STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525403	A. Building B. Wing	08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clark County Rehabilitation & Living Center	W4266 County Highway X Owen, WI 54460

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47657 Based on interview and record review, the facility did not report an incident of potential misconduct to the state agency immediately upon learning of the incident and did not submit the 5-day investigation within 5 days as required. The facility practice had the potential to affect 1 of 2 residents (R) reviewed for abuse (R78). This is evidenced by: The facility policy entitled Abuse, neglect, mistreatment & misappropriation of resident property policy and procedure, indicates the definition of abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. According to Appendix PP of the State Operation manual Willful is defined at S483.5 in the definition of abuse, and means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. R78 was admitted to the facility on [DATE], and has diagnoses that include unspecified dementia, unspecified, severity, with agitation. R78's Minimum Data Set (MD) assessment dated [DATE], indicated during the assessment period that R78: -has short term and long-term memory problems. -physical behavioral symptoms directed toward others that occurred 4 to 6 days. -verbal behavioral symptoms directed toward others that occurred 4 to 6 days. -put others at significant risk for physical injury. -significantly intrudes on the privacy or activity of others. (continued on next page)

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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R78's care plan initiated on 07/14/24 for psychopharmacological medication/behavior has a goal of Zero altercations with peers related to wandering and confusion daily. Interventions include to be mindful of the environment and interactions, R78 is impulsive/unpredictable and will become verbally and physically aggressive at any moment. One staff person should be directing R78, however there should be an additional staff close enough to assist in case R78 should become physically aggressive. On 08/15/24 at 1:42 PM, Surveyor reviewed an investigation of resident-to-resident altercation involving R78 attempting to take candy from another resident, resulting in R78 willfully slapping another resident. This action would potentially cause psychosocial harm to a reasonable person. On 08/15/24 at 2:48 PM, Surveyor interviewed Director of Nursing (DON) B, regarding the resident-to-resident altercation. DON B indicated the facility did not report the altercation after completing investigation. Surveyor questioned DON B regarding R78's intention to take candy from another, if that would be considered willful. DON B stated, Yes, I understand that it could be considered willful and should be reported.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46694 Based on record review and staff interview, the facility did not ensure 2 residents (R), R56 and R127, of 7 sampled residents reviewed for hospitalization s received the proper notice of transfer, reason for transfer and location of transfer. R56 was transferred to the hospital on 03/10/24. R56 was own decision maker and was not provided a written notice of the transfer. R127 was transferred to the hospital on 02/22/24. R127 was not provided with written notice of the transfer. Findings: Example 1 R56 was admitted to the facility on [DATE] with a Brief Interview of Mental Status of 15; the resident was cognitively intact. On 03/10/24, R56's medical record indicated that R56 had a fever of 101.5 degrees. R56 had not slept since 03/08/24, and R56 could feel an 'infection brewing inside.' R56 was requesting transfer to the hospital. On 08/15/24 at 1:19 PM, Surveyor requested hospitalization notification of transfer provided to the resident. On 08/15/24 at 1:55 PM, Surveyor interviewed Director of Nursing (DON) B regarding notification of transfer for R56 on 03/10/24. DON B replied, I don't know what you are talking about. Surveyor asked DON B, When you transfer a resident to the emergency room , do you notify them or their representative in writing why they are being transferred and to where they are being transferred to? DON B replied, No we don't. 43352 Example 2 R127 was admitted to the facility on [DATE] and has diagnoses that include paranoid schizophrenia, type 2 diabetes, dementia and anxiety. R127 was sent to the emergency roiagnom on [DATE] and later admitted to the hospital. On 08/15/24, Surveyor was unable to locate a written notice of discharge/transfer form for this hospitalization . (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/15/24 at approximately 3:00 PM, Surveyor requested a transfer notice from DON B for R127's transfer to the hospital on 02/22/24. DON B indicated they did not do it.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46694 Based on record review, observation and interview, the facility did not implement the comprehensive, person-centered care plan for 1 of 29 sampled residents (R) (R12), reviewed with comprehensive, person-centered care plans. Findings: The facility's policy titled, Care Plans, dated 5/31/23 states in part, Staff is expected to follow the individual baseline plan of care at all times for each resident. R12 was admitted on [DATE] with diagnoses of Huntington's disease (a fatal genetic disorder that causes the progressive breakdown of nerve cells in the brain) and pneumonitis (a general term that refers to swelling and irritation, also called inflammation, of lung tissue) due to inhalation of food and vomit. R12's care plan reads, This resident has a history of inadequate oral intake related to Huntington's disease a need for enteral nutrition. The resident needs the HOB (head of bed) elevated 45 degrees during and thirty minutes after tube feed. On 08/14/24 at 8:47 AM, Surveyor observed tube feeding administered by Registered Nurse (RN) C. Surveyor noted the position of the resident was flat and R12 had slid down to the bottom of the bed with R12's head resting on top portion of the bed. R12's head was resting at about pillow height. This position was not changed during the tube feeding administration. On 08/14/24 at 9:06 AM, RN C had finished the administration, Surveyor asked RN C, I notice the care plan indicates that the HOB needs to be at 45 degrees during and 30 minutes after feeding. Is the bed at that angle? RN C replied, No, it is definitely not, I will raise it up. On 08/15/24 at 10:00 AM, Surveyor explained the tube feeding observation with the HOB being low to supervisor, RN D. Surveyor asked RN D, What is your expectation of what should have happened? RN D replied, The nurse should have put on the call light to ask for help with a boost up in bed and then raised the bed to 45 degrees before starting this procedure because this resident has Huntington's disease, and this slows gastric motility, and this resident has problems with emesis. On 08/15/24 at 11:29 AM, Surveyor explained the tube feeding process observed to Director of Nursing (DON) B. Surveyor asked DON B, What would your expectation be for the nurse in this instance? DON B replied, The bed should have been raised according to the care plan.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47657 Based on record review and interview, the facility did not ensure that each resident receives adequate supervision and assistance devices to prevent accidents for 2 of 6 residents (R) R34 and R100. Findings include: The facility's policy titled, Care Plans, dated 5/31/23 states in part, Staff is expected to follow the individual baseline plan of care at all times for each resident. R34 was admitted to facility on 11/02/22 and has diagnoses that include dementia and seizure disorder. R34's Significant Change Minimum Data Set (MDS) assessment, dated 07/12/24, indicated short term and long-term memory problems and requires substantial/maximal assistance for transfers with one-person physical assist. R34's Fall Risk Assessment completed by facility on 05/27/24 indicates high risk score of 23. R34's care plans indicate R34 is at risk for falls related to confusion, gait/balance problems, psychoactive drug use, unaware of safety needs, vision problems, wandering/pacing, lower extremity edema, calloused feet, and seizure disorder. R34's fall interventions include to place chair sensor alarm in chair R34 is sitting in. Check function and placement of pad prior to sitting down. On 08/14/24 at 9:01 AM, Surveyor reviewed the facility's fall-root cause analysis of 2 separate falls of R34, wherein the question of Were all applicable safety interventions in place/followed at time of fall? The questions were answered No. -Explanation for the fall dated 07/25/24 stated, Chair alarm inappropriately placed. -Explanation for the fall dated 08/12/24 stated, Chair alarm was not under resident when he was sitting in his wheelchair. 47807 Example 2 R100 was admitted to the facility on [DATE] after hospitalization for worsening agitation, restlessness, delusions, & inability to care for self. R100 has diagnoses that include dementia with agitation, anxiety disorder and major depressive disorder. R100 has behaviors that include wandering, repetitive movement, push, grab, verbal abuse/threaten behavior, cry, reject care, yell, delusional thought processes/actions (i.e. believes she is giving birth) socially inappropriate (disrobing, stripping bed, smearing BM, playing with urine & BM in toilet), aggression, wander. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R100's care plan indicated: SAFETY: 1:1 at all times. Keep [resident name] at least arms length away from all peers, at all times. Date initiated was 07/11/24 and care plan was revised on 07/29/24. On 08/15/24, Surveyor completed record review of R100's incident that occurred on 7/28/24. Report: On 07/28/24 at 8:30 PM, Resident has placed herself on the floor in peer's room and refused to get up. Peer was resting in her bed. Staff were 1:1 with resident and standing by the door. Resident [R100] got up off the floor, and sat on the edge of peers bed. Staff attempted to redirect [R100]. [R100] then threw her body backwards on top of peer multiple times with force. Staff continued to try and move her away from peer. Resident began striking out and hitting staff. Staff were eventually able to get her back to her room to calm. Description: Resident's separated. Law enforcement contacted who also reached out to crisis center . DON updated, Guardian updated, MD Updated . Resident continues to be 1:1 and stay at least an arms length away from all peers at all times. Both residents were evaluated, and neither was found to have any injury. On 08/15/24 at 2:45 PM, Surveyor interviewed Registered Nurse (RN) O and RN P regarding the incident where R100 slammed back into another sleeping resident. RN O was the RN on duty at that times and said although they could not recall which Certified Nursing Assistant (CNA) was 1:1 with R100, what they do remember is the CNA was new and did not believe they had worked with R100 before. The CNA who was on one-on-one duties at the time of the incident, took over for another seasoned CNA who was taking a break at this time. RN P stated that they have been working with R100 and the medical director to get the correct medications to help R100 and recently behaviors have been getting better. It takes time to learn how best to help the resident. Both RNs reiterated the CNA was new and that normally they have CNAs in the dementia wing that have experience with the violent outburst and are aware of the 1:1 supervision needed for R100. On 08/15/24 at 3:45 PM, Survey interviewed Director of Nursing (DON) B regarding expectations of staff when a resident is considered to be one on one with a resident. DON B said they would have expected the CNA to provide supervision and step in prior to R100 throwing her body backwards onto another resident preventing the resident-to-resident altercation. DON B indicated the facility has been working on training new employees, but after Covid they have not got a chance to get back on a regular training schedule. They would have expected that the CNA who was one on one with R100 to have the training to stop the incident before it occurs.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observe each nurse aide's job performance and give regular training. 43352 Based on record review and staff interviews, the facility did not ensure Certified Nursing Assistant (CNA) received a performance review every 12 months for three of five CNAs reviewed. (CNA H, CNA I, CNA J). The facility failed to have a system in place to ensure that performance reviews were being done for any of the facility CNAs. This had the potential to affect all 147 residents residing in the facility. This is evidenced by: On 08/15/24, a random sample of CNAs employed by the facility was selected for review for the completion of annual performance reviews. The facility provided the following information: CNA H has been employed at the facility since 06/14/22. An annual performance review could not be located. CNA I has been employed at the facility since 07/13/17. An annual performance review could not be located. CNA J has been employed at the facility since 08/15/22. An annual performance review could not be located. On 08/15/24 at 4:23 PM, Surveyor asked Human Resources Manager (HR) G for their policy on performance reviews. On 08/15/24 at 4:28 PM, HR G indicated the county policy doesn't say they will do performance reviews. HR G verified there were no performance reviews for the CNAs, and the facility has not completed yearly performance reviews on any of their staff. The lack of regular performance reviews significantly impacts the quality of care provided by the staff.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 47807 Based on observation, interview and record review, the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety. Facility staff were walking trays with uncovered food past other residents' rooms. This has the opportunity to effect 3 of 3 residents (R117, R296, R295). Findings: The facility policy titled, Dining - Meal Service that was not dated states, 4. Nursing Staff will notify the food and nutrition serviced staff serving their unit of those who wish to receive meals in their rooms. When residents receive meals in their room, all food must be covered that travels through the unit. On 08/13/24 at 12:50 PM, Surveyor observed room trays being passed by Certified Nursing Assistant (CNA) M and CNA N. CNA M walked a food tray down R117's unit hallway to R117's room. The tray had uncovered cake and drinks. CNA N walked a tray down the unit's hallway with uncovered cake and drinks to R295. CNA M walked a tray with uncovered cake and drinks to R296. R296 was eating in their own room located on this unit. All drinks and desserts did not have a cover when they were transported to the residents' rooms, who were observed to be eating in their own rooms. This has potential to contaminate the uncovered food items. On 08/15/24 at 2:53 PM, Surveyor interviewed Director of Hospitality (DOH) L who oversees kitchen and dining services. Surveyor asked about their expectations regarding covering food and drinks when being transported down the halls. DOH L said they would expect that all food items and drinks should be covered when leaving the dining area. Many of the units should have extra covers as well and they will need to investigate this.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46694 Based on record review and staff interview, the facility did not ensure vaccinations were reviewed, offered, or administered for 1 of 5 sampled residents (R) for immunizations. R23. Findings: The most recent Centers for Disease Control and Prevention (CDC) recommendations for pneumococcal vaccinations indicate: For adults [AGE] years or older who have only received PPSV23, the CDC recommends: Give 1 dose of PCV15 or PCV20. The PCV15 or PCV20 dose should be administered at least 1 year after the most recent PPSV23 vaccination. Regardless of if PCV15 or PCV20 is given, an additional dose of PPSV23 is not recommended since they already received it. For those who have received PCV13 and 1 dose of PPSV23, the CDC recommends you give 1 dose of PCV20 at least 5 years after the last pneumococcal vaccine. For adults [AGE] years or older who have received PCV13, give 1 dose of PCV20 or PPSV23 at least 1 year after PCV13. Regardless of vaccine used, their vaccines are then complete. R23 was admitted on [DATE] with a Brief Interview of Mental Status (BIMS) of 01 (indicating severe cognitive impairment) with diagnoses of chronic cough and obstructive sleep apnea. On 08/14/24 at 7:32 AM, Surveyor asked Infection Preventionist (IP) E for immunization information regarding R23. IP E replied, That resident is on a different unit you can get that information from that nurse. On 08/14/24 at 2:09 PM, Surveyor asked Registered Nurse (RN) F for proof of pneumococcal vaccination for R23. Surveyor asked how residents get screened for immunizations. RN replied, We catch residents that need any immunizations upon admit to the facility. On 08/15/24 at 9:07 AM, Surveyor asked RN F, Can you show me proof that [R23] received a pneumococcal vaccine? RN F replied, I don't even have any proof that [R23] was offered it. The resident did not admit to my unit, she transferred to my unit from another unit. Surveyor asked RN F, What is the process and how do you catch if a resident admits to another unit and transfers to your unit and needs a pneumococcal vaccine? RN F replied, I don't really have a good answer for you.