STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525371	A. Building B. Wing	05/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Silver Springs Health Care Center	1300 West Silver Spring Dr Glendale, WI 53209

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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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and policy review, the facility failed to inform a resident of a lab draw so the resident could make a decision regarding the procedure for one (Resident (R) 3) of three residents reviewed for self-determination out of a total sample of 15 residents. This had the potential for the resident not be able to make a decision about daily care and services. Findings include: Review of the facility's undated policy titled, Your Rights and Protections as a Nursing Home Resident, indicated, As a nursing home resident, you have certain rights and protections under Federal and state law that help ensure you get the care and services you need. You have the . right to be informed, make your own decisions, and have your personal information kept private . . Get Proper Medical Care: You have the following rights regarding your medical care: . To participate in decisions that affects your care . Review of R3's admission Record found on the Profile page of the electronic medical record (EMR) revealed R3 was admitted to the facility on [DATE] with a diagnosis of type 2 diabetes mellitus. Review of R3's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/14/25, located in the MDS tab of the EMR, revealed a Brief Interview Mental Status (BIMS) score of 15 out of 15, which indicated R3 was cognitively intact. Review of a 04/29/25 physician's Order for R3, provided by the Director of Nursing (DON), indicated, Order Summary: A1C [a laboratory test which measures a person's average blood sugar level over the prior two to three months] every 90 days one time a day every 90 day(s) for DM [diabetes mellitus] for 1 day. Review of R3's EMR revealed no documentation regarding staff notifying R3 of the 04/29/25 physician's order for the A1C laboratory test or the resident's response to any discussion about the lab test which required her blood to be drawn. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/27/25 at 12:55 PM, R3 stated that on 05/01/25 at 4:20 AM, a man entered her room while she was sleeping, woke her up, and informed her that he was there to draw her blood. R3 stated this scared her because she did not know this person and had no prior knowledge that a blood draw needed to be performed. R3 stated she refused to allow the man to draw her blood. R3 explained on 05/02/25 at 9:20 AM a young woman entered her room and on 05/03/25 at 5:39 AM another woman entered her room, and they both informed her they were there to draw her blood. R3 stated she also refused both of these subsequent requests to have her blood drawn as well. The resident stated that no one at the facility informed her of an order for drawing her blood and that people would be coming into her room to obtain her blood. R3 stated she would have liked to have been informed by facility staff about the blood draw because she would told them that she did not want her blood to be drawn. During an interview on 05/27/25 at 1:10 PM, R14 (R3's roommate) confirmed that on 05/01/25 at around 4:20 AM, a man entered her and R3's room, woke up R3, and informed her that he was there to draw her blood. R14 stated this upset R3 because she did not know the man who woke her up, and she refused to allow him to take her blood. During an interview on 05/29/25 at 1:45 PM, the DON stated the nurse who received the 04/29/25 physician's order for R3 to have an A1C laboratory test perform was not available for interview. The DON stated that he expected nursing staff to inform R3 of the order for the A1C prior to the lab test being performed and provide her with the opportunity to refuse the blood draw. The DON explained that if a resident refused to have a laboratory test performed the nursing staff should notify the physician of the refusal and document this refusal in the resident's EMR. The DON confirmed the nursing staff failed to document any information in the resident's EMR regarding R3's 04/29/25 order for an A1C lab draw and any discussions that staff had with the resident regarding drawing her blood. During an interview on 05/29/25 at 3:50 PM, a Laboratory Supervisor (LS) with the laboratory company that came to draw R3's blood, in response to the 04/29/25 physician's order for an A1C test, indicated, the laboratory's records reflected that their staff came to the facility and attempted to obtain R3's blood on 04/30/25 at between 4:30 AM and 5:00 AM, on 05/01/25 at between 4:45 AM and 5:15 AM, and on 05/02/25 at between 4:45 AM and 5:20 AM. The LS stated each of these three attempts were noted to be refused by R3.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 2. Review of R1's admission Record located in the EMR under the tab titled Profile revealed the resident was admitted to the facility on [DATE] with a diagnosis of gastrostomy (g-tube). Review of R1's Physician Orders dated 03/14/25 located in the resident's EMR under the tab titled Orders revealed the resident was to receive Nepro with Carb Steady at 60 centimeters (cc) from 6:00 PM to 6:00AM for a total of 720 cc. During an observation on 05/27/25 at 9:00AM revealed the resident was in bed positioned on his right side facing the door. The intravenous pole and feeding pump had dried, beige color, formula splatter. During an observation on 05/28/25 at 8:45 AM revealed the resident had tube feeding infusing at 60 ccs an hour with a water bolus bag hanging. The IV pole and feeding pump had dried beige color formula splatter. 3. Review of R9's admission Record located in the resident's EMR under the tab titled Profile revealed the resident was initially admitted to the facility on [DATE] and readmitted [DATE] with diagnoses that included acute and chronic respiratory failure with hypoxia, asthma, and chronic obstructive pulmonary disease. Review of R9's Physicians Orders dated 03/25/25 located in the resident's EMR tab titled Orders revealed the resident was to receive Nepro (or Glucerna) 1.2 tube feeding 237 cc bolus every four hours. During an observation on 05/28/25 at 9:15 AM revealed dried, beige color formula splatter on the IV pole, on the floor and the resident's oxygen concentrator. During an observation on 05/29/25 at 10:10 AM revealed there was dried beige color, formula splatter on the resident's IV pole, the floor, and the oxygen concentrator. During an observation on 05/29/25 at 3:10 PM with Licensed Practical Nurse (LPN)4 revealed R1's and R9's enteral feeding equipment remained in the same condition with dried, beige color, formula splatter. Review of the facility's staff meeting agenda dated 04/10/25 and provided by the facility documented the following .Tube feeding spills were not being cleaned up .nursing staff responsible for cleaning up body fluids and housekeeping responsible for mopping afterwards . Based on observation, interview, record review, and policy review, the facility to maintain a clean and safe environment for three residents (Resident (R)1, R4, and R9) out of a total of 15 sampled residents whose environment was reviewed. This had the potential for a break in infection control and potential injury. Findings include: (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's policy titled, Routine Cleaning and Disinfection, dated 01/03/25, indicated, It is the policy of this facility to ensure the provision of routine cleaning and disinfection in order to provide a safe, sanitary environment and to prevent the development and transmission of infection to the extent possible . 3. Consistent surface cleaning and disinfection will be conducted with a detailed focus on high touch areas include, but not limited to: . j. IV poles . l. Sinks and faucets . 1. Review of R4's Medical Diagnosis, sheet located in the Med [Medical] Diag [Diagnosis] tab of the Electronic Medical Record (EMR), indicated, the resident was admitted to the facility on [DATE]. Review of R4's quarterly Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 02/27/25 located in the EMR under the MDS tab, indicated a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the resident was cognitively intact. Review of R4's Census Record located in the EMR under the Census tab revealed R4 had resided in her current room since 02/01/25. During an observation on 05/27/25 at 9:50 AM of R4's room, revealed the room's sink had a large crack that extended from the near the front of the sink to the sink's faucet. The crack was elevated and had very sharp edges. Observation underneath the sink revealed one of the sink's two corner support braces was broken. When pressure was applied to the top or the sink it was unstable. During an interview on 05/27/25 at 9:50 AM, R4 stated she had resided in her current room since the first of February 2025. R4 explained the room's sink had been cracked and unstable since she moved into the room. R4 stated she had spoken to the facility's prior maintenance director about the broken sink, but it had never been repaired or replaced. The resident revealed she used the sink on a daily basis. During an interview on 05/28/25 at 1:53 PM, the Maintenance/Housekeeping Director (MHD) observed the sink in R4's room. The MHD confirmed the sink was cracked with sharp edges along the crack, was unstable and needed to be repaired or replaced. The MHD stated he was unaware the sink was broken, and he would have expected staff to inform him the sink needed to be fixed. The MHD stated that he performed routine rounds in the facility each morning and he had not noticed that the sink in R4's room was broken. During an interview on 05/28/25 at 2:15 PM, the Administrator observed the sink in R4's room and confirmed it was cracked and unstable. The Administrator felt the edges along the crack and confirmed the edges were sharp and were a hazard. The Administrator stated he was unaware the sink was broken and would see if staff could repair the sink or if it needed to be replaced. During an interview on 05/29/25 at 10:55 AM, Housekeeper (HSK)1 stated he regularly cleaned R4's room and he had not noticed that the sink in the resident's room was broken. During an interview on 05/29/25 at 12:45 PM, Certified Nursing Assistant (CNA)3 stated she regularly cared for R4 and she had not noticed that the sink in the resident's room was broken.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and policy review, the facility failed to ensure the accuracy of the Minimum Data Set (MDS) assessment for one (Resident (R) 3) of 15 residents whose assessments were reviewed in a total sample of 15 residents. The facility failed to accurately assess the rejection of care for R3. This failure placed the resident at risk of having unmet care needs and services. Findings include: Review of the facility's undated policy, titled MDS, indicated, Residents are assessed, using a comprehensive assessment process, in order to identify care needs and to develop an interdisciplinary care plan . 4. Care Plan Team Responsibility for Assessment Completion: . a. ii. Persons completing part of the assessment must attest to the accuracy of the section they completed by signature and indication of the relevant sections . Review of the admission Record found on the Profile page of the electronic medical record (EMR) revealed R3 was admitted to the facility on [DATE]. Review of R3's Care Notes found under the Progress Notes tab of the EMR revealed the following entries: 04/12/25 at 12:26 PM: Resident refuse medication NP [Nurse Practitioner] updated . 04/14/25 at 2:14 PM: Blood pressure monitoring one time a day for Ongoing hypertension Resident refuse. 04/15/25 at 2:07 PM: Blood pressure monitoring one time a day for Ongoing hypertension Resident refuse NP updated. 04/16/25 at 2:52 PM: Blood pressure monitoring one time a day for Ongoing hypertension Resident refuse NP updated. 04/17/25 at 12:41 PM: Blood pressure monitoring one time a day for Ongoing hypertension resident refused blood pressure check. 04/18/25 at 9:59 AM: Blood pressure monitoring one time a day for Ongoing hypertension Refused. Review of R3's Therapy Screening Form dated 04/15/25, provided by the facility's Physical Therapist (PT), indicated, Resident was screened by writer, however resident refused to be talked to or to be screened. Review of R3's quarterly MDS with an Assessment Reference Date (ARD) of 04/18/25, located in the MDS tab of the EMR, indicated, R3 did not reject evaluation or care. This MDS entry was noted as being locked by the Social Worker (SW) on 04/21/25. During an interview on 05/28/25 at 10:35 AM, Licensed Practical Nurse (LPN)1 stated she provided care for R3 and the resident at times did refuse care and blood pressure checks. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/29/25 at 12:30 PM, the SW reviewed R3's April 2025 progress notes and the resident's 04/18/25 quarterly MDS. The SW confirmed the progress notes specified R3 did reject care and evaluation on multiple occasions during the seven day look back period for her 04/18/25 quarterly MDS and the resident's quarterly MDS inaccurately specified the resident did not reject care. a

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and review of facility policy, the facility failed to develop a baseline care plan for one Resident (R)1 from a total of 15 residents reviewed for care plans. This failure had the potential to cause staff to not provide the necessary instructions needed to provide effective care and meet the needs of resident. Findings include: Review of the facility document titled Baseline Care Plan with an implementation date of 03/01/19 revealed . the base line care plan will be developed within 48 hours of a resident's admission .include the minimum healthcare information necessary to properly care for a resident .a written summary of the baseline care plan shall be provided to the resident and representation in a language that the resident/representative can understand . Review of R1's admission Record located in the resident's electronic medical record (EMR) under the tab titled Profile revealed the resident was admitted to the facility on [DATE] with diagnoses that included nontraumatic cerebral hemorrhage with right sided hemiplegia and hemiparesis, dysphagia, urinary tract infection, and gastrostomy. A review of R1's Care Plans located in the resident's EMR tab titled Care Plans failed to reveal a Baseline Care Plan for the resident. During an interview on 05/28/25 at 9:10 AM with Family (F)1 revealed they did not receive a copy of the baseline care plan which discussed the facility's concerns of care areas that should be addressed. During an interview on 05/29/25 at 2:10 PM with Licensed Practical Nurse Unit Manager (LPN)4 revealed that she initiated a care plan for R1 that was reviewed at his admission care conference held on 02/19/25. LPN4 stated that she has never given a resident or family a copy of the base line care plan within 48 hours of admission. During an interview on 05/29/25 at 4:10 PM with the Director of Nursing (DON) revealed they were unable to locate a copy of the resident's baseline care plan.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, interview, and review of facility policies, the facility failed to revise the care plan of one resident (R2) out of 15 residents reviewed for care plans out of a total sample of 15 residents related to a new medication and a self-administration assessment. This had the potential for staff to not be aware of the resident's ability to administer medication per herself and cause confusion. Findings include: Review of the facility policy titled Comprehensive Care Plans with a review date of 10/01/22 revealed .the comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly Minimum Data Set (MDS) assessment . Review of the facility policy titled Self-Administration of Medications with an effective date of 10/25/14 revealed .The results of the interdisciplinary team assessment of resident skills and of the determination regarding bedside storage are recorded in the resident's medical record, on the care plan. For each medication authorized for self-administration, the label contains a notation that it may be self-administered . Review of R2's admission Record located in the resident's electronic medical record (EMR) under the tab titled Profile revealed the resident was admitted to the facility on [DATE] with diagnoses that included morbid obesity, systemic lupus erythematosus (autoimmune disease), major depressive disorder. Review of R2's Physician Orders dated 03/26/25 located in the EMR under the tab titled Orders revealed the resident was to receive Mounjaro Subcutaneous Solution Auto-Injector five milligrams one time a day every Saturday for weight support. A review of R2's Self -Administration of Medication Assessment dated 03/26/25 located in the EMR under the tab titled Assessments revealed the resident was assessed to self-administer the Mounjaro medication without any difficulty. The resident was approved to self-administer the medication and keep it at the bedside. Review of R2's Care Plan with a recent revision date 04/07/25 located in the EMR under the tab titled Care Plans failed to reveal the resident's care plan was revised to reflect the self-administration of the Mounjaro medication. During an observation on 05/29/25 at 12:30 PM revealed R2 maintained her Mounjaro syringes at her bedside in a locked box. During an interview on 05/29/25 at 2:10 PM with Licensed Practical Nurse (LPN) 4 revealed R2 had received the new medication of Mounjaro along with training about three months ago. LPN4 stated the resident's care plan should have been revised to reflect the new medication as well as the resident being assessed to administer the medication herself. After reviewing the resident's care plan during this interview, LPN4 acknowledged the care plan was not revised to reflect the Mounjaro medication.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one (Resident (R) 4) of three residents reviewed for transportation services to outside medical appointments were transported to the correct medical provider out of a total of 15 sampled residents. This failure created the potential for medical needs to remain unaddressed for the resident. Findings include: Review of R4's Medical Diagnosis, sheet located in the Med [Medical] Diag [Diagnosis] tab of the Electronic Medical Record (EMR), indicated, the resident was admitted to the facility on [DATE] with diagnoses including fractures of the right arm, left arm, tibia, ribs, and humerus following a motor vehicle accident. Review of R4's quarterly Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 02/27/25 located in the EMR under the MDS tab, indicated a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the resident was cognitively intact. During an interview on 05/27/25 at 3:15 PM, R4 stated on 04/18/25 she had a scheduled orthopedic appointment to have her right arm evaluated. R4 stated that the facility provided the transportation driver, who drove her to her appointment with the wrong address of the orthopedic provider which resulted in her missing her appointment. R4 stated she was upset because she missed her scheduled appointment, and she felt like it wasted her day. R4 stated she rescheduled the appointment herself and had a friend drive her to the appointment to ensure that she did not miss the appointment again. During an interview on 05/29/25 at 11:29 AM, the facility's Receptionist (R) stated she assisted in arranging transportation for residents to outside medical appointments. The R stated when she was contacted by the orthopedic office about R4's 04/18/25 appointment she wrote down the information provided, but the office did not provide her with the city where their office was located. The R stated she did not ask the provider's office what city they were located, and she assumed their office was in Glendale, Wisconsin. The R stated she was incorrect because the provider's office was in Mequon, Wisconsin, so the driver who transported R4 to her appointment was provided with the wrong address which resulted in R4 missing her scheduled appointment on 04/18/25. During an interview on 05/29/25 at 3:30 PM, the Administrator stated the facility did not have a policy for transporting residents to outside medical providers or a policy for scheduling resident medical appointments. The Administrator confirmed that R4 missed her scheduled 04/18/25 orthopedic appointment because the facility did not provide the transport driver with the correct address. The Administrator stated he expected the facility to obtain the provider's correct information and address for resident scheduled medical appointments and for residents to be transported to the correct medical provider and to not miss any of their scheduled appointments.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, interview, and review of facility policy, the facility failed to properly position urinary drainage bag for one resident (R)1 from a sample of three residents with urinary drainage bags out of a total sample of 15 residents reviewed. This failure has the potential to promote reoccurring urinary tract infections (UTIs). Findings include: Review of the facility's undated policy titled Catheter Care revealed It is the policy of this facility to provide catheter care to call residents that have an indwelling catheter in an effort to reduce bladder and kidney infections . Review of R1's admission Record located in the resident electronic medical record (EMR) under the tab titled Profile revealed the resident was admitted to the facility on [DATE] with a diagnosis that included UTIs. Review of R1's admission Minimum Date Set (MDS) with an Assessment Reference Date (ARD) of 01/23/25 located in the resident's EMR under the tab titled MDS revealed the resident had an indwelling catheter/suprapubic catheter for urinary retention. Review of R1's Care Plan with revision date of 02/25/25 located in the EMR under the tab titled Care Plans directed staff to assist with incontinent care as needed; observe and report signs and symptoms of urinary tract infection; provide indwelling catheter care every shift and PRN (as needed) and secure the catheter and tubing appropriately. During an observation on 05/28/25 at 9:30 AM revealed R1 was receiving incontinence care from the three Certified Nursing Assistants (CNAs)1, CNA3, and CNA4. R1 was positioned on his side with the urinary drainage bag in the bed with the resident. The resident had amber colored urine backing up into the bladder area. The catheter's tubing was secured to the resident's right thigh with a securement device. As the resident was turned from his side, the urinary drainage bag remained in bed with the resident. At one point CNA3 was holding the resident's drainage bag above the resident's waist with urine in the tubing going back into the resident's bladder area. During an interview with the three CNAs (1, 3, 4) on 05/28/25 at 10:10 AM the question was asked how they were trained to position residents with urinary drainage bags while providing care. CNA1 stated that she was not sure since she had only been employed at the facility for two months. CNA1 stated that she probably needed more training regarding urinary catheters and positioning. CNA3 stated that she did not realize that she was holding the drainage bag above R1's bladder and that the urine was backing into the resident's bladder. CNA4 stated this was her second day of training and acknowledged that the urine flowing into the resident's bladder could cause a UTI.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, interview, and review of facility policy, the facility failed to provide care of oxygen equipment for two residents (R9 and R15) from a sampled fifteen residents. The oxygen tubing for R9 was unlabeled with a date and sticky to the touch. This failure has the potential to provide unsanitary equipment for oxygen therapy. Findings include: Review of a facility undated policy titled Oxygen Administrationrevealed .Change oxygen tubing and mask/cannula weekly and as needed if becomes soiled or contaminated. Change the humidifier bottle when empty, every 72 hours or as recommended by the manufacturer. If applicable change the nebulizer tubing and delivery devices every 72 hours and as needed if they become soiled or contaminated. 1. Review of R9's admission Record located in the electronic medical record (EMR) under the tab titled Profile revealed the resident was initially admitted to the facility on [DATE] and readmitted [DATE] with diagnoses that included acute and chronic respiratory failure with hypoxia, asthma, and chronic obstructive pulmonary disease (COPD). Review of R9's Physicians Orders dated 02/28/25 in the electronic medical record (EMR) under the tab titled Orders revealed the resident was to receive two to three liters per minute to maintain oxygenation saturation of 90% or higher. During an observation on 05/28/25 at 9:15 AM revealed the resident was in bed and was receiving oxygen therapy at 2 liters per minute via nasal cannula. The oxygen tubing was unlabeled with a date and was sticky. During an observation on 05/29/25 at 10:10 AM revealed R9 was receiving oxygen therapy via nasal cannula at two liters per minute. The oxygen tubing remained unlabeled with a date and was sticky to touch. 2. Review of R15's admission Record located in the EMR under the tab titled Profile revealed the resident was admitted to the facility on [DATE] with diagnosis that included acute and chronic respiratory failure with hypoxia. Review of R15's Physicians Orders dated 05/29/25 located in the EMR under the tab titled Orders directed the staff to change all oxygen tubing, masks, and humidification every Sunday. During an observation on 05/27/25 at 11:30 AM revealed R15 was receiving oxygen therapy at two liters per minute via nasal cannula. The tubing was undated. During an observation on 05/28/25 at 1:30 PM revealed R15's nasal cannula tubing remained undated. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525371	A. Building B. Wing	05/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Silver Springs Health Care Center	1300 West Silver Spring Dr Glendale, WI 53209

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 05/29/25 at 3:10 PM with Licensed Practical Nurse (LPN)4 revealed R9's and R15's oxygen tubing remained in the same condition as the observations above. LPN4 revealed the night shift nurses were responsible for changing and labeling the oxygen tubing with the correct date. LPN4 also stated that the oxygen tubing on R9 felt like it had not been changed in quite a while since it was so sticky.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525371	A. Building B. Wing	05/29/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, interview, and review of facility policy, the facility failed to ensure staff used appropriate personal protective equipment (PPE) for two (Residents (R)1 and R13) of two observed for enhanced barrier precautions (EBP) out of 15 residents reviewed in the sample. This failure had the potential to expose residents to infection. Findings include: Review of facility policy titled Enhanced Barrier Precautions with an implementation date 02/25/24 revealed, Enhanced barrier precautions (EBP) refers to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown, and gloves use during high contact resident care activities. An order for enhanced barrier precautions will be initiated for residents with any of the following: wounds (chronic wounds such as pressure ulcer, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers) indwelling medical devices, tracheostomies, feeding tubes. Personal protective equipment (gowns and gloves) must be worn when dressing, bathing, transferring, providing hygiene, changing linen, changing briefs, or assisting with toileting, device care or use (such as central lines, catheters, feeding tubes, tracheostomy/ventilators tube); wound care any chronic skin opening requiring a dressing . 1. Review of R1's admission Record located in the electronic medical record (EMR) under the tab titled Profile revealed the resident was admitted to the facility on [DATE] with diagnoses that included urinary tract infection, stage IV sacral ulcer, and gastrostomy (g-tube). Review R1's Physician Orders dated 01/20/25 located in the EMR under the tab titled Orders revealed an order for a suprapubic catheter size 16 French with a 10-milliliter balloon, daily wound care and enteral feedings every 12 hours. During an observation on 05/28/25 at 9:30 AM revealed R1's room had signage on the wall indicating that R1 was on EBP and there was a cabinet outside the resident's room that contained gowns, gloves, and face masks. In the room, R1 was receiving incontinence care from the three Certified Nursing Assistants (CNAs)1, CNA3, and CNA4. CNA4 was wearing a gown, mask, and gloves. CNA3 was wearing only a face mask (no gown or gloves); and CNA 1 was wearing a face mask and gloves but no gown. While providing care to the resident CNA3 was observed holding R1's urinary drainage bag without any gloves. CNA1 was holding R1 on his side while CNA4 (wearing gown and gloves) applied barrier cream to the resident's buttocks. During an interview on 05/28/25 on 10:10 AM with CNA1, CNA3, and CNA4 they were asked what it meant if a resident was on EBP. The CNAs were unable to answer the question. After reading the signage in the room all three CNAs were able to identify why R1 was on EBP. Both CNA1 and CNA3 acknowledged that they had failed to don the appropriate PPE while providing care for R1. 2. Review of R13's admission Record located in the EMR under the tab titled Profile revealed the resident was admitted to the facility on [DATE] with diagnoses that included chronic ulcer of the buttocks. (continued on next page)

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	525371	A. Building B. Wing	05/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R13's Physician Orders dated 04/19/25 located in the EMR under the tab titled Orders documented the resident was to receive Santyl ointment to sacral wound after being cleansed with wound cleanser. During an observation on 05/28/25 at 10:30 AM revealed R13's room had EBP signage posted and an isolation cart set up with gowns and gloves. In the room, R13 was receiving a bed bath provided by CNA5. CNA5 was not wearing a gown. During an interview on 05/28/25 at 10:40 AM with CNA5 revealed R13 was on EBP due to her wounds. CNA5 stated that she should be wearing a gown but forgot to don the appropriate PPE while providing the resident's bath.