STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525412	A. Building B. Wing	09/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Birch Hill Health Services	1475 Birch Hill Lane Shawano, WI 54166

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 43361 Based on observation, staff interview, and record review, the facility did not ensure 1 resident (R) (R25) of 14 sampled residents was assessed as able to safely and accurately self-administer medication. On 9/23/24, R25 took R25's inhalers to a dialysis appointment to self-administer. R25 did not have a self-administration of medication assessment or a physician order that indicated R25 could safely and accurately self-administer the inhalers. Findings include: The facility's Self-Administration by Resident policy, dated 1/2023, indicates: Residents who desire to self-administer medications are permitted to do so with a prescriber's order and if the nursing care center's interdisciplinary team has determined that the practice would be safe and the medications are appropriate and safe for self-administration. If the resident desires to self-administer medications, an assessment is conducted by the interdisciplinary team of the resident's cognitive, physical, and visual ability to carry out this responsibility, during the care planning process. Between 9/23/24 and 9/25/24, Surveyor reviewed R25's medical record. R25 was admitted to the facility for rehab post patellar tendon rupture and bilateral repair on 8/14/24 and had a diagnosis of unspecified asthma. R25's Minimum Data Set (MDS) assessment, dated 8/21/24, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R25 had intact cognition. R25 attended dialysis 3 times per week. R25's medical record indicated R25 was prescribed the following medications: ~ Advair HFA Inhalation Aerosol (Fluticasone-Salmeterol) 1 puff inhale orally two times a day ~ Albuterol Sulfate HFA Inhalation Aerosol Solution 108 (90 Base) MCG/ACT (micrograms/actuation) (Albuterol Sulfate) 2 puffs inhale orally every 4 hours as needed for SOB (shortness of breath) and wheezing A Self-Administration of Medication Assessment, dated 8/14/24, indicated R25 either did not wish to self-administer medication or was unable to make R25's own decision and may not self-administer medication. (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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/23/24 at 1:07 PM, Surveyor observed the medication cart and noted R25's inhalers were missing. Surveyor interviewed Licensed Practical Nurse (LPN)-D who indicated R25 took R25's inhalers to dialysis. On 9/25/24 at 11:47 AM, LPN-C provided Surveyor with a physician notification, dated 9/25/24, that indicated R25 wished to self-administer R25's inhalers and keep the inhalers at bedside. R25 currently used albuterol as needed and fluticasone-salmeterol twice daily and was R25's own decision maker. The provider response was to have nursing staff assess for the appropriateness of self administration and indicated it was okay for R25 to self-administer and keep the inhalers at bedside. LPN-C acknowledged R25's self-administration of medication assessment should have been completed prior to 9/25/24.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50467 Based on record review and staff interview, the facility did not revise care plans in accordance with current care needs for 4 residents (R) (R38, R21, R40, and R35) of 14 sampled residents. The facility did not revise R38, R21, and R40's care plans when R38, R21, and R40 started Hospice care. R35 had a restorative program that indicated R35 should be walked to meals. The facility did not revise R35's care plan to indicate staff did not always ambulate R35 to meals but ambulated R35 at other times during the day. Findings include: 1. From 9/23/24 to 9/25/24, Surveyor reviewed R38's medical record. R38 was admitted to the facility on [DATE] and had diagnoses including encephalopathy, depression, and dementia. R38's Minimum Data Set (MDS) assessment, dated 9/11/24, had a Brief Interview for Mental Status (BIMS) score of 1 out of 15 which indicated R38 had severe cognitive impairment. R38's medical record contained an order for Hospice evaluation and treatment. On 9/10/24, R38's Hospice paperwork was completed. R38's medical record did not contain a Hospice care plan. 2. From 9/23/24 to 9/25/24, Surveyor reviewed R21's medical record. R21 was admitted to the facility on [DATE] and had diagnoses including adjustment with depressed mood and secondary malignant neoplasm of the brain (brain cancer). R21's MDS assessment, dated 9/6/24, had a BIMS score of 5 out of 15 which indicated R21 had severe cognitive impairment. R21's medical record contained an order, dated 2/13/23, for Hospice evaluation and treatment. R21's medical record did not contain a Hospice care plan. 3. From 9/23/24 to 9/25/24, Surveyor reviewed R40's medical record. R40 was admitted to the facility on [DATE] and had diagnoses including progressive neurological condition, Alzheimer's disease, and dementia. R40's MDS assessment, dated 8/23/24, had a BIMS score of 4 out of 15 which indicated R40 had severe cognitive impairment. R40 started Hospice services on 8/21/24. R40's medical record did not contain a Hospice care plan. On 9/24/24 at 1:56 PM, Surveyor interviewed Director of Nursing (DON)-B who confirmed residents who receive Hospice services should have a facility-completed care plan that reflects the needs of the residents. 45943 (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. From 9/23/24 to 9/25/24, Surveyor reviewed R35's medical record. R35 was admitted to the facility on [DATE] for therapy and had diagnoses including traumatic brain injury, epilepsy, impulsivity disorder, post-traumatic stress disorder (PTSD), and anxiety. R35's MDS assessment, dated 9/18/24, had a BIMS score of 3 out of 15 which indicated R35 had severe cognitive impairment. R35 had a guardian for healthcare decisions. R35's care plan, revised 4/23/24, indicated R35 required assistance to restore function for mobility related to decreased balance and inability to move independently. The care plan contained a restorative walking program intervention to ambulate R35 with a 4-wheeled walker, gait belt, and the assistance of 1 staff to meals. On 9/24/24 at 11:50 AM, Surveyor observed Nursing Home Administrator (NHA)-A begin to transport R35 to the dining room in a wheelchair with leg rests. Maintenance Director (MD)-H took over and completed the transport. On 9/24/24 at 11:52 AM, Surveyor interviewed NHA-A who indicated NHA-A was not aware R35 should be walked to the dining room for meals. On 9/24/24 at 11:55 AM, Surveyor interviewed MD-H who indicated MD-H was not aware R35 should be walked to the dining room for meals. MD-H indicated MD-H was told R35 should stay in the wheelchair so R35 didn't fall. On 9/24/24 at 1:43 PM, Surveyor interviewed Activities Director (AD)-I who verified AD-I took R35 to the dining room in the morning in a wheelchair. AD-I indicated AD-I was not aware R35 should be walked to the dining room for meals but stated R35 was walked in the hallway at other times. On 9/24/24 at 3:00 PM, Surveyor interviewed Minimum Data Set Coordinator (MDSC)-K who indicated Certified Nursing Assistants (CNAs) document on R35's plan of care the number of minutes R35 is walked. Surveyor reviewed the documentation and noted the following: ~ From 7/1/24 to 7/31/24, R35 was walked 3 times per day except on 4 dates when R35 was walked once, 3 dates when R35 refused, and 3 instances that were documented as not applicable. ~ From 8/1/24 to 8/31/24, R35 was walked three times per day except on 3 dates. ~ From 9/1/24 to 9/25/24, R35 was walked three times per day except on 1 date when R35 was not available and 1 date when R35 refused. On 9/25/24 at 10:09 AM, Surveyor interviewed DON-B who verified R35's care plan indicated R35 should be walked to meals. DON-B verified R35 was walked to breakfast that morning and stated DON-B observed R35 walked to supper on 9/24/24. DON-B also observed staff walk R35 at different times of the day other than meals. DON-B indicated DON-B would check with therapy to see if the ambulation order could be changed to include other times than meal time.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43361 Based on staff and resident interview, and record review, the facility did not ensure bowel movements were monitored in accordance with the facility's protocol for 1 resident (R) (R3) of 14 sampled residents. R3 had a history of bowel obstruction. From 7/16/24 through 7/20/24, R3 went 5 days without a bowel movement (BM). Staff did not monitor R3's BMs and R3 did not have a bowel elimination care plan. Findings include: The facility did not have a written policy for bowel management; however Director of Nursing (DON)-B indicated the facility had a non-written procedure for bowel management. Between 9/23/24 and 9/25/24, Surveyor reviewed R3's medical record. R3 was admitted to the facility on [DATE] and had diagnoses including occlusive mesenteric ischemia (a condition that occurs when blood flow to the small intestine is blocked or reduced), history of small bowel obstruction, and other intestinal obstruction unspecified as to partial versus complete obstruction. R3's Minimum Data Set (MDS) assessment, dated 8/17/24, had a Brief Interview for Mental Status (BIMS) score of 13 out of 15 which indicated R3 had intact cognition. R3 was R3's own decision maker. R3's medical record indicated R3 was hospitalized with bowel obstructions from 8/15/23 to 8/23/23 and 8/6/24 to 8/10/24. R3's medical record did not contain a bowel elimination care plan R3 had the following physician orders: ~ 8 ounces (oz) of Benefiber oral powder (wheat dextrin) once daily for constipation. ~ 30 milliliters (ml) of Milk of Magnesia every 24 hours as needed for constipation. ~ 1 scoop of polyethylene glycol 3350 powder every 24 hours as needed for constipation. ~ 1 tablet of sennosides 8.6 mg (milligrams) as needed for constipation. Take 1 to 4 tablets twice daily (BID). Start with 1 tablet BID and titrate up to 8 tablets per day. ~1 tablet simethicone 80 mg every 6 hours as needed for bloating and gas (starting 8/6/24). ~ 2.5 mg of oxycodone every 4 hours as needed for pain. Between 7/16/24 and 7/20/24, R3 did not have a documented BM. R3 continued to take scheduled Benefiber. Per R3's Medication Administration Record (MAR), R3 was not offered any as needed medication for constipation during the 5 days R3 did not have a BM. R3's medical record indicated the following: ~ On 7/21/24, R3 had 2 BMs (medium and small size, normal formed). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	~ On 7/22/24, R3 had 1 BM (small size, normal formed). ~ On 7/23/24, R3 was given Milk of Magnesia at 2:11 PM and 9:18 PM. R3 had 1 BM (medium size, normal formed) and was given oxycodone for pain. ~ On 7/24/24, R3 had 2 BMs (small size, normal formed) and was given oxycodone for pain. ~ On 7/26/24, R3's Benefiber was held due to loose stools. R3 also had 1 BM (medium size, normal formed). ~ On 7/29/24, R3 had 1 BM (medium size, normal formed). ~ On 7/30/24, R3 had 1 BM (medium size, normal formed). ~ On 7/31/24, R3 had 2 BMs (small size, normal formed). ~ On 8/1/24, R3 was given 1 tab of senna at 7:10 AM ~ On 8/2/24, R3 was given 1 tab of senna at 7:10 AM and had 2 BMs (large size, normal formed) at 9:55 PM. ~ On 8/3/24, R3 had 2 BMs (medium and large size, normal formed) and was given oxycodone for pain. ~ On 8/4/24 at 9:24 AM, R3 complained of abdominal pain. The nurse did an assessment and documented bowel sounds were active in all 4 quadrants. R3 was not eating much due to a concern of constipation. The physician gave an order to hold Lasix and potassium and draw labs. R3 had 1 BM (medium size, normal formed). ~ On 8/5/24, R3 had 1 BM (small size, normal formed). A progress note at 10:35 PM indicated R3 felt bloated. Bowel sounds were present in all 4 quadrants. R3 passed gas after auscultation and stated R3 felt better. A request for Gas-X was sent to the physician. R3 was given oxycodone which was effective. ~ On 8/6/24, R3 had 1 BM (small size, normal formed). A progress note at 10:23 AM indicated a Physician's Assistant (PA) faxed an order for simethicone 80 mg. At 9:55 PM, R3 had increased abdominal pain, was given oxycodone that was not effective, and was sent to the emergency room (ER). Surveyor reviewed R3's oxycodone use. Between 7/1/24 and 7/15/24 (prior to going 5 days without a BM), R3 took oxycodone 12 times for pain. Between 7/21/24 and 8/6/24 (after going 5 days without a BM), R3 took oxycodone 5 times for pain (3 of the 5 were between 8/3/24 and 8/6/24). R3's documented pain levels after 7/21/24 were not higher or out of the norm compared to R3's documented pain levels prior to 7/15/24. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/25/24 at 12:10 PM, Surveyor interviewed Certified Nursing Assistant (CNA)-J who worked regularly with R3. CNA-J indicated before R3 was hospitalized , R3 asked to go to the bathroom and staff assisted R3 though at times R3 tried to go without assistance. CNA-J indicated R3 was more independent now due to therapy, could go to the bathroom by R3's self, and would tell staff if R3 had a BM. CNA-J indicated R3 had always gone to the bathroom regularly but R3 did not feel like it was enough. CNA-J indicated R3 was good about telling staff when R3 went to the bathroom. CNA-J indicated BMs were documented in CNA charting and nursing staff gave CNAs a list of residents on watch for BMs. CNA-J could not recall if R3 was on the list during the 5 days in July that R3 did not have a documented BM. CNA-J indicated CNA-J felt if R3 didn't have a BM for multiple days, R3 would tell staff right away because R3 was concerned about BMs and liked to direct R3's care. On 9/25/24 at 12:17 PM, Surveyor interviewed R3 who indicated R3 kept a close eye on R3's BMs and staff did a good job keeping track as well. R3 indicated R3 had medication to take and asked for it as needed. R3 indicated sometimes R3 refused the medication because R3 didn't want to have diarrhea. R3 stated R3 had back pain for a couple weeks prior to hospitalization but thought it was a muscle pull. R3 indicated the pain was gradual and R3 didn't take anything for it and didn't tell staff. When the pain got worse, R3 was sent to the hospital and diagnosed with a bowel obstruction. R3 felt staff responded appropriately and monitored R3's bowels appropriately. On 9/25/24 at 12:48 PM, Surveyor interviewed Licensed Practical Nurse (LPN)-D who worked regularly with R3. LPN-D indicated R3 did not express anything out of the ordinary until close to the time R3 was sent to the ER. LPN-D indicated close to that time, R3 reported belly pain but was assessed and had bowel sounds in all 4 quadrants. LPN-D indicated belly pain wasn't unusual for R3 because R3 was anxious and worried. LPN-D indicated when R3 expressed bloating and pain, LPN-D completed an assessment and there were bowel sounds in all 4 quadrants. R3 passed gas after auscultation and felt better. R3's physician was contacted for Gas-X. LPN-D indicated nurses were usually given a sheet by the night (NOC) shift nurse if residents were on watch for a BM or if they hadn't had one in a few days. LPN-D did not recall from if R3 was on one of the sheets in July after R3 did not have a documented BM for 5 days. LPN-D indicated the facility protocol was if no BM for 3 days, give prune juice, then Milk of Magnesia, then if still nothing, NOC shift staff would administer a suppository. On 9/25/24 at 1:17 PM, Surveyor interviewed DON-B who confirmed due to R3's history of bowel obstruction, R3 should have had a bowel elimination care plan. DON-B indicated DON-B could not find a bowel management policy. DON-B indicated staff should offer a resident senna on day 3 if the resident did not have a BM. If the resident didn't have a BM by day 4, staff should offer Milk of Magnesia. On day 5, staff should administer a suppository. DON-B indicated DON-B was unsure what the Medical Director wanted since DON-B had just started the DON role full-time the previous week. DON-B indicated nursing staff should look at the bowel report daily and provide a list of residents who were on watch. When Surveyor informed DON-B that R3's medical record indicated R3 did not have a BM and was not offered PRN medication between 7/16/24 and 7/20/24, DON-B indicated sometimes R3 went to the bathroom but did not tell staff or staff may have provided R3 with PRN medication but didn't document it. DON-B confirmed BMs and medications should be documented in a resident's medical record On 9/25/24 at 1:56 PM, DON-B provided Surveyor with a half sheet of paper with a graph that indicated what staff should do for bowel protocol. The sheet indicated on day 3, the resident should be offered prune juice. On day 4, the resident should be offered Milk of Magnesia. On day 5, the resident should be offered a suppository. If there were no results by day 5, staff should contact the physician.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49563 Based on observation, staff interview, and record review, the facility did not ensure 1 resident (R) (R194) of 2 residents reviewed for pressure injuries received appropriate care and services to promote healing and/or prevent pressure injuries from developing. During R194's dressing change on 9/24/24, Director of Nursing (DON)-B did not apply iodine as ordered by the physician. Findings include: On 9/24/24, Surveyor reviewed R194's medical record. R194 was admitted to the facility on [DATE] with diagnoses including rhabdomyolysis, sepsis due to methicillin-resistant Staphylococcus aureus (MRSA), pressure ulcer of foot, and diabetes. R194's Minimum Data Set (MDS) assessment, dated 9/19/24, had a Brief Interview for Mental Status (BIMS) score of 13 out of 15 which indicated R194 had intact cognition. R194's medical record indicated R194 was responsible for R194's healthcare decisions. R194 had a wound care order, dated 9/19/24, to place iodine and a Xeroform dressing on the stitch area with 4 x 4 gauze and Kerlix and ACE or Coban wrap daily on the left foot. On 9/24/24 at 10:28 AM, Surveyor observed DON-B and Licensed Practical Nurse (LPN)-C perform a dressing change for R194. DON-B applied Xeroform dressing to the stitch area with 4 x 4 gauze, Kerlix, and an ACE wrap. Surveyor noted DON-B did not apply iodine during the dressing change in accordance with the wound care order. On 9/24/24 at 11:55 AM, Surveyor interviewed LPN-C who verified iodine was not applied during the dressing change. LPN-C stated R194 was leaving shortly for an infectious disease appointment and nursing staff would correct the error upon R194's return. On 9/25/24 at 1:35 PM, Surveyor interviewed DON-B who verified DON-B did not apply iodine during R194's dressing change.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43361 Based on staff interview and record review, the facility did not ensure 1 resident (R) (R5) of 7 sampled residents was monitored for adverse reactions to antipsychotic medication. R5 was prescribed Seroquel (an antipsychotic medication) for dementia with behaviors. The facility did not complete a baseline Abnormal Involuntary Movement Scale (AIMS) assessment for R5 prior to the start of the medication. Findings include: The National Institute for Health, www.ncbi.nlm.nih.gov Tardive Dyskinesia, updated 4/24/23, indicates: Numerous rating scales determine the presence and severity of tardive dyskinesia. The most widely used instrument is the AIMS. It is recommended to administer the AIMS at baseline before initiating antipsychotic medications, with a follow-up screening performed no longer than three months later. Upon evaluation of the patient, it can be noted that tardive dyskinesia is present at rest and somewhat diminished when there is any form of volitional movement. For example, tongue dyskinesias reduce when the patient is asked to protrude their tongue. The facility's Psychotropic Medications policy, with a review date of 10/24/22, indicates: .8. Residents who receive an antipsychotic medication will have an AIMS test performed on admission, or at least every 6 months, when the antipsychotic medication is changed, and as needed (PRN). Between 9/23/24 and 9/25/24, Surveyor reviewed R5's medical record. R5 was admitted to the facility on [DATE] and had diagnoses including dementia with behavioral disturbance. R5's Minimum Data Set (MDS) assessment, dated 8/14/24, had a Brief Interview for Mental Status (BIMS) score of 8 out of 15 which indicated R5 had moderate cognitive impairment. R5 had an activated Power of Attorney for Healthcare (POAHC). R5's medical record indicated R5 was prescribed 25 milligrams (mg) of Seroquel once daily for dementia with behaviors on 9/18/24. R5's medical record did not contain an AIMS assessment. On 9/25/24 at 1:17 PM, Surveyor interviewed Director of Nursing (DON)-B who indicated R5 was scheduled to have an AIMS assessment completed on 9/26/24. When Surveyor requested the facility's policy, DON-B indicated the facility's policy did not indicate if a baseline AIMS assessment should be completed. DON-B acknowledged a baseline AIMS assessment prior to the start of antipsychotic medication provided a comparison for symptoms in subsequent AIMS assessments.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50467 Based on observation, staff interview, and record review, the facility did not ensure 1 of 2 refrigerators in the medication storage room that contained vaccines and insulin maintained an appropriate temperature per the facility's policy and instructions on the facility's temperature log. In addition, the facility did not ensure medications for 7 residents (R) (R40, R33, R21, R22, R1, R194, and R3) of 19 residents in 1 of 1 medication cart were dated appropriately when opened. The medication refrigerator log for [DATE] indicated temperatures had been taken only once per day and 8 of the 22 temperatures were out of range. The refrigerator contained vaccines and insulin which required a temperature between ,d+[DATE] degrees F to preserve their integrity. In addition, the facility's policy indicated refrigerator temperatures should be checked twice daily. The medication storage room and medication refrigerator contained expired items and items that were not dated when opened. A medication cart contained open inhalers and eye drops that were not dated when opened. Findings include: The facility's Medication Storage, Storage of Medication policy, dated ,d+[DATE], indicates: .11. Medications requiring refrigeration or temperatures between 36 and 46 degrees F are kept in a refrigerator with a thermometer to allow temperature monitoring .A temperature log or tracking mechanism is maintained to verify the temperature has remained within accepted limits. The temperature of any refrigerator that stores vaccines should be monitored and recorded twice daily .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. The facility's Medication Administration, General Guidelines policy, dated ,d+[DATE], indicates: .8. Check expiration date on package/container. No expired medication will be administered to a resident .B. Nurse shall place a date opened sticker on the medication if one is not provided by the dispensing pharmacy and enter the date opened. C. Certain products or package types such as multi-dose vials and ophthalmic drops have specified shortened end-of-use dating, once opened, to ensure medication purity and potency. When date open expiration dating is not available from the manufacturer, the following may be considered in determining facility policy: Position statement from American Society of Ophthalmic Registered Nurse and American Society of Cataract and Refractive Surgery state that multi-use eye drops and ointments should be disposed of 28 days after initial use .All other ophthalmic drops are to be considered expired after 60 days from the date opened. The glargine insulin manufacturer [NAME] Lilly insert at 16.2 Storage indicates: Store unused insulin glargine in a refrigerator between 36 F and 46 F (2 C (Celsius) and 8 C). Do not freeze. Discard insulin glargine if it has been frozen. Protect insulin glargine from direct heat and light. (continued on next page)

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	525412	A. Building B. Wing	09/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Birch Hill Health Services	1475 Birch Hill Lane Shawano, WI 54166

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Diabetes Disaster Response Coalition Safe Storage of Insulin pamphlet Pdf., dated 2018, indicates: According to the product labels from all three U.S. insulin manufacturers, it is recommended that insulin be stored in a refrigerator at approximately 36 F to 46 F (this is recommended for unopened insulin). The MSF medical guidelines for povidone-iodine, updated [DATE], indicate: Once the bottle has been opened, solution keeps 30 days. Pfizer labeling for 0.25% acetic acid irrigation, revised [DATE], indicates: The contents of an opened container should be used promptly to minimize the possibility of bacterial growth or pyrogen formation. 3. Discard the unused portion of irrigating solution since it contains no preservative. 3. Discard the unused portion of irrigating solution since it contains no preservative. The National Institutes of Health (NIH) for albuterol nebulizers, dated [DATE], indicates: Store between 2 C to 25 C (36 F to 77 F). Protect from light and excessive heat. Store unit-dose vials in protective foil pouch at all times. Once removed from the foil pouch, use vial(s) within two weeks. Discard the vial if the solution is not colorless. Ipratropium bromide and albuterol nebulizer packaging indicates: Protect from light. Unit-dose vials should remain stored in the protective foil pouch at all times. Once removed from the foil pouch, the individual vials should be used within two weeks. Discard if the solution is not colorless. 1. On [DATE] at 8:50 AM, Surveyor noted a medication log posted on the refrigerator in the medication storage room. The log contained one temperature per day. Surveyor also noted 8 of the 22 temperatures on the log were out of range. The log indicated the temperature should be between ,d+[DATE] degrees F. If the temperature was not within range, staff were instructed not to administer medication and alert the Executive Director (ED) or Maintenance Director immediately. Surveyor noted the log contained a range of low temperatures between 24 and 34 degrees on [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE]. On [DATE] at 8:50 AM, Surveyor noted a sign on the refrigerator that indicated temperatures should be checked twice daily due to vaccines in the refrigerator. On [DATE] at 11:00 AM, Surveyor reviewed the [DATE], [DATE], and [DATE] mediation refrigerator temperature logs. The [DATE] log indicated refrigerator temperatures were out of range on 11 of 30 days. The temperatures ranged from ,d+[DATE] degrees F on [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE]. The temperature logs for all 3 months indicated temperatures were checked once per day. 2. On [DATE] at 8:55 AM, Surveyor observed the following items in the medication refrigerator: ~ A multi-use vial of Tubersol (tuberculous testing solution) with no open date. (A PharMerica policy, dated , d+[DATE] and provided by Nursing Home Administrator (NHA)-A, indicated the vial expired 30 days after opening.) ~ One syringe of Prevnar 20 (pneumococcal vaccine) ~ Five syringes of daptomycin (an antibiotic) with expiration dates of [DATE] (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	~ A clear container with a can of tomato soup with an expiration date of [DATE] on top of the refrigerator The medication supply closet contained: ~ Three bottles of one daily multivitamins with expiration dates of ,d+[DATE] ~ A 2 pack of Equate multi-purpose solution for soft contact lenses with an expiration date of [DATE] A second refrigerator in the medication storage room labeled for resident food contained the following: ~ A container of Sysco imperial thickened lemon-flavored water opened on [DATE] and expired 7 days after opening ~ A bottle of International Delight zero iced coffee with an expiration date of [DATE] ~ Two chocolate Magic Cups with expiration dates of [DATE] On [DATE] at 9:55 AM, Surveyor confirmed the expired items with Licensed Practical Nurse (LPN)-C. Storage shelves in the medication room contained: ~ Ten DermaPrep liquid barrier skin prep pads with expiration dates of [DATE] ~ Five E-swab collection and transport systems with expiration dates of [DATE] ~ Four povidone-iodine pads with expiration dates of ,d+[DATE] ~ Personal cleaning cloths with expiration dates of [DATE] ~ Nineteen Binax Now COVID-19 tests with expiration dates of [DATE] ~ Two iodoform packing strips with expiration dates of [DATE] and [DATE] ~ XLB transparent film dressing with an expiration date of [DATE] ~ A 300 ml (milliliter) canister with gel for active a.c. therapy system with an expiration date of [DATE] ~ A Bard Touchless Plus unisex pre-lubed urethral catheter kit with an expiration date of [DATE] ~ Two 25 ounce Dover urine leg bags with expiration dates of [DATE] ~ A Vac white foam dressing with an expiration date of [DATE] ~ A Genadyne Y connector for XLR8 Luer with an expiration date of [DATE] (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	~ A skin staple remover with an expiration date of [DATE] On [DATE] at 11:00 AM, Surveyor verified the expired items with LPN-D. 3. On [DATE] at 12:41 PM, Surveyor observed the medication cart labeled D/E and noted the following: ~ Loteprednol 0.5% ophthalmic gel for R40 with no open date ~ A bottle of Artificial Tears for R33 with an open date of [DATE]. (A PharMerica policy, dated ,d+[DATE] and provided by NHA-A, indicated Artificial Tears should be used used within 60 days after opening) and an albuterol sulfate 90 mcg (microgram) inhaler with no open date. ~ A bottle of Artificial Tears for R21 with an open date of [DATE] ~ An albuterol sulfate 90 mcg inhaler for R22 with no open date ~ An open foil package of albuterol inhalation nebulizers for R22 with no open date ~ A bottle of prednisolone 1% opthalmic suspension for R194 with no open date ~ An open foil Duoneb package for R1 with no open date ~ A bottle of 0.25% acetic acid irrigation for R3 with no open date Following the observation, Surveyor verified the above items with LPN-D. On [DATE] at 1:56 PM, Surveyor interviewed Director of Nursing (DON)-B who confirmed staff should date medication when opened. DON-B confirmed medications should be discarded by the expiration date and/or beyond-use date. DON-B also confirmed refrigerator temperatures should be checked twice daily and should be between ,d+[DATE] degrees F. DON-B indicated staff should follow the temperature log instructions; however, DON-B did not have documentation that was completed for the out-of-range temperatures dates.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49563 Based on observation, staff and resident interview, and record review, the facility did not establish and maintain an infection prevention and control program designed to help prevent the development and transmission of disease and infection for 1 resident (R) (R194) of 5 residents observed during the provision of care. A transmission-based precautions (TBP) sign was not posted outside R194's room to alert staff that R194 was on contact precautions for methicillin-resistant Staphylococcus aureus (MRSA). In addition, staff were observed providing care for R194 without gloves or gowns. Findings include: The facility's Infection Prevention and Control Program policy, dated 7/23/24, indicates: 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 guideline .5. Isolation Protocol (Transmission-Based Precautions): a. A resident with an infection or communicable disease shall be placed on transmission-based precautions as recommended by current Centers for Disease Control and Prevention (CDC) guidelines .d. When a resident on transmission-based precautions must leave the resident care unit/area, the nurse shall communicate to all involved departments the nature of the isolation and shall prepare the resident for transport in accordance with current transmission-based precaution guidelines. The CDC guidelines signage documents indicate: Contact Precautions Everyone Must: Clean their hands, including before entering and when leaving the room. Providers and Staff Must Also: Put on gloves before room entry. Discard gloves before room exit. Put on gown before room entry. Discard gown before room exit. Do not wear the same gown and gloves for the care of more than one person. Use dedicated or disposable equipment. Clean and disinfect surfaces and equipment with a sporicidal agent. On 9/23/24, Surveyor reviewed R194's medical record. R194 was admitted to the facility on [DATE] with diagnoses including Charcot foot wound with infection with MRSA, diabetes, and cancer. R194's Minimum Data Set (MDS) assessment, dated 9/12/24, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R194 had intact cognition. R194's medical record indicated R194 was responsible for R194's healthcare decisions. On 9/23/24 at 3:05 PM, Surveyor observed a cart outside R194's room. Surveyor did not observe a sign posted outside R194's room to alert staff that R194 was on contact precautions. On 9/23/24 at 3:13 PM, Surveyor interviewed Licensed Practical Nurse (LPN)-E who verified R194 was on contact and droplet precautions and indicated the sign must have fallen down. On 9/23/24 at 3:15 PM, Surveyor interviewed R194 who indicated staff wore masks and gloves but R194 had not seen staff wear gowns during cares other than dressing changes. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/23/24 3:20 PM, Surveyor interviewed Director of Nursing (DON)-B who verified a contact precautions sign was not posted but should be. On 9/24/24 at 7:33 AM, Surveyor observed Physical Therapist Assistant (PTA)-F and Occupational Therapist Assistant (OTA)-G perform dressing and grooming for R194. Surveyor noted PTA-F and OTA-G did not don gowns while working with R194 in R194's room. On 9/24/24 at 7:47 AM, Surveyor observed PTA-F provide therapy for a resident with PTA-F's mask pulled down around PTA-F's neck. On 9/24/24 at 7:53 AM, Surveyor interviewed OTA-G who indicated staff should wear gloves, a gown, and a mask when providing therapy for residents on contact precautions. OTA-G indicated staff are allowed to treat residents on contact precaution in the gym as long as other residents are not present. OTA-G indicated a gown was worn if staff provided physical contact. On 9/24/24 at 7:56 AM, Surveyor observed PTA-F provide therapy for R194 with stretch bands around R194's knees. Surveyor observed PTA-F hold the bands to create tension without wearing gloves or a gown. On 9/24/24 at 8:03 AM, Surveyor interviewed PTA-F who indicated staff should don a gown and gloves for any cares in R194's room. PTA-F indicated holding the bands on R194's legs was not considered physical contact. On 9/25/24 at 1:38 PM, Surveyor interviewed DON-B who verified R194 was on contact precautions due to MRSA in R194's foot wound and drainage from the dressing. DON-B verified therapy staff should wear gowns with R194 to ensure there was no accidental exposure if R194's wound dressing came off during therapy.