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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525411 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 01/22/2025 |
| NAME OF PROVIDER OR SUPPLIER Willowdale Health Services | | STREET ADDRESS, CITY, STATE, ZIP CODE 1610 Hoover St New Holstein, WI 53061 | |

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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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
| <p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>45943</p> <p>Based on staff interview and record review, the facility did not review and revise a care plan intervention for 1 resident (R) (R2) of 2 sampled residents.</p> <p>On 10/27/24, R3 alleged R2 hit R1 on the forearm in the doorway of the dining room. The facility implemented an intervention to serve R2 meals in R2's room or anywhere R2 preferred other than the dining room. There were no monitoring interventions to ensure R2 wasn't being secluded from other residents. In addition, the intervention was meant to be short term but was not removed from R2's care plan.</p> <p>Findings include:</p> <p>The facility's Abuse, Neglect and Exploitation Policy, revised 7/15/22, indicates: .Involuntary seclusion refers to the separation of a resident from other residents or .confinement to his/her room against the resident's will or the will of the resident's legal representative. Emergency or short-term monitored separation from other residents will not be considered involuntary seclusion and may be permitted if used for a limited time as a therapeutic intervention to reduce agitation until professional staff can develop a plan of care to meet the resident's needs as long as the least restrictive approach is used for the minimum amount of time .</p> <p>On 1/22/25, Surveyor reviewed R2's medical record. R2 had diagnoses including dementia with behavioral disturbance, anxiety, bipolar disease, and delusional disorder. R2's Minimum Data Set (MDS) assessment, dated 11/17/24, indicated R2 was rarely/never understood. R2 had a Guardian for healthcare decisions. R2 was monitored for behaviors including refusal of care, aggression toward staff, and yelling.</p> <p>R2's care plan indicated R2 was at risk for behavior related to a history of bipolar disorder and delusional disorders. The care plan contained interventions (initiated 10/27/24) to serve R2 meals in R2's room or anywhere R2 preferred other than the dining room and to intervene/redirect if R2 was near R1.</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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>On 1/22/25, Surveyor reviewed a facility-reported incident (FRI) that indicated on 10/27/24 at 8:40 AM, R2 hit R1 on the left forearm when R2 and R1 passed each other in the doorway of the dining room. R3 reported the interaction to a nurse. R1 was assessed and had no visible injuries. R1 initially indicated R1 was hit by R2. In a later interview, R1 indicated R1 was not hit by R2 but R2 pushed R1's wheelchair. R3 witnessed the incident and indicated there was an interaction but R3 was not certain what happened. R4 was interviewed and indicated R2 hit R1 but could not provide further details. In a later interview, R4 indicated R2 pushed R1's wheelchair. Because the information obtained during the investigation was variable, the incident was determined to be inconclusive for abuse. An intervention was added to R2's care to serve R2 meals in R2's room or anywhere R2 preferred other than the dining room. Surveyor noted the intervention did not contain a time frame, did not include monitoring to ensure R2 was not involuntarily secluded from other residents, and was still listed on R2's care plan.</p> <p>On 1/22/25 at 1:43 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A who verified the intervention to have R2 eat meals in R2's room or somewhere other than the dining room did not contain a stop or review date but was meant to be short term. NHA-A indicated if R2 refused the intervention and redirection did not work, staff were directed to stay with R2 in the dining room. NHA-A verified that was not included in R2's care plan. NHA-A indicated R2 currently ate in the small dining room (adjacent to the main dining room) or R2's room per R2's preference. NHA-A agreed R2's care plan should have indicated the intervention was short term and should have included monitoring to ensure R2 was not involuntarily secluded from other residents. NHA-A indicated R2's behaviors had improved since the incident on 10/27/24 and the intervention should have been removed from R2's care plan.</p> | | |