STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525373	A. Building B. Wing	07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Care and Rehab - Boscobel	207 Parker St Boscobel, WI 53805

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41788 Based on interview and record review the facility failed to ensure that all residents were able to formulate an advance directive, specifically related to code status, for 9 of 12 residents (R7, R185, R8, R22, R13, R28, R11, R17, & R10) reviewed for code status of total sample of 34 residents. R7's Provider Orders for Scope of Treatment (POST) form is dated and signed by the physician but not the resident or resident representative. R185's POST form is dated and signed by the physician but not the resident or resident representative. R185 does not have Advance Directives in place and no documentation to show the facility spoke with R185 regarding Advance Directives. R8's POST form is dated and signed by the physician but not the resident or resident representative. R8's Power of Attorney for Healthcare does not have the two required witness signatures and dates. R22's POST (Provider Orders for Scope of Treatment) form did not match his CNA (Certified Nursing Assistant) Kardex in the closet of his room; POST form said Full code and Kardex in closet said DNR (Do Not Resuscitate). R22's POST form is not signed by his Court-appointed Guardian. R22 only has his code status on file, no further advance directives. R13 did not have a POST form in the POST form book at the Nurse's Station until the afternoon of [DATE]. R13's POST form is not signed by herself or her representative. R11 and R28 POST (Provider Orders for Scope of Treatment) form was not signed by the resident or representative. R10 and R17's POST (Provider Orders for Scope of Treatment) was not signed by the resident or representative. This is evidenced by: The facility's policy entitled Resident Rights Regarding Treatment and Advance Directives, dated [DATE], states, in part: . (continued on next page)

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Policy: It is the policy of this facility to support and facilitate a resident's right to request, refuse and/or discontinue medical or surgical treatment and to formulate an advance directive. Policy Explanation and Compliance Guidelines: 1. On admission, the facility will determine if the resident has executed an advance directive, and if not, determine whether the resident would like to formulate an advance directive. 2. The facility will provide the resident or resident representative information, in a manner that is easy to understand, about the right to refuse medical or surgical treatment and formulate an advance directive. 3. Upon admission, should the resident have an advance directive, copies will be made and placed on the chart as well as communicated to the staff . 9. Any decision making regarding the resident's choices will be documented in the resident's medical record and communicated to the interdisciplinary team and staff responsible for the resident's care . The facility's policy entitled, Respiratory and/or Cardiac Arrest-Code Blue Procedure, dated ,d+[DATE], states, in part: . POLICY: It is the policy of Care & Rehab Boscobel to provide immediate medical attention as needed for our residents who become pulseless and breathless unless: 1) The resident has a do not resuscitate (DNR) order; . Code status will be addressed by social worker upon admission. PROCEDURE: . 2. Call for help- The staff member is to determine if resident is Full Code indicators for full code: Full Code sticker inside the resident's closet, and in Point Click Care - Care Profile- Special Instructions . Example 1 R7 admitted to the facility on [DATE]. R7's Provider Orders for Scope of Treatment (POST), dated [DATE], indicates R7 is a Do Not Attempt Resuscitation/DNR. The POST form is signed and dated by physician. The resident or resident representative did not sign and date the form. Example 2 R185 admitted to the facility on [DATE]. R185's POST, dated [DATE], indicates R185 is a Do Not Attempt Resuscitation/DNR. The POST form is signed and dated by physician. The resident or resident representative did not sign and date the form. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 10:48 AM, Surveyor interviewed SW C (Social Worker) and asked what the facility's process is for Advance Directives. SW C indicated the staff talks to the residents on admission, during care conferences, and nurses on the floor talk with residents also. Surveyor asked SW C for R185 if there is documentation on a discussion with R185 regarding Advance Directives. SW C indicated no. Surveyor asked if there should be and SW C indicated yes. On [DATE] at 4:05 PM, Surveyor asked R185 if the facility spoke with him regarding Advance Directives on admission and R185 indicated he does not remember being talked to here at the facility but at the hospital he does remember a conversation. He remembers signing something at the hospital. Example 3 R8 admitted to the facility on [DATE]. R8's POST, dated [DATE], indicates R8 is a Do Not Attempt Resuscitation/DNR. The POST form is signed and dated by the physician. The resident or resident representative did not sign and date the form. R8's Power of Attorney for Healthcare, dated [DATE], does not have the two required witness signatures and dates; therefore, the form is not valid. On [DATE] at 4:20 PM, Surveyor interviewed RN D (Registered Nurse) and asked where she would look for a resident code status and RN D indicated first, she would look at the paper the nurses carry with all the residents' code statuses listed. RN D indicated the residents' closets also have code status's along with PCC (Point Click Care). RN D indicated and showed Surveyor the list of all residents' code status' that is kept hanging in the medication room. RN D indicated in the dining room there possibly might be a list as well with residents' code statuses. On [DATE] at 12:15 PM, Surveyor interviewed SW C and asked what the process is for obtaining code status for new residents. SW C indicated the facility looks at the hospital code status and have a discussion with the resident to see if the resident would like to keep that status or change it. If resident chooses to stay the same, the facility keeps the hospital form. If the resident wishes to change status, the facility completes a new the code status form. Surveyor asked who is required to sign the code status forms and SW C indicated the physician signs, and the facility gives the resident the option to sign the form. Surveyor asked SW C how one would know by looking at the form not signed by resident or resident representative if it was the resident's choice. SW C indicated the SW knows. Surveyor asked SW C is the facility uses the POST form as the main form to determine code status that is entered in various areas such as PCC and SW C indicated yes, the other forms and places are formed from the POST. Surveyor asked if the resident/resident representative should sign the POST forms and SW C indicated the facility is reviewing the policy and will be changing the policy. Surveyor asked SW C if R8's Advance Directives is valid without the required two witness signatures and SW C indicated no not without the signatures. Surveyor asked if residents should be asked about Advance Directives and SW C indicated yes. Surveyor asked if there should be documentation showing these conversations and SW C indicated yes. 38725 Example 4 R22's POST form is dated [DATE] with Physician signature only, there is no resident/resident representative/guardian signature present. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R22's POST form, banner in Electronic Health Record (EHR), Order, on Nurse Report sheet, and Code status list in medication room all document Full Code. R22's CNA Kardex in R22's closet had DNR sticker on it. R22 only has code status on file, he does not have any other advance directive in place. Example 5 R13's POST form is dated [DATE] with Physician signature only, no resident/resident representative/guardian signature present. On [DATE] at 11:03 AM, Surveyor observed POST form book at Nurse's Station. R13 did not have a POST form in binder. On [DATE] at 10:47 AM, Surveyor observed POST form book at Nurse's Station. R13 did not have a POST form in binder. On [DATE] at 4:36 PM, Surveyor interviewed LPN E (Licensed Practical Nurse). Surveyor asked LPN E where he would look to find a resident's code status, LPN E said in our computer system and POST book. Surveyor asked LPN E if all residents should have a POST form in the POST book, LPN E stated yes, they should. Surveyor asked LPN E when is the POST form completed, LPN E replied on the day of admission. Surveyor asked LPN E who completes the POST form, LPN E said I think Social Worker does that. Surveyor asked LPN E if there are any other places where a resident's code status is documented, LPN E explained it is on our report sheet- typed on there, list in medication room, and in room in closet. On [DATE] at 5:32 PM, Surveyor interviewed DON B (Director of Nursing). Surveyor asked DON B who obtains residents' code status upon admission, DON B said Social Service. Surveyor asked DON B how a residents' code status is determined, DON B explained there's a discussion with resident/family and Social Services. Surveyor asked DON B where you would expect your staff to look for code status in the event of an emergency, DON B stated in the EHR if they are in the hallway or in residents' closet on the CNA Kardex, there's a sticker; it's also on their report sheets that they carry. Surveyor asked DON B who ensures all areas where code status is documented are up to date, DON B said our MDS (Minimum Data Set) Coordinator. Surveyor asked DON B if all areas that code status are documented should match, DON B replied yes. Surveyor asked DON B are you aware of any residents that don't have matching code status, DON B stated no. It is important to noted that in the event of an emergency in R22's room, if staff looked in his closet and did not provide Cardiopulmonary Resuscitation (CPR; can help save a life during cardiac arrest), they would not have been following his code status order. On [DATE] at 5:33 PM, Surveyor interviewed SW C (Social Worker). Surveyor asked SW C how a resident's code status is determined, SW C explained there's a discussion with resident/family where I ask the resident, complete POST form, take to the clinic and have Physician sign. Surveyor asked SW C how discussion is had if family isn't able to be present in person, SW C said I'd call them and if there's a guardian company, we email. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 10:55 AM, Surveyor interviewed LPN F. Surveyor asked LPN F if all residents should have a POST form in the POST book, LPN F said yes. On [DATE] at 11:16 AM, Surveyor interviewed DON B. Surveyor asked DON B if all residents should have a POST form in the POST book, DON B stated yes. On [DATE] at 12:04 PM, Surveyor interviewed SW C. Surveyor asked SW C if all residents should have a POST form in the POST book, SW C replied yes. Surveyor asked SW C if R22 had any further advance directive information on file, SW C said she would look and come back. On [DATE] at 1:06 PM, SW C came back to Surveyor to say that R22 does not have any other advance directive on file here. SW C stated I called his Corporate Guardian and asked her if they had anything that we didn't have, and she stated they did not. 36253 Example 6 R11's POST form, indicating her wish to be a Do Not Resuscitate (DNR), was signed by the physician on [DATE]. The form was not signed by R11 despite the form indicating that she was of capacity to do so and had not indicated she did not wish to sign. Example 7 R28's POST form, indicating her wish to be a DNR, was signed by the physician on [DATE]. The form was not signed by R28 despite the form indicating that she was of capacity to do so and had not indicated she did not wish to sign. On [DATE] at 12:10 PM, Surveyor interviewed DON B (Director of Nursing). When asked if she would expect the POST form to be filled out thoroughly and signed by all the parties, DON B stated that she would leave that to SW C (Social Worker) as that is her job to complete. When asked how she knows what the wishes are of the resident, DON B stated that the facility has electronic orders for their code status. When asked where those electronic orders come from, DON B stated it was the POST form. 50228 Example 8 R10's POST form, indicating her wish to be a DNR, was signed by the physician on [DATE]. The form was not signed by R10 despite the form indicating that she was of capacity to do so and had not indicated she did not wish to sign. Example 9 R17's POST form, indicating her wish to be a DNR, was signed by the physician on [DATE]. The form was not signed by R17 despite the form indicating that she was of capacity to do so and had not indicated she did not wish to sign.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. 50228 Based on observation and interview, the facility did not ensure a resident who is fed by and receives medications by enteral means (also known as tube feeding, a way of sending nutrition and / or medications directly to the stomach or small intestine) receives the appropriate treatment and services. This affects 1 (R2) of 5 residents observed during medication pass. The facility did not properly check placement, ensuring the marking on the tube has not changed, of R2's jejunostomy tube (tube placed through the skin of the abdomen into the small intestine for nutrition, hydration, and/or medication administration) prior to administering medications. This is evidenced by: The Facility's policy entitled Verifying Placement of Feeding Tube dated 5/22/24, documents in part: It is the practice of this facility to ensure proper placement of feeding tubes prior to beginning a feeding, flushing the tube, or before administering medications via feeding tube.Procedure for verifying placement of feeding tubes: . Verify tube placement: for gastrostomy tubes, check that the enteral retention device is properly approximated to the abdominal wall by gently tugging on the tube and taking note of the marking on the tube. If unable to confirm placement, notify supervisor and/or physician. Consider alternative verification methods such as x-ray. Do not proceed with feeding, flush, or medication administration until tube placement is verified. On 07/01/24 at 4:39 PM, surveyor observed RN G (Registered Nurse) perform medication administration with R2. RN G performed hand hygiene, prepared medications, again performed hand hygiene, applied gown and gloves, and took medications, water flush, and prune juice to R2's bedside. RN G placed the tube feeding on hold, palplated R2's abdomen, attached the bulb of the syringe to the tube and poured water flush into syringe to instill by gravity. RN G administered medications one at a time through the syringe with water flush in between. RN G poured prune juice the syringe after the last medication, and followed this with an additional water flush. RN G removed the syringe from tube and restarted the tube feeding. Surveyor asked RN G, when placement of a feeding tube is verified. RN G stated, Good question. I do not do it. On 7/2 24 at 4:44 PM, Surveyor interviewed LPN E (Licensed Practical Nurse). Surveyor asked LPN E if placement of a feeding tube is verified. LPN E stated, Yes, we measure the tube prior to any administration; the measurement is listed on the pump. LPN E showed surveyor a sticker on the top of R2's tube feeding pump that stated 23 cm. On 7/02/24 at 5:27 PM, Surveyor interviewed DON B (Director of Nursing). Surveyor asked DON B when would you expect staff to check placement of the tube feeding? DON B stated before giving meds, feeding, or flushes. Surveyor asked DON B, how do you expect staff to check placement? DON B stated measure the tube.