

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525371	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/20/2024
NAME OF PROVIDER OR SUPPLIER Silver Springs Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1300 West Silver Spring Dr Glendale, WI 53209	

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)
<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22692</p> <p>Based on observation, interview and record review, the facility did not provide reasonably accommodated access to 1 (R16) of 20 sampled residents who did not have equipment repaired timely according to resident's preference.</p> <p>* R16's wall fan was broken and not repaired or replaced timely.</p> <p>Findings include:</p> <p>R16 was admitted to the facility on [DATE] with diagnoses that included Hemiplegia and Chronic Respiratory Failure. R16's Quarterly Minimum Data Set (MDS) dated [DATE] was reviewed and documented R16 had a Brief Interview for Mental Status score of 14 which would indicate he is cognitively intact and able to make his needs known.</p> <p>On 06/17/24 at 9:36 AM, Surveyor observed R16 lying in bed in his room. R16 indicated that the fan on his wall was removed about 2 months ago and not repaired or replaced. R16 indicated he was very hot and uncomfortable in his room. R16 indicated he [NAME] stays in his bed in his room.</p> <p>On 6/18/24 at 8:54 AM, Surveyor observed R16 lying in bed in his room. R16 indicated he was miserable and very hot, making it hard to breathe. The thermostat in the hall outside his room was 86 degrees.</p> <p>On 6/18/24 at 10:05 AM, Director of Nurses (DON-B) was interviewed and indicated she was unaware that R16's fan was taken off his wall and would look into the situation.</p> <p>On 6/19/24 at 10:30 AM, Surveyor observed R16 lying in bed in his room. A fan was placed on the floor and directed toward R16. R16 indicated the fan was just blowing hot air around and not helpful.</p> <p>The thermostat in the hall outside his room was 86 degrees.</p> <p>On 6/19/24 at 10:38 AM, Maintenance Director (MD)-D was interviewed and indicated he did not remember R16's fan being taken off the wall or any requests for a replacement. MD-D indicated the facility's air conditioning on that wing had been out for the last 3 days and should be fixed today as they are working on it now.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/19/24 the facility's maintenance recording system was reviewed and there was no documentation that R16's fan needed repair or replacement.</p> <p>The above findings were shared with Administrator-A and Director of Nurses- B on 6/19/24 at the daily exit meeting. Additional information was requested if available. None was provided as to why R16's fan was not repaired or replaced on the wall in his room according to his preference.</p>		

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47094</p> <p>Based on Interview and record review the facility did not ensure advanced directives were in the resident's medical record for 1 (R2) of 20 residents reviewed.</p> <p>R2 did not have a State Do Not Resuscitate (DNR) form to indicate if R2 was a full code or DNR. R2 had a facility DNR/ cardiopulmonary resuscitation (CPR) instruction consent form filled out that indicated R2 was a DNR however, a green sheet was located in R2's hard chart that had FULL CODE printed on it.</p> <p>Findings include:</p> <p>R2 was readmitted to the facility on [DATE] and has diagnoses that include metabolic encephalopathy, end stage renal disease- dependent on renal dialysis Type 2 diabetes mellitus, protein-calorie malnutrition, cerebral infarction with dysphagia and dysarthria, major depressive disorder, schizophrenia, heart failure, anxiety disorder, prostate cancer, and history of alcohol and cocaine abuse.</p> <p>R2's admission minimum data set (MDS) dated [DATE] indicated R2 had moderately impaired cognition with a Brief Interview for Mental Status (BIMS) score of 11 and the facility assessed R2 requiring maximal assist with 1 staff member for activities of daily living (ADL's). R2 has an activated Healthcare Power of Attorney (HCPOA) that assists with making medical decisions with R2.</p> <p>On [DATE], R2's medical record was reviewed. A form titled DNR/ CPR INSTRUCTION/ CONSENT was signed by facility nursing staff on [DATE]. Full Code option was crossed out and an X with a circle around it was filled in for the DNR option. At the bottom of the page staff documented Verbal received at [DATE]. The form does not state the person the verbal consent was received by. Surveyor reviewed R2's hard chart located at the nurse's station. In R2's hard chart Surveyor noted a green piece of paper that had FULL CODE' printed on it.</p> <p>R2's advance directives care plan, with no initiation date, documented resident has been educated on advanced directives and opted not to execute [R2's] rights in this regard. [R2] remains to be [R2's] own person and code status remains to be FULL CODE.</p> <p>R2 had the following physician order initiated on [DATE]: Do Not Resuscitate- No directions specified for order.</p> <p>Surveyor noted that an order for code status was not in place until [DATE] and R2's care plan documents R2 is R2's own person and a Full Code.</p> <p>(continued on next page)</p>

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On [DATE], at 12:18 PM, Surveyor notified Director of Nursing (DON)-B of Surveyors concern that R2 had a form documenting R2's code status, Surveyor showed DON-B the green form in R2's medical chart. Surveyor requested to see the State DNR form for R2. Surveyor asked DON-B how staff are made aware of what a resident's code status is. DON-B stated that staff do not look in the resident's hard charts, staff would look on the residents' face sheet and at the physician order for the code status. DON-B stated that there have been multiple attempts made to have R2's POA come in and sign the DNR form. DON-B gave Surveyor the facility DNR/CPR Instruction Consent form for R2 that had [initials of HCPOA] documented and staff signature with a verbal order obtained dated [DATE]. DON-B stated DON-B would look into R2's code status and forms. Surveyor asked DON-B if R2 would need CPR, what the proper paperwork for the emergency medical technicians (EMT's)/ paramedics is to indicate if R2 were to need CPR or not. DON-B stated they would need to see the State DNR form.</p> <p>On [DATE] at 12:57 PM, in the progress notes, nursing documented . (R2's) [HCPOA] stated (R2) to be a full code until [HCPOA] discussed with family member and (R2's) wishes.</p> <p>On [DATE] at 10:50 AM, in the progress notes, social services documented . (R2) code status reviewed and was a full code, after long discussion, (R2) is currently going to be changing to DNR after activated HCPOA agreed to this.</p> <p>Surveyor notes that a signature from R2's HCPOA and State DNR form were not obtained at this time.</p> <p>On [DATE], at 8:08 AM, Nursing Home Administrator (NHA)-A provided a copy of the facility DNR/ CPR Instruction/ Consent form. NHA-A stated that when a resident is admitted , the admitting nurse has the resident or resident representative fill out the form on admission and then the State DNR form should get signed and faxed over to the resident provider to be signed and an order obtained for the resident's code status. NHA-A stated the facility was waiting for R2's POA to sign the form but never followed up on. Surveyor asked NHA-A if R2 should have a State form for DNR. NHA-A stated that R2 should have the State DNR form filled out and document R2 as being DNR.</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22692</p> <p>Based on observation and interview, the facility did not provide a safe, clean, comfortable, and homelike environment for 2 of 4 resident units with the potential to affect 53 residents residing on the units.</p> <p>Findings include:</p> <p>On 6/20/24 at 9:30 AM the following were observed on the B unit.</p> <ul style="list-style-type: none"> * The entrance to the hall, on the east wall, was observed with an approximately 11 inch x 8 inch area not painted same color, with nails in the wall. The handrail was observed to be loose right under this area. * The entrance to the hall, on the west wall, was observed with an approximately 8 inch by 4 inch area of missing drywall and was not painted. * A brown substance was observed on the wall outside of room [ROOM NUMBER] at baseboard. * The baseboard was missing in the hall between rooms [ROOM NUMBERS]. * R29's room was observed and R29 pointed out her sink, which she indicated had been leaking 2-3 days. The sink was observed to have a partially filled basin with water under it and a wet bath blanket. There was also a hole behind R29's bed with exposed wires and R29 indicated she was afraid she would get electrocuted. The window in R29's room was very dirty and the window track had 2 dead bugs and was very soiled. * The resident common area, at the end of the hall, had 2 window that were very dirty and the screens had large areas that appeared as cobwebs. In the window tracks, 4 dead flies were observed and the track was very dirty. <p>On 6/20/24 at 11:30 AM Maintenance Director (MD) -D was interviewed and indicated he did not know about the leaking sink or hole in the wall in R29's room but that the hole had already been fixed and just needed a plate screwed over it.</p> <p>Observation on C wing:</p> <p>On 06/17/2024, at 10:48 AM, Surveyor noted the floor under the couch/chairs in the main area on C wing had debris/crums and dust.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 06/18/2024, at 08:03 AM, Surveyor interviewed Housekeeper-L. Surveyor asked Housekeeper-L what her routine is with cleaning and what she cleans. Housekeeper-L stated she prepares her cart and will clean the dining room first. Housekeeper-L stated she will then go to resident rooms who are awake and out of their rooms and clean those rooms. Housekeeper-L stated she will work her way down the hall and then do isolation rooms last. Housekeeper-L stated an auto scrubber is used to clean the floors and is supposed to be done every day. Housekeeper-L stated the auto scrubber has not been used and is unable to be used on C wing due to isolation containment of the C wing.</p> <p>On 06/18/2024, at 08:08 AM, Surveyor observed and noted the following on C wing:</p> <ul style="list-style-type: none"> *Unknown brown matter on curtain and tile missing on the floor, near the bed in R66's room. *The floor in common area still sticky, crumbs/wrapper on the floor. *Crusty, brown matter on the wall in the hallway of C wing outside of R59's room. *Dried, brown splash marks on wall, near nurses station. *Thick layer of dust build up on the ceiling vent in hallway near nurses' station. <p>On 06/20/2024, at 09:34 AM, Surveyor observed the following on C wing:</p> <ul style="list-style-type: none"> *Crusty brown matter still on wall outside of R59's room. *Brown splashes of unknown substances still on wall near nurses station window. *R66's room to have a sticky floor, unknown brown substance still on curtain and tile still missing from floor near the bed. <p>On 06/20/2024, at 09:40 AM, Surveyor interviewed Housekeeper-L. Surveyor asked Housekeeper-L how staff communicates regarding things that need to be fixed or cleaned on the unit or in resident rooms. Housekeeper-L stated maintenance will be notified of things put into the electronic system. Housekeeper-L stated anyone can put in a electronic request for maintenance.</p> <p>On 06/20/2024, at 09:43 AM, Surveyor interviewed Licensed Practical Nurse (LPN)-M. LPN-M stated the missing tiles in R66's room is very new, but she is putting it into the electronic system now to notify maintenance.</p> <p>The above findings were shared with Administrator-A and Director of Nurses-B on 5/25/22. Additional information was requested if available. None was provided as to why the housekeeping and maintenance hadn't been completed.</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>20025</p> <p>Based on interview and record review the facility did not ensure the 3 of 8 staff reviewed received the necessary background checks every four years. This had the ability to affect all 99 residents.</p> <p>CNA F's last background check was completed on 3/18/20 and the required 4 year check was due 3/18/24 and this was not completed.</p> <p>CNA G's last background check was completed on 3/12/20 and the required 4 year check was due 3/12/24 and this was not completed.</p> <p>CNA H's last background check was completed on 3/11/20 and the required 4 year check was due 3/11/24 and this was not completed.</p> <p>Findings include:</p> <p>The facility's Abuse/Neglect/Exploitation policy (undated) documents:</p> <p>I. Screening</p> <p>A. Potential employees will be screened for a history of abuse, neglect, exploitation, or misappropriation of resident property.</p> <ol style="list-style-type: none"> 1. Background, reference, and credentials' checks shall be conducted on potential employees, contracted temporary staff, students affiliated with academic institutions, volunteers, and consultants. 2. Screenings may be conducted by the facility itself, third-party agency or academic institution. 3. The facility will maintain documentation of proof that the screening occurred. <p>Surveyor reviewed a sample of 8 staff to ensure the necessary background checks were completed.</p> <p>CNA F's last background check was completed on 3/18/20 and the required 4 year check was due 3/18/24 and this was not completed.</p> <p>CNA G's last background check was completed on 3/12/20 and the required 4 year check was due 3/12/24 and this was not completed.</p> <p>CNA H's last background check was completed on 3/11/20 and the required 4 year check was due 3/11/24 and this was not completed.</p> <p>On 6/17/24 at 3:00 p.m. during the exit meeting with Director of Nursing (DON)-B and Nursing Home Administrator (NHA)-A, Surveyor explained the concern the mentioned CNAs did not have a completed 4 year background check completed.</p> <p>(continued on next page)</p>

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/20/24 at 10:56 a.m. Surveyor interviewed BOM (business office manager)-I regarding the background checks. BOM-I stated she took over the employee files at the end of February and has been trying to complete audits on background checks. BOM-I stated she missed the three CNAs background checks.		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47094</p> <p>Based on observations, interview, and record review, the facility did not ensure individualized comprehensive care plans were initiated for 1 (R94) of 5 residents reviewed for unnecessary medications and 1 (R94) of 1 resident's reviewed for the use of an indwelling catheter.</p> <p>R94 was prescribed an antidepressant medication and was admitted with an indwelling catheter. R94 did not have a comprehensive plan of care with individualized interventions to address the use of an antidepressant medication or for R94's indwelling catheter.</p> <p>Findings include:</p> <p>The facility policy entitled 'COMPREHENSIVE CARE PLAN' dated 10/1/2022 documents: It is the policy for this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that included measurable objectives and timeframe's to need a resident's medical, nursing, and mental and psychosocial needs that ate identified in the resident's comprehensive assessment.</p> <p>Policy Explanation and Compliance Guidelines: .</p> <p>2. The comprehensive care plan will be developed within 7 days after the completion of the comprehensive minimum data set (MDS) assessment but no more than 21 days from admission. All Care Assessment Areas (CAAs) triggered by the MDS will be considered in developing the plan of care.</p> <p>3. The comprehensive care plan will describe, at a minimum, the following:</p> <p>a. The services that are to be furnished to attain or maintain the residents highest practical physical, mental, and psychosocial well-being.</p> <p>b. Any services that would otherwise be furnished but are not provided due to the resident's exercise of his or her right to refuse treatment.</p> <p>d. The residents' goals for admission, desired outcomes, and preferences for future discharge.</p> <p>f. Resident specific interventions that reflect the residents needs and preferences and align with the resident's cultural identity, as indicated.</p> <p>5. The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS assessment.</p> <p>6. The comprehensive care plan will include measurable objectives and timeframe's to meet the residents need as identified in the resident's comprehensive assessment. The objectives will be utilized to monitor the resident's progress. Alternative interventions will be documented, as needed.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>8. Qualified staff responsible for carrying out interventions specified in the care plan will be notified of their roles and responsibilities for carrying out the interventions, initially and when changes are made.</p> <p>R94 was admitted to the facility on [DATE] and has diagnoses that include osteomyelitis of sacral and sacrococcygeal region, protein-calorie malnutrition, pressure ulcer of sacral region stage 4, schizophrenia, and urine retention.</p> <p>R94's quarterly MDS dated [DATE] indicated R94 has severely impaired cognition with a Brief Interview for Mental Status (BIMS) score of 0 and the facility assessed R94 needing maximal assistance with 1 staff member for toileting hygiene, bathing, and transfers and moderate assistance with 1 staff member for personal hygiene, and transfers. R94 was admitted with an indwelling foley catheter for wound healing. R94 has an activated healthcare power of attorney (HCPOA) that assists in making decisions for R94.</p> <p>FOLEY CATHETER</p> <p>On 6/17/2024, at 9:30 AM, Surveyor observed R94 sitting in a wheelchair and a foley catheter was hooked to the back of the wheelchair in a privacy bag.</p> <p>Surveyor reviewed R94's electronic medical record. In review of R94's comprehensive care plan, Surveyor was not able to locate a care plan with interventions to address R94's foley catheter.</p> <p>On 1/30/2024, R94 had a significant change MDS completed, Surveyor reviewed the CAAs and noted Urinary Incontinence/ Indwelling catheter was triggered with the following documentation:</p> <p>-Resident has an indwelling foley catheter d/t (due to) urinary retention r/t (relate to) neurogenic bladder. Resident is incontinent of bowel. Resident receives catheter cares per policy q (every) shift and prn (as needed). Catheter and drainage bag are changed per policy. Catheter bag emptied q shift and prn. Resident is at risk for complications including UTIs (urinary tract infections), etc. Will proceed to care plan to monitor and prevent or minimize complications.</p> <p>Surveyor reviewed R94's quarterly MDS dated [DATE], the facility documented in section H: Bladder and Bowel the facility documented R94 having an indwelling catheter and marked that R94 is occasionally incontinent for bladder.</p> <p>On 6/19/2024, at 10:57 AM, Surveyor shared concern with Director of Nursing (DON)-B that R94 did not have a care plan for R94's indwelling catheter. DON-B stated that a care plan for a catheter should be initiated especially since R94 was admitted with it. DON-B stated not sure why R94 did not have a care plan and that DON-B follows up with all of that and must have overlooked it. Surveyor shared that in R94's quarterly MDS section H: concern that it states R94 has an indwelling catheter and also marked for occasionally incontinent for bladder. DON-B stated DON-B will follow up with that especially since care plans are reviewed in the weekly interdisciplinary meetings and definitely should not have been missed.</p> <p>ANTI-DEPRESSANT</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Surveyor reviewed R94's quarterly MDS dated [DATE], the facility assessed R94 being mildly depressed with a Patient Health Questionnaire (PHQ-9) score of 6 documenting R94's symptoms of having little energy, tired, trouble falling asleep, feeling down, and having little interest in things.</p> <p>Surveyor reviewed R94's medication orders in the electronic medical record and noted R94 was prescribed:</p> <p>-Mirtazapine oral tablet 7.5 mg- Give 15 mg by mouth in the evening for depression. (Start: 5/29/2024)</p> <p>In review of R94's comprehensive care plan, Surveyor was not able to locate a care plan with interventions to monitor for side effect of R94's Mirtazapine medication.</p> <p>On 6/19/2024, at 10:57 AM, Surveyor shared concern with Director of Nursing (DON)-B that R94 did not have a care plan for R94's Mirtazapine anti-depressant medication. DON-B stated that there should be a care plan for R94's anti-depressant. DON-B stated not sure why R94 did not have a care plan and that DON-B follows up on that and must have overlooked it. DON-B stated she will follow up with that.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47094</p> <p>Based on observation, interview, and record review, the facility did not ensure residents received adequate supervision to prevent accidents for 1 (R64) of 5 residents reviewed for falls.</p> <p>R64 had unwitnessed falls on 3/29/2024, 5/6/2024 (4 falls same day), and 5/16/2024. R64 had a habit of moving self to the floor. Fall investigations were not thoroughly investigated to document when R64 was last checked on, toileted, what interventions were in place, or why R64 was lowering self to the floor.</p> <p>Findings include:</p> <p>The facility policy entitled Falls Management Process dated 2011 documents: . 5. If able, ask the resident to explain what happened and what they were attempting to do at the time of the fall (helpful for root cause analysis later). 11. The nurse will complete an event documentation report, fall risk assessment, pain assessment, and obtain witness statements. 12. The nurse will determine the most appropriate intervention, implement, and update care plan.</p> <p>R64 was admitted to the facility on [DATE] and has diagnoses that include encephalopathy, type 2 diabetes, dementia with behavioral disturbance, anxiety disorder, paranoid schizophrenia, urine retention, and repeated falls.</p> <p>R64's significant change minimum data set (MDS) dated [DATE] indicated R64 had moderately impaired cognition with a Brief Interview for Mental Status (BIMS) score of 10 and the facility assessed R64 needing maximal assistance with 1 staff member for toileting hygiene, bathing, and transferring to a wheelchair or bed and moderate assistance with 1 staff member for repositioning personal hygiene, and upper body dressing. R64 has an indwelling catheter, always incontinent of stool and wears an adult brief for protection. R64 has an activated healthcare power of attorney (HCPOA) and is enrolled on Hospice.</p> <p>Falls was triggered in the care area assessment (CAA) and documents the following: Resident is at risk for falls d/t (due to) impaired mobility, cognitive deficits, medication usage, and history of falls. Resident is assisted with transfers and mobility. Resident is screened by therapies per policy. Will proceed to care plan to monitor and maintain resident safety. The facility assessed R64 on 4/2/2024 to be a moderate fall risk with a fall risk score of 19.</p> <p>R64's at risk for falls care plan initiated on 11/29/2022 due to (R64) having a history of falls, use of medication, impaired mobility. (R64) has a bx (behavior) of putting self on floor, resident will crawl out of bed onto floor, and resident choosing to place self on floor to sleep at night. (R64) had the following interventions implemented:</p> <ul style="list-style-type: none"> - Assess that wheelchair is of appropriate size, assess need for footrests, assess for need to have wheelchair locked/unlocked for safety, anti-tippers. (Initiated 11/29/2022). - Call light and personal items available and in easy reach. <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Silver Springs Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1300 West Silver Spring Dr Glendale, WI 53209	
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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<ul style="list-style-type: none"> - Clear and monitor environmental obstacles (tubing, cords, etc.). - Keep environment well-lit and free of clutter. - Encourage participation in activities to improve strength or balance such as therapies, in room exercise programs. - Encourage rest periods if feeling fatigued. - Therapy referral as ordered and PRN (as needed). - Observe for side effects of medications and update medical doctor/ nurse practitioner (MD/NP) if present. - Health teaching regarding to change positions slowly (Initiated 1/5/2023) - Offer to lay down in bed after lunch (Initiated 7/27/2023) - Offer a Reacher (Initiated 10/31/2023). - Staff will ask (R64) between 1530 (3:30 PM) and 1600 (4:00 PM) if (R64) would like to get up and assist (R64) into wheelchair. - 2/1/2024 psych medication review (initiated 2/2/2024). - 5/1/2024 offer resident to get up in wheelchair in the AM. - 5/6/2024 Evaluate resident for periods of increased anxiety during the night. - Fall mat next to bed while in bed, resident uses self-determined right to lay on the floor at times during night. (Initiated 5/7/2024) <p>On 3/29/2024, at 16:36 (4:36 PM), in the progress notes nursing documented . (R64) put self on floor this afternoon, no injuries, . call light in reach and bed in the lowest position.</p> <p>On 4/1/2024, at 9:51 AM, in the progress notes social services documented IDT (Interdisciplinary Team) reviewed resident's fall care plan and interventions currently monitored for behavior of history of putting self on the floor. Resident has a low bed and mat in place. Therapy is treating resident.</p> <p>Surveyor reviewed the fall investigation for R64's unwitnessed fall on 3/29/2024. Staff documented that R64 was incontinent at the time of the fall, but the fall investigation does not include staff interviews that indicates when R64 was last rounded on or toileted. The fall investigation did not indicate what interventions were in place at the time of R64's fall.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 5/6/2024, at 6:37 AM, in the progress notes nursing documented a post fall evaluation for R64. Fall details included that R64 had a witnessed fall by R64's roommate at 12:30 AM. R64's roommate stated R64 was attempting to self-transfer. Facility staff answered R64's call light and found R64 sitting on R64's bed mat against R64's bed.</p> <p>On 5/6/2024, at 7:15 AM, in the progress notes nursing documented . at 12:30 AM resident was found sitting on the floor mat beside (R64's) bed. Resident stated put self-down trying to get up from bed. (R64's) roommate told (R64) not to get up because it was midnight. at 1:30 AM residents roommate put call light on, (R64) was found sitting on the floor mat and R64 stated put self on the floor. PRN (as needed) Lorazepam given to (R64) . (R64) was put back to bed. At 4:15 AM (R64) was yelling for the nurse, (R64) was sitting on the floor mat stating that (R64) put self on the floor mat.</p> <p>On 5/6/2024, at 9:24 AM, in the progress notes nursing charted resident was found on the floor and stated (R64) wanted to go out for a smoke. (R64) is impulsive.</p> <p>Surveyor reviewed the fall investigations for R64's fall on 5/6/2024 at 12:30 AM, 1:30 AM, 4:14 AM, and 8:00 AM and noted that there were no staff interviews to indicate when R64 was last rounded on or toileted. The fall investigation did not indicate what intervention was put in place for R64 after R64 attempted to get out of bed, or what was put in place to prevent R64 from wanting to get out of bed and lay on R64's floor mat There was no root cause analysis to determine why it is that R64 wants to lay on the floor or what could be done for R64 to keep R64 safe.</p> <p>On 5/16/26, at 5:55 AM, in the progress notes nursing charted (R64's) roommate notified staff that R64 was on the floor. Resident was on the floor beside (R64's) bed. R64 brought into hallway in view of the nursing staff.</p> <p>Surveyor reviewed the fall investigation for R64's fall on 5/16/2024 and noted there were no staff interviews to indicate when R64 was last rounded on, last toileted, or what interventions were in place at time of R64's fall.</p> <p>On 6/19/2024, at 9:30 AM Surveyor interviewed registered nurse (RN)-L who stated if a resident falls, they are to be assessed, vitals obtained, and gotten to safety if able or sent to the hospital. RN-L stated a post fall evaluation in PCC (Point Click Care- healthcare software) is filled out, a progress note written up, and fall investigation form filled out. RN-L stated that RN-L fills in the prompts when asked in the drop down box. RN-L stated that sometimes interventions can be put in place if it is evident on what needs to be done, otherwise the resident is just lifted off the floor and put in a safe place. Surveyor asked RN-L if interviews are obtained from staff that was working with the resident. RN-L stated that if anyone saw what happened that gets put in the note, otherwise staff just write what happened when the resident was observed. Surveyor asked RN-L what kind of interventions are in place for R64 to keep R64 safe from falling. RN-L stated that R64's bed is to remain low to the ground with fall mat on the floor and frequent checks. RN-L stated that R64 at times puts self on the floor but not sure why R64 does that.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/19/2024, at 10:37 AM, Surveyor interviewed director of nursing (DON)-B. Surveyor asked DON-B if it was ever investigated why R64 likes to put self onto the floor. DON-B stated that after R64 had all the falls on 5/6/2024 DON-B called R64 HCPOA to get more of a background on R64 and was told that R64 used to work 3rd shift and is a Tinkerer and is historically restless and fidgety according to R64' s HCPOA. DON-B stated R64 likes to lay on the floor and not really sure why, R64 just stated sometimes R64 prefers it. DON-B stated that Hospice assisted with getting a bed that goes lower to the floor than the bed R64 did have and to increase supervision at night time to make sure R64 is safe. Surveyor notified DON-B of Surveyor's concern that not all of R64's falls were thoroughly investigated to include staff interviews on when R64 was last rounded on, toileted, what interventions were in place at time of fall, and what interventions were put in place after R64's falls.</p> <p>On 6/19/2024, at 11:30 AM, Surveyor interviewed certified nursing assistant (CNA)-E who stated staff do frequent checks on R64. CNA-E stated that R64 can get agitated if you stand around or watch R64 for long period of times so staff have to try to observe R64 without R64 feeling like staff is watching R64. CNA-E stated staff try to encourage R64 to stay in bed and not crawl onto the floor or try to distract R64 by doing something or taking to an activity of able to go.</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42037</p> <p>Based on interviews and record review, the facility did not ensure residents maintained 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 1 (R34) of 7 residents reviewed for nutrition.</p> <p>R34 sustained a significant weight loss of 9.60% from 2/7/24 to 5/10/24. R34's weights were not obtained in accordance with R34's physician orders.</p> <p>Findings include:</p> <p>The facility policy titled Weight Monitoring which was not dated, documents (in part)</p> <p>.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.</p> <p>Weight can be a useful indicator of nutritional status. Significant unintended changes in weight (loss or gain) or insidious weight loss (gradual unintended loss over a period of time) may indicate a nutritional problem.</p> <p>1. The facility will utilize a systemic approach to optimize a resident's nutritional status. This process includes:</p> <ul style="list-style-type: none"> a. Identifying and assessing each resident's nutritional status and risk factors. b. Evaluating/analyzing the assessment information. c. Developing and consistently implementing pertinent approaches. d. Monitoring the effectiveness of interventions and revising them as necessary. <p>2. A comprehensive nutritional assessment will be completed upon admission on residents to identify those at risk for unplanned weight loss/gain or compromised nutritional status. Assessments should include the following:</p> <ul style="list-style-type: none"> a. General appearance (e.g., robust, thin, obese or cachectic). b. Height c. Weight d. Food and fluid intake. <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>e. Fluid loss or retention.</p> <p>f. Laboratory/Diagnostic Evaluation.</p> <p>3. Information gathered from the nutritional assessment and current dietary standards of practice are used to develop an individualized care plan to address the resident's specific nutritional concerns and preferences. The care plan should address the following to the extent possible:</p> <p>a. Identified causes of impaired nutritional status.</p> <p>b. Reflect the resident's goals and preferences.</p> <p>c. Identify resident-specific interventions.</p> <p>d. Time frame and parameters for monitoring.</p> <p>e. Updated as needed such as when the resident's condition changes, goals are not met, interventions are determined to be ineffective or a new cause of nutrition-related problems are identified.</p> <p>f. If nutritional goals are not achieved, care planned interventions will be re-evaluated for effectiveness and modified as appropriate.</p> <p>Documentation:</p> <p>a. The physician should be informed of a significant change in weight and may order nutritional interventions.</p> <p>b. The physician should be encouraged to document the diagnosis or clinical conditions that may be contributing to the weight loss.</p> <p>c. Meal consumption information should be recorded and may be referenced by the interdisciplinary care team as needed.</p> <p>e. The Registered Dietician or Dietary Manager should be consulted to assist with interventions; actions are recorded in the nutrition progress notes.</p> <p>f. Observations pertinent to the resident's weight status should be recorded in the medical record as appropriate.</p> <p>g. The interdisciplinary plan of care communicates care instructions to staff.</p> <p>R32 admitted to the facility on [DATE] with diagnoses that include Diabetes Mellitus, Protein-Calorie Malnutrition and hypothyroidism.</p> <p>(continued on next page)</p>

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R34's Nutritional care plan with an initiation date of 1/3/24 of documents the following: Resident is at risk for malnutrition r/t (related to) recent hospitalization r/t severe sepsis with altered mental status and an BKA (below the knee amputation). PM Hx (primary history): asthma, chronic embolism of DVT (Deep Vein Thrombosis), Thrombocytopenia, T2DM (Type 2 Diabetes Mellitus), Hypothyroidism, alcohol use disorder, tobacco dependence, anxiety, depression, hyperlipidemia, constipation, absence of kidney. R34's Nutritional care plan interventions include the following: Continue Current Diet order: CCHO (consistent carbohydrate) diet, Regular texture, Regular (thin) consistency, Double protein portions, Monitor lab data as available, Monitor PO (by mouth) intake: goal 76-100% of meals and Monitor weights per facility protocol. Surveyor could not identify facility's weight protocol in the facility's Weight monitoring policy.</p> <p>On 1/5/2024, R34's weight was documented as 202.0 Lbs. On 1/22/2024, R34's weight was documented as 202.1 Lbs. On 2/7/2024, R34's weight was documented as 208.0 Lbs. On 4/7/24, R34's weight was documented as 204.0 Lbs. On 5/6/24, R34's weight was documented as 204.8 Lbs. On 5/10/24, R34's weight was documented as 188.0 Lbs. Surveyor could not locate any documented weights for December 2023, March 2024 or June 2024.</p> <p>On 6/19/24 at 11:30 AM, Surveyor reviewed R34's nutritional progress notes. Surveyor requested to interview to facility's Dietician. Dietician-M told Surveyor that they were not familiar with R34 as another dietician had been following R34 at the facility but they were no longer employed by facility. Surveyor asked Dietician-M what the facility's procedure would be for obtaining resident weights. Dietician-M told Surveyor that resident weights should be obtained upon admission, daily for 3 days then monthly thereafter.</p> <p>On 6/19/24 at 3:00 PM at the daily exit meeting, Surveyor shared concerns with NHA (Nursing Home Administrator)-A and DON (Director of Nursing)-B regarding R34's missing weights and documented weight loss of 9.60% from 2/7/24 to 5/10/24 without implementation of new interventions or assessments. No additional information was provided by the facility at this time.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20025</p> <p>Based on observation, interview and record review the facility did not ensure 1 of 2 medication storage rooms did not have expired stock medications.</p> <p>On [DATE] Surveyor observed 4 bottles of Vitamin B12 stock medication that was expired on ,d+[DATE] and 1 bottle of docusate sodium expired ,d+[DATE].</p> <p>Findings include:</p> <p>On [DATE] at 10:34 a.m. Surveyor observed the C and D wing medication storage room along with Director of Nursing (DON)-B.</p> <p>Surveyor discovered 4 bottles of Vitamin B12 stock medication that was expired on ,d+[DATE] and 1 bottle of docusate sodium expired ,d+[DATE].</p> <p>Surveyor showed the expired stock medications to DON-B. DON-B stated she thought they look all the stock medications for expired meds. DON-B had no further information.</p>

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<p>F 0814</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Dispose of garbage and refuse properly.</p> <p>49845</p> <p>Based on observation, interview, and record review the Facility did not dispose of garbage and refuse properly having the potential to affect all 100 residents in the Facility.</p> <p>Findings include:</p> <p>On 6/19/24 at 1:56 pm Surveyor observed:</p> <p>*15 [NAME] pallets piled up on the ground near the dumpster.</p> <p>*5-gallon bucket full of a chemical substance outside near dumpster and dryer vent</p> <p>The Facility's policy titled: Waste Disposal Policy, with an implementation of 03/01/2020, documents in part: dumpster's shall be emptied according to the facilities contract. Garbage should not accumulate or be left outside the dumpster.</p> <p>The Facility provided Surveyor with the Safety Data Sheet for the chemical product, Pyxis Sour. Surveyor reviewed the document titled: Safety Data Sheet which documents in part: Product name: Pyxis Sour . 7. Handling and Storage P402 Store in dry place. P402 store locked up.</p> <p>On 06/20/2024, at 09:09 AM, Surveyor informed Nursing Home Administrator (NHA)-A of above concerns. NHA-A stated the dumpster will be picked up twice per week. NHA-A stated if needed, they get big dumpster to rent for larger items. NHA-A added, a local person comes to pick up the wood pallets. No information was provided regarding the Pyxis Sour and why it was outside.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p>49845</p> <p>Based on observation, interviews and record review, the Facility's water management program (WMP) was inaccurate, incomplete and was not consistent with current American Society of Heating, Refrigerating and Air-Conditioning Engineers (ASHRAE) Guidelines, the Centers for Disease Control and Prevention (CDC) Toolkit, and the Wisconsin State Plumbing Code SPS 382.50, creating a potential for all 100 facility residents to be infected by Legionella or other water born bacteria. In addition, the Facility did not store or process linens to prevent the spread of infection.</p> <p>The WMP did not:</p> <ul style="list-style-type: none"> ~Include water management team members who were knowledgeable about the facility's water system. ~Describe the building water system using an accurate flow diagram of the system with specific locations. ~Identify all locations where Legionella could grow and spread. ~Include a process to confirm the WMP is being implemented and is effective. <p>The facility laundry was observed to have:</p> <ul style="list-style-type: none"> ~ Dirty linens in cart labeled clean linen only. ~Saturated bath blankets between washers from leaking washing machines. ~Washing machines to be covered in a crusty white substance. ~Containers without lids, containing unknown liquids. <p>Findings include:</p> <p>WMP:</p> <p>The 6/24/2021 CDC Toolkit, titled: Developing a Water Management Program to Reduce Legionella Growth & Spread in Buildings identifies the key elements of a water management program for healthcare facilities to include:</p> <ol style="list-style-type: none"> 1. Establish a water management program team 2. Describe the building water systems using text and flow diagrams 3. Identify areas where Legionella could grow and spread 4. Decide where control measures should be applied and how to monitor them <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>5. Establish ways to intervene when control limits are not met</p> <p>6. Make sure the program is running as designed and is effective</p> <p>7. Document and communicate all the activities</p> <p>The CDC toolkit identifies locations in a buildings water system where Legionella can grow and spread to include but not limited to:</p> <ul style="list-style-type: none"> ~Hot and cold water storage tanks ~Water heaters ~Water Filters ~Electronic and manual faucets ~Aerators ~Shower heads and hoses ~Pipes, valves and fittings ~Infrequently used equipment including eye wash stations ~Ice machines ~Hot tubs <p>The CDC toolkit identifies factors internal to buildings that can lead to Legionella growth to include:</p> <ul style="list-style-type: none"> ~Biofilm (microorganisms that are adhered to surface and form a protective slime layer, like the inside of plumbing system) ~Scale and sediment ~Water temperature fluctuations: Provides conditions where Legionella grows best (77 -108 F) ~Water pressure changes ~PH (measurement of acidity or alkalinity of a solution on a scale 0 to 14) ~Inadequate disinfectant: Does not kill or inactivate Legionella ~Water stagnation: Encourages biofilm growth and reduces temperature and levels of disinfectant <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>The Wisconsin State Plumbing Code, Chapter SPS 382.50(3)(b)6, requires a nursing homes hot water system to be installed and maintained to provide bacterial control by one of the following methods:</p> <p>~Water stored and circulation initiated at a minimum of 140 F and with a return of a minimum of 124 F. This standard is best practice even considering the facility was built prior to May 2003 and grandfathered to meet requirement.</p> <p>~Water chlorinated at 2mg/L residual</p> <p>~Another disinfection system approved by the department</p> <p>The Facility's policy, titled: Infection Prevention and Control Program, with an implementation date of 10/01/2022, documents in part: This 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 national standards and guidelines . 16. Water Management: a. A water management program has been established as part of the overall infection prevention and control program. B. Control measures and testing protocols are in place to address potential hazards associated with the facilities water systems. C. The maintenance director serves as the leader of the water management program.</p> <p>The Facility's policy, titled Water Management Program, dated 10/01/2022, documents in part: it is the policy of this facility to establish water management plans for reducing the risk of legionellosis and other opportunistic pathogens (e.g. Pseudomonas, Acinetobacter, Burkholderia, Stenotrophomonas, nontuberculous mycobacteria, and fungi) in the facilities water systems based on nationally accepted standards (e.g., ASHRAE, CDC, EPA) . Policy explanation and compliance guidelines: 1. A water management team has been established to develop and implement the facility's water management program, including facility leadership, the Infection Preventionist, maintenance employees, safety officers, risk and quality management staff, and director of nursing. a. Team members have been educated on the principles of an effective water management program, including how Legionella and other waterborne pathogens grow and spread. Education is consistent with each team members role. 7. Testing protocols and control limits will be established for each control measure. a. Individuals responsible for testing or visual inspections will document findings b. When control limits are not maintained corrective actions will be taken and documented accordingly c. Protocols and corrective actions will reflect current industry guidelines . 13. In the event of an update to the water management program the water management team shall: b. Train those responsible for implementing and monitoring the updated program.</p> <p>The Facility's document, titled: Water Management Plan dated 02/14/2022 with an expiration date of 01/01/0001, documents in part:</p> <p>Purpose: The purpose of this water management plan (WMP) is to establish the minimum legionellosis risk management requirements by illustrating the procedures for minimizing the risk of Legionnaires disease within the building water systems of one facility. General Requirements: This water management plan will conform to the steps below outlining the elements of a water management program. Program team-identify persons responsible for program development and implementation.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Silver Springs Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1300 West Silver Spring Dr Glendale, WI 53209	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Describe water systems/ flow diagrams-describe the potable and nonpotable water systems within the building and on the building site and develop water system schematics. Analysis of building water systems-evaluate where hazardous conditions may occur in the water systems and determine where control measures can be applied. Control measures-determine locations where control measures must be applied and maintained in order to stay with established control limits. Monitoring/ corrective actions-established procedures for monitoring whether control measures are operating within established limits and if not take corrective actions.</p> <p>Confirmation-established procedures to confirm that the program is being implemented as designed (verification), and the program effectively controls the hazardous conditions throughout the building water systems(validation) to establish a water management program with the intent of reducing the risk of growth/spread of Legionella and other Opportunistic Pathogens</p> <p>Documentation-established documentation and communication procedures for all activities of the program.</p> <p>Per the Facility's Water Management Plan, documents the program team for Bedrock at Glendale and lists: the Facilities Manager, Director of Maintenance and includes names and contact information for both. Per The Nursing Home Administrator (NHA)-A, the current listed employees' no longer work for the Facility.</p> <p>Surveyor reviewed the Facility's water system/flow diagram and noted cold water distribution and heating water source locations are not specifically identified in the diagram.</p> <p>Surveyor reviewed maintenance task logs for water management and noted under Eyewash Station, the control measure documents in part: Plumbed units are to be activated weekly to flush the line and verify operation; at least a 3 minute flush is recommended. Fluid replacement frequency in self-contained units depends on whether a preservative is used. Plain water: weekly replacement; if a preservative is used, 1-4 month replacement depending upon conditions. If a factory prepared concentrate with an additive is used, then follow the manufacturer's instructions. If factory-sealed cartridges are used, up to two years may be acceptable. Follow manufacturers operations and maintenance instructions. Under monitoring, for Eyewash Station, documents execute the control measure based on the stated frequency and the type of eye wash station present as indicated in the control measure. The control measure for the eyewash station does not specify which type of eyewash station the Facility utilizes. Surveyor noted, The Facility did not provide documentation or logs during survey to indicate what type of control measure was preformed to the Facility's specific eyewash station.</p> <p>Surveyor reviewed the maintenance task log titled: Water Heaters- Monthly Task one which documents in part: Control measure- check flow and return temperatures at hot water heater. Monitoring-supply temperature should be checked at the outlet of the hot water heater and should not be lower than 140 F. The return temperature should also be checked monthly and should not be lower than 122 Fahrenheit (F). The Facility did not provide temperature documentation or logs of the water heater at time of survey. The Facility is not following the minimum control standard set by The Wisconsin State Plumbing Code, Chapter SPS 382.50(3)(b)6, of 124 F for return temperature.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Surveyor reviewed the maintenance task log titled: Water Heaters- Monthly Task Two which documents in part: check water temperature at the end of each return leg at time of no water use. Ensure temperature is at a minimum of 122 F. The Facility did not provide temperature documentation or logs of the water heater during time of survey. The Facility is not following the minimum control standard set by The Wisconsin State Plumbing Code, Chapter SPS 382.50(3)(b)6, of 124 F for return temperature.</p> <p>The Facility's Water Management Plan, Control Measure for water heaters, documents in part: check temperatures after 30 seconds and 60 seconds of running at all tabs to ensure that you are receiving the appropriate temperature and it being achieved in a reasonable amount of time.</p> <p>Surveyor reviewed the maintenance task log titled: Water Heaters- Annual Task Two which documents in part: check temperatures after 30 seconds of running all taps . Ensure temperature is at a minimum of 122 F. The Facility did not provide temperature documentation or logs of the water heater and is also not following the minimum control standard set by The Wisconsin State Plumbing Code, Chapter SPS 382.50(3)(b)6, of 124 F for return temperature.</p> <p>Surveyor noted that all references for the water heater tasks are documented from: European technical guidelines for the prevention, control and investigation of infections caused by Legionella species; June 2017; hot water systems 3.129.</p> <p>The Facility's Water Management Plan control measure, titled: Hot & Cold Water Systems documents in part: Electric and Manual Faucets . location, Silver Cafe frequency, weekly/25% of fixtures on a rotational basis. The Facility did not provide documentation of a maintenance task associated with this control measure during time of survey.</p> <p>Surveyor reviewed the Facility's Water Management Plan control measure, titled: Hot & Cold Water Systems which documents in part: check for residual (free) disinfectant (Chlorine) levels . Measure and record residual (free) disinfectant (Chlorine) levels on the incoming city water supply as well as a representative most distal location within the facility. The frequency of this task is documented to be preformed weekly. The facility provided a maintenance task titled: Disinfectant which documents a date of 03/31/2024 with no action recorded. Task completion, with a due date of 04/30/2024, marked done on 05/17/2024 by Maintenance Director (MD)-D. The Facility did not provide any other logs or documentation of this task being completed weekly.</p> <p>On 06/20/2024, at 09:45 AM, Surveyor was informed by Regional Corporate Consultant (RCC)-K that Interdisciplinary Team (IDT) is the water committee, and the water management is part of the monthly Quality Assurance (QA) meetings held by the IDT. RCC-K stated, no water flushes are being preformed at the Facility because the facility does not have any closed wings and all pipes/fixtures are frequently used.</p> <p>On 06/20/2024, at 11:33 AM, Surveyor interviewed MD-D. MD-D stated he is assigned tasks in the electronic system and will sign off the tasks in the electronic system once completed. MD-D stated he randomly selects rooms to run the water to make sure it runs clear. MD-D stated he fills up a cup with water from the randomly selected sinks to test for Chlorine. MD-D stated he does not document which rooms/sinks that are tested . MD-D stated there is no committee for water management, but he will go over any issues in the monthly QA meetings with the IDT.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On 06/20/2024, at 01:01 PM, Surveyor interviewed NHA-A who stated MD-D is in charge on the Facility's Water Management Plan. Surveyor informed NHA-A of above concerns with the Facility's WMP. NHA-A stated the Facilities Manager and Maintenance Director listed on the Facility's Water Management Plan are incorrect.</p> <p>On 06/20/2024, at 01:09 PM, Surveyor interviewed MD-D. Surveyor asked MD-D who oversees the Water Management Plan for the Facility. MD-D stated Corporate. MD-D informed Surveyor that he has been working for the Facility for about 6 months and was not provided training on the Water Management Plan and states he is self-taught.</p> <p>Laundry:</p> <p>The Facility's policy, titled: Infection Prevention and Control Program, with an implementation date of 10/01/2022, documents in part: This 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 national standards and guidelines . 11. Linens: b. Clean linen shall be separated from soiled linen at all times</p> <p>Surveyor reviewed the maintenance task log titled: Check Washers. The maintenance task log lists, in part: inspect for water leaks and check for cleanliness. The electronic maintenance log shows task completed on 04/04/2024, 05/07/2024 and 06/06/2024 by MD-D.</p> <p>On 06/19/2024, at 01:56 PM, Surveyor observed the laundry room located in the basement of the Facility. Surveyor observed a linen cart labeled clean linen only with several clear bags containing clothes. Surveyor asked Housekeeping Manager (HM)-J where the dirty linen is kept, HM-J pointed to the cart labeled clean linen only. Surveyor observed washers to be covered in a crusty, white substance. HM-J stated he has cleaned the washers many times, but the substance is very difficult to remove and always comes back. Surveyor observed a saturated bath blanket on the floor between the two washing machines and noted water on the floor under one of the washing machines. HM-J stated he informed NHA-A as well as the previous NHA regarding the leaking washing machines. Surveyor observed a green bucket on top of washing machine containing an unknown liquid, and a red sharps container located behind the washing machine containing an unknown liquid. HM-J stated he does not know what liquid is in the containers and stated the containers have been there for about 3-4 months.</p> <p>On 06/19/24, at 03:15 PM, Surveyor informed NHA-A of above findings.</p> <p>NHA-A stated cooperate is aware of the issues with the washer and dryer, and stated it was cited during the last complaint survey. No further information was provided at that time.</p>		

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<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Keep all essential equipment working safely.</p> <p>49845</p> <p>Based on observation, interview, and record review the Facility did not maintain mechanical and/or electrical equipment in safe operating condition having the potential to affect all 100 residents in the Facility.</p> <p>Surveyor observed the following outside as a potential fire hazard:</p> <p>*Dryer vent with copious amounts of lint.</p> <p>Findings include:</p> <p>The facility's maintenance task log, titled: check dryer, documents in part, lint removed from exhaust ducts Log documents this task was competed once per month by Maintenance Director (MD)-D.</p> <p>On 06/19/2024, at 01:56 PM, Survey observed the outside dryer vent to be completely covered in lint. A few feet from the dryer vent, was a 5-gallon bucket of Pyxis Sour and a few feet from the bucket of Pyxis Sour was 15 wood pallets near the dumpster.</p> <p>On 06/20/2024, at 09:09 AM, Surveyor informed Nursing Home Administrator (NHA)-A of above concerns.</p> <p>On 06/20/2024, at 11:33 AM, Surveyor interviewed MD-D. MD-D stated he cleans the outside dryer vents once per month as indicated in the electronic maintenance task system.</p>

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that a working call system is available in each resident's bathroom and bathing area.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22692</p> <p>Based on observation and interview the facility did not provide adequate equipment to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member, or to a centralized staff work area, for 1 residents (R16) out of 20 sampled residents.</p> <p>* R16's call light did not work when pressed and R16 had to pull it out of the wall to get it to work.</p> <p>Findings include:</p> <p>R16 was admitted to the facility on [DATE] with diagnosis that included Hemiplegia and Chronic Respiratory Failure. R16's Quarterly Minimum Data Set (MDS) dated [DATE] was reviewed and documented R16 had a Brief Interview for Mental Status score of 14 which would indicate he is cognitively intact and able to make his needs known.</p> <p>On 06/17/24 at 9:36 AM, Surveyor observed R16 lying in bed in his room. R16 indicated for the past 2 or 3 days his call light has not worked when pressed and to get it to ring he has to pull it out of the wall. R16 indicated he reported it to nursing and no one has fixed it or given him an alternate way to call for assistance. R16's call light was tested during the observation and did not work when pushed.</p> <p>On 6/18/24 at 8:54 AM, Surveyor observed R16 lying in bed in his room. R16 indicated his call light still did not work and no one had fixed it. R16's call light was tested during the observation and did not work when pushed.</p> <p>On 6/18/24 at 9:00 AM, Licensed Practical Nurse (LPN)-C was interviewed and indicated that she was unaware R16's call light wasn't functioning and he usually just yells out when he needs something.</p> <p>On 6/18/24 at 10:05 AM, Director of Nurses (DON) -B was interviewed and indicated she was unaware that R16's call light wasn't working and she would take care of it right away.</p> <p>On 6/18/24 at 1:30 PM, Surveyor observed R16 lying in bed. R16 indicated his call light was replaced with a new one as was now working. R16 pushed the button and it was observed to be functioning.</p> <p>On 6/19/24 at 10:38 AM, Maintenance Director (MD)-D was interviewed and indicated he was not told about R16's call light not working.</p> <p>On 6/19/24 the facility's maintenance recording system was reviewed and there was no documentation that R16's call light needed repair.</p> <p>The above findings were shared with Administrator-A and Director of Nurses B on 6/19/24 at the daily exit meeting. Additional information was requested if available. None was provided as to why R16's call light was not functioning or that he was provided an alternate method to call for assistance on 6/17/24 and 6/18/24.</p>		