis for the use of an antipsychotic, NHA A responded, It depends. When asked if using quetiapine for appetite stimulation was appropriate, NHA A responded, No. R17 is taking quetiapine without an appropriate diagnoses or indications for its use. 50285 (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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Example 2 R30 was admitted on [DATE] with diagnosis that include Unspecified Dementia, Depression Unspecified, Pain Unspecified, Adjustment Disorder with Mixed Anxiety and Depressed Mood. R30's most recent Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 9/11/24 indicates R30 has significant cognitive impairment with a Brief Interview of Mental Status (BIMS) score of 6 out of 15. R30's Care Plan states in part: --Focus: The resident has impaired cognitive function/dementia or impaired thought processes r/t (related to) diagnosis of Unspecified Dementia, Unspecified Severity, Without behavioral disturbance, Mood Disturbance, and Anxiety. --Interventions: Administer medications as ordered. Monitor/document for side effects and effectiveness. Ask yes/no questions in order to determine the resident's needs . Review medications and record possible causes of cognitive deficit: new medications or dosage increases; anticholinergics, opioids, benzodiazepines, recent discontinuation, omission or decrease in dose of benzodiazepines, drug interactions, errors or adverse drug reactions, drug toxicity. --Focus: The resident uses psychotropic medications r/t adjustment disorder with anxiety and depression. --Interventions: Administer psychotropic medications as ordered by physician. Monitor for side effects and effectiveness Q-shift (every shift) . Review behaviors/interventions and alternate therapies attempted and their effectiveness as per facility policy. Educate the resident/family/caregivers about risks, benefits and the side effects and/or toxic symptoms of medications. --Focus: The resident has a mood problem r/t diagnosis of Depression and Adjustment Disorder with mixed anxiety and depressed mood. --Goals: The resident will have improved mood state as noted by resident indicating 1 to 2 less episodes of depression and 1 to 2 less episodes of anxiety through the review date. Interventions: Administer medications as ordered. Monitor/document for side effects and effectiveness. R30's December 2024 Physician orders include: *Quetiapine Fumarate Oral Tablet 25 MG (Quetiapine Fumarate). Give 1 tablet by mouth two times a day for Adjustment Disorder with Mixed Anxiety and Depressed Mood. *Lorazepam Oral Tablet 0.5 MG (Lorazepam) (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give 1 tablet by mouth one time a day related to Adjustment Disorder with Mixed Anxiety and Depressed Mood. *Sertraline HCl Oral Tablet 25 MG (Sertraline HCl) Give 1 tablet by mouth one time a day related to Adjustment Disorder with Mixed Anxiety and Depressed Mood; AND Give 2 tablet by mouth one time a day for Adjustment Disorder with Mixed Anxiety and Depressed Mood. (Of note: R30's Electronic Health Record does not indicate what side effects to monitor for while R30 is taking an antipsychotic, a benzodiazepine, and an antidepressant.) On 12/12/24 at 4:58 PM, Surveyor interviewed CNA J (Certified Nursing Assistant). Surveyor asked CNA J if she knew what side effects of R30's medication she should monitor for. CNA J stated she didn't know but that she would ask the nurse. On 12/12/24 at 4:59 PM, Surveyor interviewed CNA K. Surveyor asked CNA K if she knew what side effects of R30's medication she should monitor for. CNA K stated that R30 gets very anxious so she thought that is what should be monitored for. On 12/12/24 at 5:01 PM, Surveyor interviewed CNA L. Surveyor asked CNA L if she knew what side effects of R30's medication she should monitor for. CNA L stated she did not know but she thought things like anxiety and depression should be monitored for. On 12/12/24 at 5:03 PM, Surveyor interviewed Med Tech M (Medication Technician). Surveyor asked Med Tech M if she knew what side effects of R30's medication she should monitor for. Med Tech M indicated that R30 has seizures and maybe dizziness should be monitored for. Surveyor asked Med Tech M how the CNAs would know what side effects to monitor for so they could let the nurse know. Med Tech M stated the nurses would have to tell them what medication side effects to monitor for. On 12/12/24 at 5:06 PM, Surveyor interviewed RN N (Registered Nurse). Surveyor asked RN N how the staff would know of what medication side effects to monitor for R30. RN N stated they are taught to notify the nurse of any change in behavior that is different from their baseline. On 12/12/24 at 5:11 PM, Surveyor interviewed NHA A (Nursing Home Administrator). Surveyor asked NHA A how staff would know what side effects to monitor for R30's antipsychotic, antidepressant, and benzodiazepine medications. NHA A indicated that the black box warning is put into their MAR (Medication Administration Record) in PCC (Point Click Care; an electronic health record system). Surveyor asked if that would include specific side effects. NHA A stated no, specific side effects would not be listed on the MAR. NHA A indicated that the nurses on the floor always have drug books available to them and they can reference those. NHA A stated that none of the residents have what medication side effects should be monitored or daily monitoring. R30's comprehensive care plan and documentation did not indicate what side effects of antipsychotic, benzodiazepine, or antidepressive medication R30 should be monitored for, nor was there any documentation to indicate that R30's side effects were being monitored by staff.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lafayette Manor	719 E Catherine St Box 167 Darlington, WI 53530

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 50285 Based on observation, interview, and record review, the facility did not ensure drugs and biological's are labeled in accordance with currently accepted professional standards for 2 of 2 Medication carts reviewed and 2 of 2 medication rooms for medication storage. The 2nd floor medication cart had an undated open insulin pen for R34, and expired morphine tablets for R25. The 3rd floor medication cart had a cough syrup for R1 with no open date or expiration date. The 2nd and 3rd floor medication storage rooms had expired stock meds. Evidenced by: The Facility's Policy, entitled Labeling of Medications and Biologicals, dated 1/5/2022 with last revision date of 11/2024 states, in part: All medications and biologicals used in the facility will be labeled in accordance with current state and federal regulations to facilitate consideration of precautions and safe administration of medications . 1. All medications and biologicals will be labeled in accordance with applicable federal and state requirements and current accepted pharmaceutical principles and practices . 9. Labels for medications designed for multiple administration (such as inhalers, eye drops), the label will identify the specific resident for whom it was prescribed . The Facility Policy, entitled, Medication Storage, dated 1/5/2024 with last revision date of 11/2024, states, in part: .It is the policy of this facility to ensure all medications housed on our premises will be stored in the pharmacy and/or medications rooms according to the manufacturer's recommendations . 9. Unused Medications: The pharmacy and all medication rooms are routinely inspected by the consultant pharmacist for discontinued, outdated, defective, or deteriorated medications with worn, illegible, or missing labels. These medications are destroyed . The Facility Policy, entitled, Medication Administration, dated 1/5/2022 with last revision date of 11/2024, states, in part: Medications are administered . in accordance with professional standards of practice . 12. Compare medication source (bubble pack, vial, etc.) with MAR (Medication Administration Record) to verify resident's name, medication name, form, dose, route, and time . 13. Identify expiration date. If expired, notify nurse manager . Example 1 On 12/12/24 at 8:28 AM, Surveyor observed the 2nd floor medication storage room with LPN I (Licensed Practical Nurse). Surveyor found two bottles of Thiamin Vitamin B1 100 mg (milligrams) with an expiration date of 11/2024, one bottle of Super View Healthy Eyes eye vitamins with expiration date of 7/2/24 and a bottle of Paxlovid 300 mg with an expiration date of 11/2024. Surveyor asked LPN I how long medications were good for after the open date. LPN I answered the medications were good for 30 days after opening. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Lafayette Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 719 E Catherine St Box 167 Darlington, WI 53530	

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Example 2 On 12/12/24 at 8:49 AM, Surveyor observed the 3rd floor medication storage room with LPN I. Surveyor found a box of acetaminophen 650 mg suppositories with an expiration date of 2/2024. LPN I indicated that the last resident to use this medication was over a year ago. Surveyor found a bottle of Vitamin D 10 mcg (micrograms) with an expiration date of 11/2024. Surveyor asked LPN I who was responsible for checking the medication storage rooms for expired medications. LPN I replied that typically the night nurses go through the storage rooms and dispose of expired medications. Example 3 On 12/12/24 at 9:11 AM, Surveyor observed the 2nd floor medication cart with DON B (Director of Nursing). Surveyor noted two bottles of GenTeal eye drops not properly dated with an open date, a box of Hydrocort (hydrocortisone) 25 mg suppositories with an expiration date of 11/2024, a bottle of fish oil capsules not properly dated with an open date, a blister pack of Muccinex removed from the original packaging with no expiration date, a used Lantus insulin pen for R34 with no open date and no expiration date, and morphine sulfate 15 mg tablets for R25 with an expiration date of 9/25/24. DON B indicated that the insulin pens are normally dated when they are first used. Surveyor asked DON B if the nurses administering the medications should be checking the expiration dates. DON B replied yes, but that hospice was responsible for checking the medication cart for expired medications for their patients. Example 4 On 12/12/24 at 9:31 AM, Surveyor observed the 3rd floor medication cart with RN H (Registered Nurse). Surveyor found a bottle of Delsym cough syrup for R1 with no expiration date and not properly dated with an open date. Surveyor asked RN H how long medications were good for after the open date. RN H answered the medications were good for 28 days after opening. On 12/12/24 at 1:47 PM, Surveyor interviewed NHA A (Nursing Home Administrator) regarding medication storage and expiration dates. Surveyor asked NHA A who was responsible for checking medication carts and medication storage rooms for expired medications. NHA A replied that the nurses are responsible for checking for expired medications, and also that the pharmacy comes every three months and does an audit looking for expired medications. Surveyor asked NHA what her expectation was for dating over the counter medications and insulin pens. NHA A stated the nurses were expected to date the bottles when they open them and also date eye drops and insulin. Surveyor asked NHA A how long medications were good for after the open date. NHA A indicated the medications were good until the manufacturer's expiration date. Surveyor asked NHA A if she expected that the medications administered to the residents would be before the expiration date. NHA A replied yes, that would be her expectation.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 36253 Based on observation and interview, the facility did not store, prepare, distribute, and serve food in accordance with professional standards for food service safety. This has the potential to affect all 39 residents. Nutritional supplements and food items were observed with improper dates. An employee walked through the kitchen with no hairnet. A scoop was observed inside a container of sugar. Findings include Example 1 On 12/10/24 at 8:48 AM, Surveyor, along with DM Q (Dietary Manager), observed the following in the kitchen's dry storage: *3 bags of unopened pasta with no use by date *28-6 lb. cans of various vegetables and pie fillings with no received or use-by dates At 9:00 AM, Surveyor and DM Q observed the following in the kitchen's main refrigerator: *A container of sunflower seeds with an open/prepared date of 5/17/24 and a use by 10/17/24 *4 thawed nutritional supplements with no thaw dates (manufacturer label states the supplement must be used within 14 days of thawing). At 9:07 AM, DM Q stated that the nutritional supplements need to be thrown away as there is no thaw date and the container of sunflower seeds is past its use-by date and needed to be discarded. Example 2 On 12/10/24 at 9:08 AM, Surveyor, along with DM Q, observed CM R (County Maintenance) walk into the main kitchen without a hairnet. CM R walked through food preparation areas. CM R acknowledged Surveyor at this time indicating that he was not wearing a hairnet and needed one. Example 3 On 12/10/24 at 9:08 AM, Surveyor, along with DM Q, observed a large container of sugar in the facility's main kitchen. Inside the container of sugar a scoop could be seen. At this time, DM Q stated the scoop should not be in there due to potential cross-contamination and infection control standards.

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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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 50285 Based on interview and record review, the facility did not identify issues to which quality assessment and assurance activities are necessary or make a concentrated effort to improve facility quality. This has the potential to affect all 39 residents. The facility does not have a Quality Assurance and Performance Improvement (QAPI) system in place and has failed to identify areas needing improvement to develop, implement, monitor, and evaluate action plans to achieve specific goals to improve quality of care. This is evidenced by the following: The facility policy, entitled Quality Assurance and Performance Improvement (QAPI) and dated 1/1/24, states, in part, It is the policy of this facility to develop, implement, and maintain an effective, comprehensive, data driven QAPI program that focuses on indicators of the outcomes of care and quality of life and addresses all the care and unique services the facility provides . The facility will maintain documentation and demonstrate evidence of its ongoing QAPI program. Documentation may include, but is not limited to: . Documentation demonstrating the development, implementation, and evaluation of corrective actions or performance improvement activities . Governing oversight responsibilities include but are not limited to: . Ensuring the program is sustained during transitions in leadership and staffing . The facility conducts at least one distinct performance improvement project (PIP) annually that focuses on high risk or problem prone areas. Additional projects may be conducted as needed, and may be clinical or non-clinical in nature . The facility policy, entitled, QAPI Change Process, dated 1/1/24, states, in part: The facility has established and utilizes a systemic approach to performance improvement activities to ensure changes are effective and improvements are sustained . The facility must conduct distinct performance improvement projects, based on the scope and complexity of facility services and available resources, identified in the facility assessment . The facility must conduct at least one improvement project annually that focuses on high-risk or problem-prone areas, identified by the facility through data collection and analysis .: On 12/11/24 at 2:22 PM, Surveyor reviewed the facility QAPI binder. There was no evidence of the facility having a PIP in place to improve quality of care for the residents. On 12/12/24 at 2:06 PM, Surveyor interviewed NHA A (Nursing Home Administrator) regarding the QAPI process and plan. Surveyor asked NHA A how the facility tracked QAPI initiatives. NHA A stated she didn't have an answer for that as she has only conducted one QAPI meeting herself since assuming the role of NHA in October. Surveyor asked NHA A if the facility was currently working on any PIPs. NHA A replied no, they were currently not working on any PIPs. Surveyor asked NHA A if they should be working on a PIP at least annually to ensure quality of care to the residents. NHA A replied yes, they should have a PIP, but with the changes in facility leadership it has been difficult to prioritize the QAPI plan and initiatives. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility did not follow their QAPI plan to identify at least one improvement project that focused on problem areas to ensure quality of care for their residents.

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F 0868

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Many

Have the Quality Assessment and Assurance group have the required members and meet at least quarterly

50285

Based on interview and record review, the facility did not maintain a Quality Assessment and Assurance Committee consisting of at a minimum, the Director of Nursing Services, the Medical Director or his/her designee, at least three other members of the facility's staff one of whom must be the administrator, owner, a board member or other individual in a leadership role, and the Infection Preventionist, which met at least quarterly. This has the potential to affect all 39 Residents residing within the facility.

Quality Assurance and Performance Improvement (QAPI) meetings did not consist of the required attendees/members for any of the quarterly meetings in the past year.

This is evidenced by:

The facility policy, entitled Quality Assurance and Performance Improvement (QAPI) and dated 1/1/24, states, in part, It is the policy of this facility to develop, implement, and maintain an effective, comprehensive, data driven QAPI program that focuses on indicators of the outcomes of care and quality of life and addresses all the care and unique services the facility provides . The QAA (Quality Assessment and Assurance) Committee shall be interdisciplinary and shall consist of a minimum of:

i. The Director of Nursing Services

ii. The Medical Director or his/her designee;

iii. At least three other members of the facility's staff, at least one of which must be the Administrator, Owner, a Board Member, or other Individual in a leadership role; and

iv. The Infection Preventionist .

On 12/11/24 at 2:22 PM, Surveyor reviewed the facility's QAPI Committee meeting sign in sheets and noted the following:

The QAPI meeting attendance sheet dated 11/6/23 did not include the Infection Preventionist (IP).

The QAPI meeting attendance sheet dated 1/31/24 did not include the IP.

The QAPI meeting attendance sheet dated 4/29/24 did not include the Administrator or IP.

The QAPI meeting attendance sheet dated 7/29/24 did not include the IP.

The QAPI meeting attendance sheet dated 10/28/24 did not include the IP.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 12/12/24 at 2:06 PM, Surveyor interviewed NHA A (Nursing Home Administrator) regarding the facility's QAPI process and QAA meetings. Surveyor asked NHA A who should be in attendance for the QAPI meetings. NHA A replied the NHA, DON (Director of Nursing), MD (Medical Director), Social Services, Dietary, Activities, Pharmacy, and the MDS (Minimum Data Set) Coordinator. Surveyor asked NHA A if the IP should be in attendance at the meetings. NHA A indicated she was not aware the IP needed to attend the meetings, as infection control is presented by the DON at the meetings. Surveyor reviewed the facility QAPI policy with NHA A. Surveyor asked if, per their policy, the IP should be included in the QAPI meetings. NHA A replied yes, the IP should attend the meetings.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 39849 Based on interview and record review, the facility has not established an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. The facility does not have a water management plan that identifies all areas where Legionella and other opportunistic waterborne pathogens can grow and spread. This has the potential to affect all 39 residents (R) in the facility. Surveyors observed missing ceiling tiles with water actively dripping from a pipe into a container near residents during the lunch meal. The facility does not have mechanism for tracking Multi-Drug Resistant Organisms (MDRO). The facility's monthly infection control rates were not segregated for specific infection types. The facility could not provide evidence their water management program included: 1) Descriptions of the building water system using text and flow diagrams. 2) Identification of areas where Legionella and other opportunistic waterborne pathogens can grow and spread. 3) Description of where control measures should be applied and how to monitor them. Findings include: The facility policy titled, Infection Surveillance, date reviewed, 10/23/24, indicates, in part: Policy: A system of infection surveillance serves as a core activity of the facility's infection prevention and control program. Its purpose is to identify infections and to monitor adherence to recommended infection prevention and control practices in order to reduce infections and prevent the spread of infections . Policy Explanation and Compliance Guidelines: .7. The facility will communicate via (specify how, e.g. written reports, staff meetings, etc.) to staff and/or prescribing practitioners information related to infection rates and outcomes in order to revise interventions/approaches and/or re-evaluate medical interventions as indicated. 8. Monthly time periods will be used to capturing and reporting data. Line charts will be used to show data comparisons over time and will be monitored for trends. 9. All resident and infections will be tracked. Separate, site-specific measures may be tracked as prioritized from the infection control risk assessment . The facility policy titled, Infection Prevention and Control Program, date reviewed, 10/23/24, indicates, in part: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Policy: The facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections as per accepted standards and guidelines .3. Surveillance: .b. The infection preventionist serves as the leader in surveillance activities, maintains documentation of incidents, findings, and any corrective actions made by the facility and reports surveillance findings to the facility's Quality Assessment and Assurance Committee . The facility policy titled, Water Management Program, date reviewed, 10/23/24, indicates, in part: Policy: It is the policy of this facility to establish water management plans for reducing the risk of legionellosis and other opportunistic pathogens .in the facility's water systems based on nationally accepted standards (e.g., ASHRAE, CDC, EPA). Policy Explanation and Compliance Guidelines: .3. A risk assessment will be conducted by the water management team annually to identify where Legionella and other opportunistic waterborne pathogens could grow and spread in the facility's water systems .4. Data to be used for completing the risk assessment may include but are not limited to: a. Water system schematic/description. b. Legionella environmental assessment .5. Based on the risk assessment, control points will be identified. The list of identified points shall be kept in the water management program binder . The CDC Legionella Toolkit-Version 1.1 - June 24, 2021, Developing a Water Management Program to Reduce Legionella Growth and Spread in Buildings. A Practical Guide to Implementing Industry Standards, indicates, in part: Page 4 - Where can Legionella grow and/or spread? . *Water heaters . *Electronic and manual faucets . *Showerheads and hoses . *Ice Machines . Page 8 - Describe Your Building Water Systems Using Text .You will need to write a simple description of your building water system and devices .This description should include details like where the building connects to the municipal water supply, how water is distributed, and where pools, hot tubs, cooling towers, and water heaters or boilers are located . Page 10 - Describe Your Building Water Systems Using a Flow Diagram .In addition to developing a written description of your building water system, you should develop a process flow diagram . Page 11 - Identify Areas Where Legionella Could Grow & Spread .Once you have developed your process flow diagram, identify where potentially hazardous conditions could occur in your building water system . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Example 1 On 12/10/24 at 11:18 AM, surveyors observed resident dining at the lunch mealtime in the first-floor dining area. Surveyors observed 5 ceiling tiles missing with exposed pipes, a ladder, a container, and towels placed under the open ceiling with water dripping into the container and debris on the floor. The container the water was dripping into was less than 2 feet from 2 residents sitting at a dining table. There were an additional 5 residents seated at another table near the open ceiling and container collecting the dripping water. On 12/10/24 at 11:30 AM, Surveyors interviewed NHA A (Nursing Home Administrator) in the first-floor dining area. NHA A indicated a pipe started leaking yesterday from a resident room above the dining room that maintenance was currently trying to repair. Surveyor asked NHA A how she would feel if she was one of the residents dining next to this. NHA A indicated not well. Surveyor asked if this could be an infection control issue in a dining area. NHA A indicated it could be and that the residents should have been seated somewhere else. On 12/10/24 at 11:36 AM, staff moved a total of 7 residents to an area away from the open ceiling and dripping water. Example 2 On 12/11/24 and 12/12/24 Surveyor reviewed the infection control program documentation provided by the facility. On 12/12/24 at 10:07 AM, Surveyor met to review the infection control program with LPN I, (Licenses Practical Nurse) who is also the Infection Preventionist (IP) for the facility, and NHA A. NHA A is the interim NHA at the facility and was DON (Director of Nursing) before her interim NHA status. Surveyor asked if the facility has a tracking mechanism for residents who have MDRO's (Multi-Drug Resistant Organisms). LPN I and NHA A indicated with the size of the building they know which residents have MDRO's and were able to list these residents for Surveyor. LPN I and NHA A indicated they do not have an actual mechanism to track these MDROs that others would be able to access. Example 3 On 12/11/24 and 12/12/24 Surveyor reviewed the infection control program documentation provided by the facility. On 12/12/24 at 10:07 AM, Surveyor met to review the infection control program with LPN I, who is also the Infection Preventionist (IP) for the facility, and NHA A. NHA A is the interim NHA at the facility and was DON (Director of Nursing) before her interim NHA status. Surveyor reviewed the monthly IC (Infection Control) rates that were provided by the facility with LPN I and NHA A. The monthly rates provided are for overall infection rates and not segregated for specific infection type. NHA A indicated that she completes the monthly infection rates and only completes overall rates and does not have them by specific infection type. Surveyor asked how they can ascertain an increase in a certain infection type without segregated rates. NHA A indicated they cannot. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Example 4 On 12/12/24, Surveyor reviewed the water management documentation provided by the facility. On 12/12/24 at 5:18 PM, Surveyor interviewed NHA A regarding the facility water management program information that had been provided. Surveyor was unable to locate: 1) Descriptions of the building water system using text and flow diagrams. 2) Identification of areas where Legionella and other opportunistic waterborne pathogens can grow and spread. 3) Description of where control measures should be applied and how to monitor them. Surveyor asked NHA A if maintenance was available to speak with as the water management policy indicates the Maintenance Director maintains documentation that describes the facility's water system. NHA A indicated that maintenance was not available at that time. Surveyor reviewed the above items that could not be located in the water management documents provided. NHA A indicated that these things should have been included in the water program and that she will check maintenance to see if she can locate the binder referenced in the policy. Of note, no further documentation related to the water management program was provided to the Surveyor.