STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525411	A. Building B. Wing	10/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willowdale Health Services	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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 50479 Based on staff interview and record review, the facility did not ensure written policies and procedures that prohibit mistreatment, neglect, and abuse of residents were consistently implemented for 1 of 8 staff reviewed during the caregiver program compliance check. Certified Nursing Assistant (CNA)-K indicated on CNA-K's Background Information Disclosure (BID) form that CNA-K lived out of state prior to moving to Wisconsin in June of 2024. The facility did not complete an out-of-state background check prior to CNA-K's hire on 7/9/24. Findings include: The facility's Abuse, Neglect and Exploitation policy, dated 7/15/22, indicates: Potential employees will be screened for a history of abuse, neglect, exploitation, or misappropriation of residential property .1. Background, reference, and credentials checks shall be conducted on potential employees, contracted temporary staff, students affiliated with academic institutions, volunteers, and consultants. Background checks, including rechecks, will be completed consistent with applicable state laws and regulation . On 10/1/24, Surveyor reviewed a BID form completed by CNA-K on 6/25/24. CNA-K indicated on the form that CNA-K lived out of state prior to moving to Wisconsin in June of 2024. Surveyor noted the facility completed a background check through the Wisconsin Department of Justice which did not include an out-of-state background check. On 10/1/24 at 11:39 AM, Surveyor interviewed Nursing Home Administrator (NHA)-A who indicated the facility had not done a federal or out-of-state background check for CNA-K. NHA-A indicated a federal background check should be completed prior to hiring a candidate who lived outside of Wisconsin.

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50479 Based on staff interview and record review, the facility did not ensure a Minimum Data Set (MDS) assessment accurately reflected the resident's status for 1 resident (R) (R15) of 16 sampled residents. R15 had a history of bipolar disorder and dementia with psychotic features. R15's Quarterly MDS assessment, dated 8/17/24, indicated R15 did not have delusion or hallucinations. Findings include: From 9/30/24 to 10/2/24, Surveyor reviewed R15's medical record. R15 was admitted to the facility on [DATE] with a medical history that included bipolar disorder and dementia with psychotic features. R15's Quarterly MDS assessment, dated 8/17/24, indicated in section E0100 that R15 did not have delusions or hallucinations. A nursing note, dated 8/17/24, stated, Resident does have visual and auditory hallucinations and is frequently seen reacting to internal stimuli. On 10/2/24 at 12:53 PM, Surveyor interviewed MDS Coordinator (MDSC)-L who indicated R15's Quarterly MDS assessment, dated 8/17/24, was based on R15's medical record between 8/11/24 and 8/17/24. MDSC-L reviewed the nursing note, dated 8/17/24, that indicated R15 had hallucinations and delusions. MDSC-L stated Social Worker (SW)-M completed section E0100 of the MDS assessment. MDSC-L indicated the 8/17/24 nursing note was not reviewed for section E because the MDS assessment was coded based on point-of-care documentation. Based on review of the 8/17/24 nursing note, MDSC-L indicated MDSC-L would have documented that R15 experienced hallucinations and delusions in section E0100. On 10/2/24 at 1:09 PM, Surveyor interviewed SW-M who indicated R15 had a history of hallucinations and delusions, but SW-M was unaware that R15 experienced those symptoms during the MDS seven day look back period. SW-M indicated SW-M had not witnessed R15 respond to internal stimuli and no other staff members had reported hallucinations to SW-M. SW-M indicated if SW-M had seen the 8/17/24 nursing note that mentioned R15's hallucinations and delusions, SW-M would have coded section E0100 differently.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49563 Based on observation, staff interview, and record review, the facility did not provide appropriate care and services to prevent urinary tract infections (UTIs) for 1 resident (R) (R182) of 2 residents with indwelling catheters. During an observation on 9/30/24, R182's uncovered catheter drainage bag was attached to R182's wheelchair and in contact with the floor. Findings include: On 10/1/24, Surveyor reviewed the facility's policy and procedure for catheter care and Relias training provided annually to nursing staff. The facility's Catheter Policy, dated 3/15/23, indicates: It is the policy of this facility to ensure that residents with indwelling catheters receive appropriate catheter care and maintain their dignity and privacy when indwelling catheters are in use .2. Privacy bags will be available and catheter drainage bags will always be covered while in use. The policy did not address positioning/placement of catheter tubing or drainage bags. The facility's Relias training for Care of a Urinary Catheter indicates: Many of the people you provide care for will have a urinary catheter. Unfortunately, urinary catheters often lead to infections and complications. According to the Agency for Healthcare Regency and Quality (2017), as many as 50-70% of urinary catheter-related infections can be prevented. You are in a position to prevent infections and complications caused by urinary catheters. By providing proper catheter care and understanding how infections and complications can develop, you can take steps to prevent them .Regular catheter care is important to prevent infection and other complications. Microbes, which cause infection, can enter the body through: .Portions of the equipment that touch a non-sterile surface, such as the floor .Follow your organization's policy on catheter care. Here are the steps to follow to provide basic catheter care: .11. Position and secure the drainage bag. The bed frame is a good place to hang the bag while the person is in bed. The drainage bag should be kept below the level of the person's bladder at all times. Do not place it on the floor. Once a bag touches the floor, it is contaminated. Place a bag cover over the bag to preserve the person's privacy. From 9/30/24 to 10/1/24, Surveyor reviewed R182's medical record. R182 was admitted to the facility on [DATE] with diagnoses including malignant neoplasm of rectum, diabetes, and malignant neoplasm of bone. R182's Minimum Data Set (MDS) assessment, dated 10/3/24, had a Brief Interview for Mental Status (BIMS) score of 13 out of 15 which indicated R182 had intact cognition. R182's medical record indicated R182 had an activated Power of Attorney for Healthcare (POAHC). On 9/30/24 at 11:37 AM, Surveyor observed R182 in a wheelchair in R182's room. R182's uncovered catheter drainage bag was attached to R182's wheelchair and in contact with the floor. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/30/24 at 11:44 AM, Surveyor interviewed Certified Nursing Assistant (CNA)-E who verified R182's catheter bag was uncovered and dragging on the floor. CNA-E indicated catheter bags should be covered and not in contact with the floor. On 10/1/24 at 1:42 PM, Surveyor interviewed Registered Nurse (RN)-F who verified the above findings for R182 and indicated catheter bags should not touch the floor and should be covered with a dignity bag. On 10/1/24 at 1:45 PM, Surveyor interviewed Assistant Director of Nursing (ADON)-C who verified catheter bags should not touch the floor and should be covered with a dignity bag. ADON-C stated ADON-C expects staff to follow the facility's policy. On 10/1/24 at 2:25 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A who verified catheter bags should not touch the floor and should be covered with a dignity bag.

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43361 Based on staff interview and record review, the facility did not ensure the provision of treatment and services to prevent weight loss for 1 resident (R) (R17) of 1 sampled resident. R17 was admitted to the facility on [DATE] and had a significant weight loss of 7.38% between 8/30/24 and 9/17/24. The facility's Registered Dietitian (RD) and physician were not notified following R17's weight loss and interventions were not put in place. Findings include: The facility's Weight Monitoring policy, with a review date of 12/21/22, indicates: The Interdisciplinary Team will strive to prevent, monitor, and intervene for undesirable weight change for our residents. 1. Nursing staff will measure residents' weight on admission, the next 2 days, and weekly for 3 additional weeks thereafter. 2. If no weight concerns are noted after the initial 3 days and 3 weeks after, routine weights will be measured monthly thereafter, unless ordered more frequently by the physician .8. The threshold for significant weight change will be based on the following criteria: a. 1 month - 5% of weight change is significant; greater than 5% is severe. 10. The nursing staff will notify the individual or responsible party, physician and RDN (Registered Dietary Nutritionist) or designee of any individual with an unintended significant weight change. Between 9/30/24 and 10/2/24, Surveyor reviewed R17's medical record. R17 was admitted to the facility on [DATE] with diagnoses including malignant neoplasm of the rectum and secondary malignant neoplasm of liver and intrahepatic bile duct. R17's Minimum Data Set (MDS) assessment, dated 9/5/24, had a Brief Interview for Mental Status (BIMS) score of 14 out of 15 which indicated R17 had intact cognition. R17 was R17's own decision maker. R17 previously resided at another facility and received Hospice services. R17's medical record indicated R17's family wanted to wait until R17 was settled to explore Hospice services. R17 had an order that indicated: Weight on admit, daily x 2, weekly x 3, then monthly. Obtain re-weight if change of 5 pounds since last weight. R17's weights between 8/30/24 and the last weight taken on 9/17/24 (which equaled a 7.38% weight loss) were as follows: ~ 8/30/24 - 151.8 pounds (lbs) ~ 9/1/24 - 147.2 lbs ~ 9/2/24 - 144.6 lbs ~ 9/9/24 - 138.2 lbs ~ 9/16/24 - 140.8 lbs ~ 9/17/24 - 140.6 lbs (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A nutrition assessment note, dated 9/6/24, indicated: R17 was a [AGE] year old short-term Hospice patient with colorectal cancer who had a nutrition problem of inadequate oral intake. R17's oral intake was likely adequate to meet R17's nutritional needs, though R17's intake was variable. The note indicated R17 might benefit from a nutritional supplement to help meet nutritional needs and indicated R17 would be seen within the next 7 days. The note also indicated R17 was independent with meals, had no skin issues/wounds, and had anticipated weight fluctuations related to fluid shifts due to diuretic therapy. R17's oral intakes and weights would be monitored and the RD was available as needed. R17's nutrition care plan, initiated 8/30/24, indicated R17 was at risk for nutritional status change related to potential for inadequate oral intake related to chronic disease state. The care plan contained interventions to review weight per facility protocol/MD orders (dated 8/30/24) and review weights and notify RD, Medical Doctor (MD), and responsible party of significant weight change (dated 9/6/24). R17's medical record did not contain any dietitian notes after the initial note and no progress notes or notification to the dietitian or MD related to R17's significant weight loss of 7.38%. Surveyor did not note any further weights after 9/17/24 or offers/orders for supplements to help increase or maintain R17's weight. On 10/2/24 at 11:00 AM, Surveyor requested any notifications and interventions implemented related to R17's significant weight loss. On 10/2/24 at 11:43 AM, R17 was weighed by staff. R17 weighed 131.8 lbs and had a 13.18% weight loss in just over 30 days. In addition, a 4 ounce med pass supplement was added on 10/2/24. On 10/2/24 at 12:52 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A who indicated the RD and nurse should look at weights and alerts in the system. NHA-A indicated R17's physician should also have been notified. NHA-A stated the system should alert nursing staff when a significant weight is entered. NHA-A acknowledged R17 received Hospice services at a prior facility, but was not currently on Hospice services. Regardless of Hospice services, NHA-A indicated R17 should be offered something such as a supplement, brownie, etc. NHA-A indicated a Registered Nurse (RN) recalled having a conversation with R17 and R17's family that R17 didn't like Boost (a nutritional supplement) which R17 had at a previous facility. NHA-A indicated there were other things the facility could offer. NHA-A indicated the facility had a contracted RD who was new to the facility, came to the facility every other week, and had access to residents' medical records when not at the facility. On 10/2/24 at 1:08 PM, Surveyor interviewed RD-G via phone. RD-G indicated RD-G was at the facility every other week and reviewed weight warnings for residents once per week. RD-G indicated RD-G did not review weights for each resident but looked at weight warnings triggered in the system. RD-G saw the weight warning for the beginning of the month when R17 triggered for a 3% weight loss. RD-G indicated RD-G was not sure why the system did not trigger for R17's 9/17/24 weight. RD-G confirmed R17 should have been reviewed for significant weight loss after the 9/17/24 weight. RD-G indicated RD-G would review R17 and follow-up with the facility.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 51044 Based on observation, staff interview, and record review, the facility did not ensure all drugs and biologicals were stored in accordance with the facility's policy. One medication cart was observed unlocked and unattended. In addition, 1 of 2 medication carts and 1 of 1 medication storage room contained expired medications and medical supplies. This practice had the potential to affect more than 4 of the 30 residents residing in the facility. The Chestnut hall medication cart (medication cart 1) and the medication storage room contained expired medications and medical supplies. In addition, the Chestnut hall medication cart was unlocked and unattended on 10/1/24. Findings include: The facility's Medication Storage policy, dated 1/2024, indicates: Medications and biologicals are stored properly, following manufacturer's or provider pharmacy recommendations, to keep their integrity and to support safe, effective drug administration. The medication supply shall be accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. Procedures: .3. In order to limit access to prescription medications, only licensed nurses, pharmacy staff, and those lawfully authorized to administer medications (such as medication aides) are allowed access to medication cares. Medication rooms, cabinets and medication supplies should remain locked when not in use or attended to by persons with authorized access .14. Outdated, contaminated, discontinued or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication disposal. Expired Medications and Supplies: On 10/1/24 at 10:24 AM, Surveyor observed 1 of 2 medication carts and 1 of 1 medication storage room and noted the following: The Chestnut hall medication cart contained the following: ~ An open 16 ounce container of Geri Care brand Milk of Mag with an expiration date of 8/24 ~ An open bottle of Geri Care Fiber Laxative (90 capsules) with an expiration date of 9/2024 ~ A Dynarex brand povidone-iodine single use swab stick with an expiration date of 10/2023 ~ A 23 gauge x 1 inch 3 ml (milliliter) syringe with hypodermic needle safety with an expiration date of 9/30/24 The medication storage room contained the following: (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	~ Twenty 4.5 mg (milligram) packages of Nestle arginaid-arginine powder with expiration dates of 8/2024 On 10/1/24 at 11:05 AM, Surveyor interviewed Licensed Practical Nurse (LPN)-D who verified the medications and supplies were expired and should have been disposed of. On 10/2/24 at 12:07 PM, Surveyor interviewed Assistant Director of Nursing (ADON)-C who verified the expired medications and supplies should have been disposed of on or by the date they expired. 49563 Medication Cart: On 10/1/24 at 2:10 PM, Surveyor observed a medication cart that was unlocked and unattended in the Chestnut hallway. On 10/1/24 at 2:21 PM, Surveyor interviewed Registered Nurse (RN)-H who verified the medication cart was left unlocked. RN-H indicated medication carts should be locked when unattended. RN-H locked the medication after the interview. On 10/1/24 at 2:33 PM, Surveyor interviewed ADON-C who verified medication carts should be locked when unattended. ADON-C indicated ADON-C expects staff to follow the facility's policy. On 10/1/24 at 2:36 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A who verified medication carts should be locked when unattended.