

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525415	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/26/2024
NAME OF PROVIDER OR SUPPLIER  Menomonee Falls Health Services		STREET ADDRESS, CITY, STATE, ZIP CODE  N84 W17049 Menomonee Ave Menomonee Falls, WI 53051	

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)
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38829</b></p> <p>Based on interview and record review, the facility did not ensure 1 (R5) of 7 residents reviewed were notified when there was a change in condition and a need to alter treatment.</p> <p>* R5's representative was not notified when R5 developed an open area below the left pinky toes on 11/5/24 and when R5 developed an area on the left outer ankle on 11/5/24.</p> <p>Findings Include:</p> <p>On 11/26/24, at 1:01 PM, Director of Nursing(DON) DON-B notified Surveyor there is no facility policy for notification.</p> <p>The facility's policy Pressure Injuries and Non pressure Injuries implemented 8/2/21 and last revised on 7/20/22 documents:</p> <p>.Resident/Responsible Party Education</p> <ol style="list-style-type: none"> <li>1. Provide Residents/responsible parties education regarding risk of pressure injuries based on the overall Resident risk.</li> <li>2. Inform Residents/responsible parties on the presence of wounds.</li> <li>3. Inform Residents/responsible parties on the status of wound progression.</li> </ol> <p>R5 was admitted to the facility on [DATE] has diagnoses that include Dementia with Mood Disturbance, Adult Failure to Thrive, Severe Protein-Calorie Malnutrition, Major Depressive Disorder, Unspecified Psychosis, and Anxiety Disorder.</p> <p>R5 was admitted into Hospice on 5/5/2023 with a diagnosis of severe protein calorie malnutrition and was discharged from hospice on 6/17/24.</p> <p>R5 has an activated health care power of attorney (HCPOA) effective 1/15/24.</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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R5's quarterly minimum data set (MDS) dated [DATE] indicated R5 had severely impaired cognition with a brief interview of mental status (BIMS) score of 0 and the facility assessed R5 needing total assistance with activities of daily living (ADLs) with one staff member. R5 has no impairment to her upper extremities and impairment to her bilateral lower extremities and uses a wheelchair. R5 is dependent assistance for showers, upper and lower body dressing and transfers. R5 requires substantial/maximum assistance for mobility. R5 is always incontinent of urine and bowel and wears an adult brief. R5 needs assistance with meal set up and there are no concerns with loss of liquids, holding food, choking, or swallowing difficulties when eating.</p> <p>On 11/25/24, at 3:09 PM, Surveyor spoke with R5's HCPOA who informed Surveyor that HCPOA was not informed of R5 having open areas to the toe or the ankle. HCPOA was notified by Wound Doctor (WD-H) last week of the status of all of R5's pressure areas and open areas.</p> <p>On 11/25/24, at 3:40 PM, Surveyor requested from Director of Nursing(DON) DON-B a timeline of R5's wounds: when the wounds started, when they healed, and when the HCPOA was notified.</p> <p>On 11/26/24, at 7:47 AM, Surveyor received a list of R5's wounds and when R5's HCPOA was notified. Surveyor reviewed R5's progress notes, WD-H documented notes, and facility assessments for notification of HCPOA located in R5's electronic medical record(EMR). Surveyor noted of all wounds, R5's HCPOA was not notified of the 11/5/24 area below left pinky toe and left outer ankle. The facility wound tracker documents representative was notified but not who was notified or the date the representative was notified. These boxes on the wound tracker document are blank.</p> <p>On 11/26/24, at 10:11 AM, Surveyor reviewed R5's EMR again. Surveyor notes that the effective on 11/5/24 weekly tracker was signed and locked by Registered Nurse(RN) on 11/5/24- RN- D. The date of the notification and specific name of who was notified is blank.</p> <p>On 11/26/24, at 10:51 AM, Surveyor notes that R5's weekly wound assessments for 11/5/25, have now been locked with a date of 11/25/24, the day Surveyors started the survey process at the facility.</p> <p>On 11/26/24, at 11:37 AM, Surveyor interviewed DON-B in regards to R5's HCPOA not being notified of the new open areas on of R5's 11/5/24 wounds on the left pinky toe and left outer ankle. DON-B informed Surveyor that the expectation is that the representative is notified immediately and that the section who is specifically updated with date should be filled out.</p> <p>On 11/26/24, at 12:00 PM, Surveyor interviewed RN-D in regards to the notification of R5's open areas. RN-D stated RN-D would typically put the name of who notified and the date on the weekly wound tracker. RN-D stated when the weekly wound tracker is completed, it is always locked the day of the assessment.</p> <p>On 11/26/24, at 12:05 PM, Surveyor reviewed R5's weekly wound tracker assessments in R5's EMR. Surveyor notes that now R5's weekly wound tracker contains documentation that R5's HCPOA was notified of the open areas on 11/5/24. Surveyor notes this document has been now locked on 11/26/24 at 11:59 AM.</p> <p>On 11/26/24, at 1:30 PM, Surveyor shared the concern with Nursing Home Administrator (NHA)-A that documentation is reflective that R5's HCPOA was notified of R5's 11/5/24 open areas. NHA-A agreed notification should be done right away, but there may be some slack possibly.</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>No additional information was provided as to why the facility did not ensure that R5's activated HCPOA was notified of R5's open areas with a change of treatment.</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38829</b></p> <p>Based on observation, interview, and medical record review, facility staff did not provide care and treatment in accordance with professional standards of practice and the comprehensive person-centered care plan for 1(R5) of 4 residents reviewed.</p> <p>* R5's current physician orders, Certified Nursing Assistant (CNA) bedside kardex, and comprehensive care plan document R5 is to wear size D double tubigrips to bilateral lower extremities (BLEs), worn toes to knees 23 hours/day as tolerated. Surveyor observed R5 to not be wearing the tubigrips during the survey process. On 11/14/24 an arterial open area was identified on R5's right 1st toe. R5's person-centered care plan was not updated with new interventions as well as R5 was not wearing physician ordered off-loading bilateral heel boots during the survey process.</p> <p>Findings Include:</p> <p>The facility's policy Pressure Injuries and Non pressure Injuries implemented 8/2/21 and last revised on 7/20/22 documents:</p> <p>Policy:</p> <p>This center will complete a comprehensive assessment to identify risk factors for the development of pressure injuries and put in place measure intended to achieve the goal of prevention of pressure injuries in our Residents. For those Residents admitted with, or who subsequently developed a pressure injury or impaired skin integrity, they will receive care, treatment, and services that seek to promote healing, prevent infection, and prevent further development of pressure injuries/impaired skin integrity.</p> <p>Examples of impaired skin integrity include, but not limited to, pressure injuries, venous(stasis) ulcers, arterial(ischemic) ulcers, diabetic(neuropathic) ulcers, surgical wounds, skin tears, and rashes.</p> <p>The staging of pressure injury is consistent with recommendation of National Pressure Injury Advisory Panel (NPIAP) and RAI Manual, Section M.</p> <p>Policy Explanation and Compliance Guideline:</p> <p>b. Assess current wounds at least every 7 days, or more frequently as needed. If a wound fails to show some evidence of progress towards healing within 2-4 weeks, the area and the Resident's overall clinical condition should be reassessed. Re-evaluation of the treatment plan includes determining whether to continue or modify the current interventions. Results may vary depending on the Resident's overall condition and interventions/treatments used. The complexity of the Resident's condition may limit responsiveness to treatment or tolerance for certain treatment modalities. The clinicians, if deciding to retain the current regimen, should document the rational for continuing the present treatment to explain why some, or all, of the plan's interventions remain relevant despite little or no apparent healing.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Care Planning:</p> <p>A comprehensive skin integrity care plan is based on Resident history, review of skin assessment, braden scale scoring, nutritional assessment, Resident and family interviews, and staff observations. Consider the areas of risk, as well as overall risk assessment score braden scale. Communicate identified risk factors and interventions to direct care staff.</p> <p>2. Develop interventions based on individual risk factors including, but not limited to, weight, presence of edema, overall health status/comorbidities, use of medical devices, presence of acute infection, end of life/hospice, Resident preferences/choices, or medications that may impact healing.</p> <p>a. In the context of the Resident's choices, clinical condition, and physician input, the Resident's care plan should establish relevant goals and approaches to stabilize or improve co-morbidities, such as attempts to minimize clinically significant blood sugar fluctuations, and other interventions aimed at limiting the effects of risk factors associated with pressure injuries. Alternatively, center staff and practitioners, should document clinically valid reasons why such interventions were not appropriate or feasible. For a Resident to exercise his/her right appropriately to make informed choices about care and treatment, to decline treatment, the center and the Resident (or if applicable, the Resident representative) must discuss the Resident's condition, treatment options, expected outcomes, and consequences of declining treatment or interventions. Centers should document this discussion in the Risk vs. Benefit UDA in the electronic medical record. The care plan should be updated to reflect the Resident's choice and what interventions will be in place to minimize risk to the Resident.</p> <p>R5 was admitted to the facility on [DATE] has diagnoses that include Dementia with Mood Disturbance, Adult Failure to Thrive, Atherosclerotic Heart Disease of Native Coronary Artery, Sensorineural Hearing Loss, Bilateral, Severe Protein-Calorie Malnutrition, Unspecified Psychosis, and Anxiety Disorder.</p> <p>R5 was admitted into Hospice on 5/5/2023 with a diagnosis of severe protein calorie malnutrition and was discharged from hospice on 6/17/24.</p> <p>R5 has an activated power of attorney (POA) effective 1/15/24.</p> <p>R5's quarterly minimum data set (MDS) dated [DATE] indicated R5 had severely impaired cognition with a brief interview of mental status (BIMS) score of 0 and the facility assessed R5 needing total assistance with activities of daily living (ADLs) with one staff member. R5 has no impairment to her upper extremities and impairment to her bilateral lower extremities and uses a wheelchair. R5 is dependent assistance for showers, upper and lower body dressing and transfers. R5 requires substantial/maximum assistance for mobility. R5 is always incontinent of urine and bowel and wears an adult brief. R5 needs assistance with meal set up and there are no concerns with loss of liquids, holding food, choking, or swallowing difficulties when eating. R5's MDS documents R5 is at risk for developing a pressure injury. At the time of assessment, R5 had 1 stage 1 pressure injury that was unhealed.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R5's Care Area Assessment(CAA) completed 7/8/24 documents R5 has an existing pressure ulcer/injury. Extrinsic risk factors include pressure requiring special mattress or seat cushion to reduce or relieve pressure, maceration due to moisture associated skin damage. Intrinsic risk factors include altered mental status, cognitive loss, incontinence, poor nutrition, antipsychotics and antidepressants, diagnoses of chronic or end-stage renal disease, malnutrition, other dementia, and depression. R5's CAA summary documents R5 is at risk for developing pressure ulcer due to needing of extensive assistance with bed mobility and is frequent incontinent of bladder and bowel. Goal is to ensure R5 maintains current clean and intact skin free of pressure ulcer. Will proceed plan of care.</p> <p>R5's physician orders document as of 7/10/24: R5 is to wear size D double tubigrips to bilateral lower extremities(BLEs), worn toes to knees 23 hours/day as tolerated. Nursing to check skin integrity every shift for tolerance. Surveyor notes placement of the tubigrips was being monitored on R5's Treatment Administration Record (TARs).</p> <p>R5's Certified Nursing Assistant (CNA) bedside kardex effective 11/26/24 instructs R5 is to wear size D double tubigrips to bilateral lower extremities(BLEs), worn toes to knees 23 hours/day as tolerated. Nursing to check skin integrity every shift for tolerance.</p> <p>R5's Bedside Kardex Report as of 11/26/24, also instructs staff to avoid positioning R5 on left side, monitoring/reminding/assistance to turn/reposition at least every 2 hours, more often as needed or requested, float heels when able, requires low air mattress on bed and cushion to chair and treatments as ordered.</p> <p>R5's comprehensive care plan initiated on 10/18/18 and revised 7/22/24 am Activities of Daily Living(ADL) self care deficit due to physical limitations, dementia, psychosis and depression. On 7/10/24, the intervention of R5 being dependent assistance of 1 to don/doff Bilateral Lower Extremity size D double tubigrips worn from toes to knees 23 hour/day as tolerated. Nursing to check skin integrity every shift for tolerance.</p> <p>R5's comprehensive care plan also documents:</p> <ul style="list-style-type: none"> <li>-Right arterial wound to 1st toe-initiated on 11/25/24</li> </ul> <p>Interventions all initiated on 11/25/24:</p> <ul style="list-style-type: none"> <li>-Administer treatment per MD orders</li> <li>-Diet and supplements per MD orders</li> <li>-Encourage and assist as needed to turn and reposition; use assistive devices as needed</li> <li>-Float heels as able</li> <li>-Special mattress/cushion on bed and wheelchair</li> <li>-Use pillows and/or positioning devices as needed</li> </ul> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Surveyor notes that focused problems for R5's open area was initiated on the first day of the survey process on 11/25/24 and no new interventions have been implemented at time of identification. The open areas on R5's 1st toe was identified on 11/14/24, but a care plan was not initiated until 11/25/24.</p> <p>R5 was evaluated and treated by wound doctor (WD)-H.</p> <p>On 11/21/24, WD-H documents:</p> <p>1. R5 has an arterial wound of the right plantar, 1st toe. 0.8 x 0.5 x not measurable. Depth is unmeasurable due to presence of nonviable tissue and necrosis. 100% black necrotic tissue. Skin prep once daily. Identified 11/14/24</p> <p>R5's current physician orders for wound care were initiated on 11/25/24 with a start date of 11/26/24</p> <p>-Cleanse right plantar, 1st toe with wound cleanser. Apply skin prep to the area daily until healed every day shift for arterial wound.</p> <p>This physician order was added to the Treatment Administration Record on 11/26/24 at 6:00 AM.</p> <p>R5's physician orders also document that R5 should be wearing off-loading bilateral boots at all times every shift for pressure wound effective 11/1/24.</p> <p>On 11/25/24, at 10:15 AM, Surveyor observed R5 up in wheelchair with a cushion in the chair, eating breakfast. Surveyor observed R5 with white ankle socks and red slippers on. Surveyor observed R5's bare legs with no bilateral tubigrips on. Surveyor also observed an air mattress on the bed. Surveyor observed 2 heel boots on top of the dresser.</p> <p>On 11/25/24, at 11:22 AM, Surveyor observed R5 in the same position in wheelchair, and no bilateral tubigrips were on. R5 is not wearing heel boots.</p> <p>On 11/25/24, at 12:55 PM, Surveyor observed R5 up in wheelchair, eating lunch and was not wearing bilateral tubigrips. R5 is not wearing heel boots.</p> <p>On 11/25/24, at 2:39 PM, Surveyor observed R5 in bed on R5's left side, facing window. R5 has heel boots on.</p> <p>On 11/26/24, at 7:35 AM, Surveyor from the team observed R5's lower legs. Surveyor describes R5's skin above the ankles to feet are dark with poor circulation, ankles are red/dark pink.</p> <p>On 11/26/24, at 9:10 AM, Surveyor observed R5 in wheelchair, eating breakfast and was not wearing bilateral tubigrips. R5 is not wearing heel boots.</p> <p>On 11/26/24, at 9:30 AM, Surveyor interviewed Certified Nursing Assistant(CNA) CNA-F who informed Surveyor that CNA-F has not seen R5 wearing bilateral tubigrips. CNA-F stated that R5 wears heel boots when in bed. CNA-F knows this because I usually take the heel boots off in the morning.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 11/26/24, at 9:32 AM, Surveyor interviewed Licensed Practical Nurse(LPN) LPN-G in regards to R5's bilateral tubigrips. LPN-G informed Surveyor that if it is part of R5's Medication or Treatment Administration Record, then LPN-G should be checking to see if it is completed and put on. Surveyor confirmed LPN-G administered medications to R5 prior to interview. Surveyor shared that R5 is not wearing bilateral tubigrips. LPN-G stated LPN-G was going to check if R5 was wearing bilateral tubigrips.</p> <p>On 11/26/24, at 10:28 AM, Surveyor observed R5 in wheelchair, no heel boots on, in common area in front of the television. R5 is now wearing bilateral tubigrips.</p> <p>On 11/26/24, at 11:15 AM, Surveyor observed R5 in wheelchair, no heel boots on, in common area in front of the television.</p> <p>On 11/26/24, at 12:10 PM, Surveyor observed R5 in wheelchair, no heel boots on, in common area in front of the television.</p> <p>On 11/26/24, at 12:56 PM, Surveyor observed R5 in wheelchair, no heel boots on, eating lunch in the dining room.</p> <p>Surveyor has not observed R5 to be repositioned at least every 2 hours during the survey process.</p> <p>On 11/26/24, at 10:30 AM, Surveyor interviewed LPN-G who informed Surveyor that R5 allowed LPN-G to put the bilateral tubigrips on with out any problem.</p> <p>On 11/26/24, at 11:37 AM, Surveyor shared that during the survey process, Surveyor has observed R5 to not have R5's bilateral tubigrips on with Director of Nursing(DON) DON-B. DON-B stated the expectation is that R5 should have been wearing the bilateral tubigrips. Surveyor and DON-B reviewed R5's comprehensive care plan addressing R5's open areas. Surveyor shared the concern that R5's care plan was revised on 11/25/24 and has no new interventions with the development of the 3 open areas. DON-B agreed R5's care plan should have been updated with new person-centered interventions when first identified. Surveyor shared that a documented root/cause analysis of the open areas is not in R5's EMR. DON-B stated she is not sure completely how R5 developed the open areas. DON-B stated that WD-H does not verbally give treatment orders. The facility gets a print out on the rounding.</p> <p>DON-B confirmed DON-B did not do the rounding with WD-H on 11/21/24. DON-B stated the floor nurse does not know how to put in the treatment orders and that DON-B is the only person who puts in new treatment orders. DON-B stated that is the disconnect. DON-B agreed that R5's treatment orders from 11/21/24 did not get processed by the facility and DON-B realized it when Surveyor was asking questions. Surveyor addressed the concern with DON-B that Surveyor has observed R5 to not have bilateral heel boots on at all times per physician orders during the survey process. DON-B stated that R5 sometimes doesn't keep them on, but agreed this is not addressed in R5's care plan and with interventions on how staff can re-approach R5 with encouragement to wear the bilateral heel boots. Surveyor also informed DON-B that Surveyor has had observations of R5 not being repositioned during the survey process.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 11/26/24, at 1:30 PM, Surveyor shared the concern with Nursing Home Administrator(NHA) that Surveyor observed R5 not wearing R5's bilateral tubigrips during the survey process. Surveyor also shared that R5 has had new open areas identified with no root/cause analysis. Surveyor shared R5's person-centered care plan focused problems for the new area on the 1st toe was not initiated until 11/25/24 and contained no new interventions. Surveyor shared with NHA-A that R5 has not had R5's bilateral heel boots on at all times and has not been repositioned every 2 hours during the survey process.</p> <p>No additional information was provided as to why the facility did not ensure that R5 received the necessary treatment and services consistent with professional standards of practice to promote healing and prevent new non-pressure injuries from developing.</p>		

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<p>F 0685</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Assist a resident in gaining access to vision and hearing services.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 38829</p> <p>Based on observation, interviews, and record review, the facility did not ensure a resident (R) with hearing and vision impairment received proper treatment and assistive devices including arrangements for an audiology (ear doctor) for 1 (R5) of 1 residents reviewed for hearing and eyesight loss.</p> <p>* Surveyor observed R5 to not be wearing R5's glasses and bilateral hearing aides during the survey process. R5's Medication Administration Record(MAR) documented in August 2024, R5 had a referral for audiology consultation to evaluate need for or appropriate type of treatment relating to hearing deficits or medical problems. A consult was not completed.</p> <p>Findings Include:</p> <p>The facility's policy Use of Assistive Devices implemented 9/19/22 documents:</p> <p>.The purpose of this policy is to provide a process for the proper and consistent use of assistive devices for those Residents requiring equipment to maintain or improve function and/or dignity.</p> <ol style="list-style-type: none"> <li>1. Assistive devices are tools, products, types of equipment, or technology that help individuals perform tasks and activities. They may help the individual move around, see, communicate, eat, or get dressed. Assistive devices include: <ul style="list-style-type: none"> <li>h. Sensory enhancements(i.e. hearing aids, glasses)</li> </ul> </li> <li>2. The use of assistive devices will be based on the Resident's comprehensive assessment, in accordance with the Resident's plan of care.</li> <li>3. The facility will provide assistive devices or obtain referral to specialist, for Resident who need them.</li> <li>4. Facility staff will provide appropriate assistance to ensure that the Resident can use the assistive devices.</li> <li>5. Direct care staff will be trained on the use of devices as needed to carry out their roles and responsibilities regarding the devices.</li> <li>6. A nurse with responsibility for the Resident will monitor for the consistent use of the device and safety use of the device.</li> </ol> <p>R5 was admitted to the facility on [DATE] has diagnoses that include Dementia with Mood Disturbance, Adult Failure to Thrive, Sensorineural Hearing Loss, Bilateral, Severe Protein-Calorie Malnutrition, Major Depressive Disorder, Unspecified Psychosis, and Anxiety Disorder.</p> <p>R5 was admitted into Hospice on 5/5/2023 with a diagnosis of severe protein calorie malnutrition and was discharged from hospice on 6/17/24.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Menomonee Falls Health Services		STREET ADDRESS, CITY, STATE, ZIP CODE  N84 W17049 Menomonee Ave Menomonee Falls, WI 53051	
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<p>F 0685</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R5 has an activated power of attorney (POA) effective 1/15/24.</p> <p>R5's quarterly minimum data set (MDS) dated [DATE] indicated R5 had severely impaired cognition with a brief interview of mental status (BIMS) score of 0 and the facility assessed R5 needing total assistance with activities of daily living (ADLs) with one staff member. R5 has no impairment to her upper extremities and impairment to her bilateral lower extremities and uses a wheelchair. R5 is dependent assistance for showers, upper and lower body dressing and transfers. R5 requires substantial/maximum assistance for mobility. R5 is always incontinent of urine and bowel and wears an adult brief. R5 needs assistance with meal set up and there are no concerns with loss of liquids, holding food, choking, or swallowing difficulties when eating. R5's MDS documents that R5 has hearing aides and can hear adequately with them. R5's MDS also documents that R5 has glasses and can see adequately with them.</p> <p>R5's Certified Nursing Assistant(CNA) Bedside Kardex Report as of 11/26/24 documents to ensure bilateral hearing aids are in and functioning for R5. The Kardex also documents that R5 wears hearing aides left and right. To power on, push white button on the hearing aide. One flash indicates that it is on. 2 flashes indicate that it is off. Charging deck, hearing aides must be inserted at night. Flashing light indicates that they are charging. Solid light indicates that they are fully charged. Staff are to monitor eyeglasses. Ensure glasses are worn as appropriate. Ensure glasses are clean, in good repair, and within reach.</p> <p>R5's comprehensive care plan documents:</p> <ul style="list-style-type: none"> <li>-Alteration in visual acuity as evidence by: wears glasses-Initiated 9/5/18</li> </ul> <p>Interventions:</p> <ul style="list-style-type: none"> <li>-Attempt to keep frequently used items within easy reach-Initiated 9/5/18, Revised 1/6/19</li> <li>-Ensure glasses are worn as appropriate. Ensure glasses are clean, in good repair, and within reach. -Initiated 9/5/18, Revised 8/19/20</li> <li>-Refer to optometry as necessary.-Initiated 2/27/23</li> <li>-Difficulty communicating due to hearing loss/deafness-Initiated 8/19/20, Revised 7/22/24</li> </ul> <p>Interventions:</p> <ul style="list-style-type: none"> <li>-Attempt to minimize excess noise-Initiated 8/19/20, Revised 2/25/23</li> <li>-Gain individuals attention before beginning to converse-Initiated 8/19/20, Revised 2/25/23</li> <li>-HEARING AIDES (FYI) (bilateral)-Initiated 8/19/20</li> <li>-Involve in activities which don't depend on ability to communicate/hear parties, crafts, movies-Initiated 8/19/20</li> </ul> <p>(continued on next page)</p>		

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<p>F 0685</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Provide accommodation for hearing impairments for activity participation such as placing near speaker, written instructions, adaptive television-Initiated 8/19/20</p> <p>-Provide reassurance and patience when communicating with R5. Repeat information as needed-Initiated 8/19/20</p> <p>-When talking to R5, use gestures and simple sentences while maintaining eye contact-Initiated 8/19/20, Revised 2/25/23</p> <p>R5's current physician orders document on 8/26/22 for R5 to have a referral for audiology consultation to evaluate need for or appropriate type of treatment relating to hearing deficits or medical problems. Record review of R5's electronic medical record(EMR) indicates there has not been an audiology consult since 3/13/24.</p> <p>Surveyor reviewed R5's EMR for optometry and audiology consults.</p> <p>On 9/29/22 the audiology consult documents has severe to profound mixed hearing loss of the right ear. Severe mixed hearing loss of left ear. With this hearing loss, R5 will not hear conversational speech for either ear.</p> <p>On 3/13/24, R5 was too belligerent to perform audiometric testing. Surveyor was not able to locate optometry consults.</p> <p>On 11/25/24, at 10:15 AM, Surveyor observed R5 in wheelchair, eating breakfast, facing the television that was on at medium volume. R5 was not wearing R5's glasses which were folded up to the right of R5's breakfast tray on the overbed table. Surveyor observed no hearing aides in R5's ears.</p> <p>On 11/25/24, at 11:22 AM, Surveyor observed R5 in same position, in front of TV with no glasses on and no hearing aides in.</p> <p>On 11/25/24, at 12:55 PM, Surveyor observed R5 in the dining room eating lunch with no glasses on or hearing aides in. R5's glasses are folded up on the table next to R5's lunch meal.</p> <p>On 11/26/24, at 9:10 AM, Surveyor observed R5 eating breakfast in the dining room. R5 has no glasses on and no hearing aides in. Surveyor does not observe R5's glasses within reach.</p> <p>On 11/26/24, at 9:30 AM, Surveyor interviewed Certified Nursing Assistant(CNA) CNA-F. CNA-F stated that R5 will take R5's glasses off at times and CNA-F try's to keep up with it. CNA-F stated that CNA-F has never seen R5 wear hearing aides since CNA-F started working in September.</p> <p>On 11/26/24, at 9:32 AM, Surveyor interviewed Licensed Practical Nurse(LPN)-G. LPN-G was unaware that R5 was to be wearing bilateral hearing aides and informed Surveyor, its not listed in the Medication Administration Record(MAR).</p> <p>On 11/26/24, at 10:28 AM, Surveyor observed R5 in wheelchair in common area in front of television that had a movie on at medium sound. Surveyor observed R5's glasses not on and no hearing aides in.</p> <p>(continued on next page)</p>		

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<p>F 0685</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 11/26/24, at 10:30 AM, LPN-G informed Surveyor that LPN-G checked with Director of Nursing(DON)-B who had stated to LPN-G that R5's hearing aides were lost a long time ago.</p> <p>On 11/26/24, at 11:15 AM, Surveyor observed R5 in common area with movie on television and no glasses on.</p> <p>On 11/26/24, at 11:37 AM, Surveyor interviewed DON-B regarding R5's glasses and hearing aides. DON-B started working at the facility in January of 2024 and understood that R5's hearing aides were lost before then. DON-B recalls being told at the 11/20/24 care conference by the Health Care Power of Attorney(HCPOA) that R5's hearing aides were lost. DON-B stated the HCPOA had stated HCPOA was not going to schedule appointments anymore because R5 was never ready in time. DON-B acknowledged the hearing aides were still documented on R5's Kardex and comprehensive care plan and stated that R5 is due for a care plan update. DON-B stated that R5 will leave glasses everywhere, but around lunch time, R5 will wear. Surveyor notes R5 leaving glasses everywhere and wearing at lunch time is not documented on R5's comprehensive care plan or Kardex.</p> <p>On 11/26/24, at 12:56 PM, Surveyor observed R5 eating lunch in the dining room and is not wearing glasses. R5's glasses are not within reach.</p> <p>On 11/26/24, at 1:30 PM, Surveyor shared the concern with Nursing Home Administrator(NHA)-A that Surveyor observed R5 not wearing R5's glasses or hearing aides during the survey process. Surveyor shared that Surveyor had been informed that R5's hearing aides have been lost, however, there is no documentation that the facility has attempted to arrange an audiology consult to obtain new hearing aides.</p> <p>No additional information was provided as to why the facility did not ensure that R5 received the necessary treatment and services consistent with professional standards of practice to promote quality of life by making sure R5's glasses were on during the survey process and that an audiology consult was completed to obtain new bilateral hearing aides so R5 could hear daily conversations.</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 38829</p> <p>Based on observations, interviews, and record review, the facility did not ensure that residents with pressure injuries received the necessary treatment and services consistent with professional standards of practice to promote healing and prevent new pressure injuries from developing for 2 of 2 residents (R5 and R7) reviewed.</p> <p>* R5, who was assessed to be at risk for pressure injuries, developed a stage 3 ischium pressure injury identified on 11/21/24. R5's care plan was not updated with new offloading interventions after the development of the ischium pressure injury. On 11/21/24, Wound Doctor (WD)-H recommended to upgrade offloading chair cushion. This was not completed by the facility. WD-H's treatment orders were not initiated until 11/26/24. During the survey process, Surveyor observed R5 to not be repositioned at least every 2 hours and R5 was not wearing heel boots at all times per R5's plan of care.</p> <p>* R7 was admitted with a Deep Tissue Injury to the left heel. Registered Nurse (RN)-D had inaccurate staging of the pressure injury staging it a Stage I. The treatment to the left heel was not initiated until 10/18/2024, two days after R7's admission. No assessments were documented in R7's medical record after 11/5/2024 showing the area had healed. Observation on 11/26/2024 showed R7 had a dark area to the left heel that was not documented.</p> <p>Findings include:</p> <p>The facility's policy Pressure Injuries implemented 8/2/21 and last revised on 7/20/22 documents:</p> <p>Policy:</p> <p>.This center will complete a comprehensive assessment to identify risk factors for the development of pressure injuries and put in place measure intended to achieve the goal of prevention of pressure injuries in our Residents. For those Residents admitted with, or who subsequently developed a pressure injury or impaired skin integrity, they will receive care, treatment, and services that seek to promote healing, prevent infection, and prevent further development of pressure injuries/impaired skin integrity.</p> <p>Examples of impaired skin integrity include, but not limited to, pressure injuries, venous (stasis) ulcers, arterial (ischemic) ulcers, diabetic (neuropathic) ulcers, surgical wounds, skin tears, and rashes.</p> <p>The staging of pressure injury is consistent with recommendation of National Pressure Injury Advisory Panel (NPIAP) and RAI Manual, Section M.</p> <p>Policy Explanation and Compliance Guideline:</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>b. Assess current wounds at least every 7 days, or more frequently as needed. If a wound fails to show some evidence of progress towards healing within 2-4 weeks, the area and the Resident's overall clinical condition should be reassessed. Re-evaluation of the treatment plan includes determining whether to continue or modify the current interventions. Results may vary depending on the Resident's overall condition and interventions/treatments used. The complexity of the Resident's condition may limit responsiveness to treatment or tolerance for certain treatment modalities. The clinicians, if deciding to retain the current regimen, should document the rationale for continuing the present treatment to explain why some, or all, of the plan's interventions remain relevant despite little or no apparent healing.</p> <p>Care Planning:</p> <p>A comprehensive skin integrity care plan is based on Resident history, review of skin assessment, braden scale scoring, nutritional assessment, Resident and family interviews, and staff observations. Consider the areas of risk, as well as overall risk assessment score braden scale. Communicate identified risk factors and interventions to direct care staff.</p> <p>2. Develop interventions based on individual risk factors including, but not limited to, weight, presence of edema, overall health status/comorbidities, use of medical devices, presence of acute infection, end of life/hospice, Resident preferences/choices, or medications that may impact healing.</p> <p>a. In the context of the Resident's choices, clinical condition, and physician input, the Resident's care plan should establish relevant goals and approaches to stabilize or improve co-morbidities, such as attempts to minimize clinically significant blood sugar fluctuations, and other interventions aimed at limiting the effects of risk factors associated with pressure injuries. Alternatively, center staff and practitioners, should document clinically valid reasons why such interventions were not appropriate or feasible. For a Resident to exercise his/her right appropriately to make informed choices about care and treatment, to decline treatment, the center and the Resident (or if applicable, the Resident representative) must discuss the Resident's condition, treatment options, expected outcomes, and consequences of declining treatment or interventions. Centers should document this discussion in the Risk vs. Benefit UDA in the electronic medical record. The care plan should be updated to reflect the Resident's choice and what interventions will be in place to minimize risk to the Resident.</p> <p>1.) R5 was admitted to the facility on [DATE] and has diagnoses that include Dementia with Mood Disturbance, Adult Failure to Thrive, Atherosclerotic Heart Disease of Native Coronary Artery, Severe Protein-Calorie Malnutrition, Unspecified Psychosis, and Anxiety Disorder.</p> <p>R5 was admitted into Hospice on 5/5/2023 with a diagnosis of severe protein calorie malnutrition and was discharged from hospice on 6/17/24.</p> <p>R5's Quarterly Minimum Data Set (MDS) dated [DATE], documents that R5 has severely impaired cognition with a Brief Interview for Mental Status (BIMS) score of 0. The MDS documents that the facility assessed R5 as needing total assistance with activities of daily living (ADLs) with one staff member. R5 has no impairment to her upper extremities and impairment to her bilateral lower extremities and uses a wheelchair. R5 is dependent for assistance with showers, upper and lower body dressing, and transfers. R5 requires substantial/maximum assistance for mobility.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>The Quarterly MDS also documents that R5 is always incontinent of urine and bowel and wears an adult brief. R5 needs assistance with meal set up and there are no concerns with loss of liquids, holding food, choking, or swallowing difficulties when eating. R5's MDS documents R5 is at risk for developing a pressure injury. At the time of assessment, R5 had 1 stage 1 pressure injury that was unhealed.</p> <p>R5's Pressure Ulcer Care Area Assessment (CAA) completed 7/8/24 documents R5 has an existing pressure ulcer/injury. Extrinsic risk factors include pressure requiring special mattress or seat cushion to reduce or relieve pressure, maceration due to moisture associated skin damage. Intrinsic risk factors include altered mental status, cognitive loss, incontinence, poor nutrition, antipsychotics and antidepressants, diagnoses of chronic or end-stage renal disease, malnutrition, other dementia, and depression.</p> <p>R5's CAA summary documents, R5 is at risk for developing pressure ulcer due to needing of extensive assistance with bed mobility and is frequent incontinent of bladder and bowel. Goal is to ensure R5 maintains current clean and intact skin free of pressure ulcer. Will proceed plan of care.</p> <p>On 8/13/24 and 11/21/24, R5's skin assessments document a score of 14.0, indicating R5 is at moderate risk for pressure injuries.</p> <p>R5's Bedside Kardex Report as of 11/26/24, instructs staff to avoid positioning R5 on left side, monitoring/reminding/assistance to turn/reposition at least every 2 hours, more often as needed or requested, float heels when able, requires low air mattress on bed and cushion to chair and treatments as ordered.</p> <p>R5's open areas with start date:</p> <p>Stage 3 pressure wound on left ischium-11/21/24</p> <p>1st right toe-arterial wound-11/14/24</p> <p>2nd right toe-unstageable due to necrosis-11/14/24</p> <p>Right inner ankle-6/11/24-healed</p> <p>Inner left thigh-10/3/24-healed</p> <p>Left outer ankle-11/5/24-healed</p> <p>Below left pinky toe-11/5/24-healed</p> <p>R5's comprehensive care plan documents:</p> <p>-Stage 3 pressure ulcer to left ischium-initiated on 11/25/24</p> <p>Original focused problem was initiated on 10/30/24 for an actual open area to left inner peri area due to impaired mobility, incontinence, nutritional deficit</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Interventions initiated 10/30/24 with no revisions</p> <ul style="list-style-type: none"> <li>-Administer analgesia per MD (medical doctor) orders</li> <li>-Administer treatment per MD orders</li> <li>-Diet and supplements per MD orders</li> <li>-Encourage and assist as needed to turn and reposition; use assistive devices as needed</li> <li>-Report evidence of infection such as purulent drainage, swelling, localized heat, increased pain. Notify MD PRN (as needed).</li> <li>-Special mattress/cushion on bed/wheelchair</li> <li>-Toileting program as indicated</li> <li>-R5 has unstageable pressure ulcer to the right 2nd hammer toe-initiated 11/25/24</li> </ul> <p>Interventions initiated:</p> <ul style="list-style-type: none"> <li>-Administer treatments as ordered and monitor for effectiveness</li> <li>-Avoid positioning R5 on left side-revised 11/25/24</li> <li>-Follow facility policies/protocols for the prevention/treatment of skin breakdown.</li> <li>-If R5 refuses treatment, confer with R5, team and family to determine why and try alternative methods to gain compliance. Document alternative methods.</li> <li>-Monitor nutritional status. Serve diet as ordered, monitor intake and record.</li> <li>-Monitor/document/report PRN any changes in skin status: appearance, color, wound healing, signs/symptoms of infection, wound size (length x width x depth), stage.</li> <li>-R5 needs monitoring/reminding/assistance to turn/reposition at least every 2 hours, more often as needed or requested.</li> <li>-R5 requires low air loss mattress on bed and cushion to wheelchair.</li> <li>-Weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue.</li> </ul> <p>Surveyor noted that the interventions for R5's open areas were initiated on the first day of the survey process on 11/25/24 and no new interventions have been implemented at the time the pressure injuries were discovered. The open areas on R5's 2nd toe were identified on 11/14/24, but a care plan was not initiated until 11/25/24. R5's stage 3 pressure wound on ischium was identified on 11/21/24, but a care plan was not initiated until 11/25/24.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>R5 was evaluated and treated by wound doctor (WD)-H on 11/21/24. WD-H documents:</p> <p>2. Stage 3 pressure wound of the left ischium, 2 x 1.5 x 0.1. Moderate Sero-sanguinous, 70% devitalized necrotic tissue, 20% slough, 10% granulation. Leptospermum honey apply once daily with foam silicone border once daily. Recommendations: cleanse with wound cleanser at time of dressing change. Limit sitting to 60 minutes. Upgrade offloading chair cushion. Identified 11/21/24</p> <p>3. Unstageable pressure (due to necrosis) of the right 2nd hammer toe. 1.0 x 0.8 x not measurable. Depth is unmeasurable due to presence of nonviable tissue and necrosis. 100% devitalized necrotic tissue. Betadine apply once daily. Recommendations: Pressure Off-loading Boot when in bed, recliner. Identified 11/14/24</p> <p>R5's current physician orders for wound care were initiated on 11/25/24 with a start date of 11/26/24 and document:</p> <p>-Cleanse left ischium wound with wound cleanser, apply medi honey to the wound bed and cover with a border gauze daily every day shift for pressure wound.</p> <p>-Cleanse right 2nd toe, hammer toe with wound cleanser. Apply betadine to calloused area daily every day for pressure wound.</p> <p>Both physician orders were added to the Treatment Administration Record on 11/26/24 at 6:00 AM.</p> <p>Surveyor noted that WD-H initiated the physician orders on 11/21/24, however, the facility did not implement both wound treatment orders until 11/25/24.</p> <p>R5's physician orders also document that R5 should be wearing off-loading bilateral boots at all times every shift for pressure relief effective 11/1/24.</p> <p>On 11/25/24 at 10:15 AM, Surveyor observed R5 up in wheelchair with a cushion in the chair. Surveyor observed an air mattress on the bed. Surveyor observed 2 heel boots on top of the dresser.</p> <p>On 11/25/24 at 11:22 AM, Surveyor observed R5 in the same position in wheelchair and not wearing heel boots.</p> <p>On 11/25/24 at 12:55 PM, Surveyor observed R5 in wheelchair eating lunch and not wearing heel boots.</p> <p>On 11/25/24 at 2:39 PM, Surveyor observed R5 in bed on R5's left side, facing window. R5 has heel boots on.</p> <p>Surveyor noted that R5 had not been repositioned to relief pressure on R5's left ischium pressure injury as documented in R5's pressure injury plan of care.</p> <p>Surveyor noted that R5 did not have her heel boots on to relief pressure per R5's pressure injury plan of care.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 11/26/24 at 7:35 AM, Surveyor observed R5's treatments being completed by Director of Nursing (DON)-B. Surveyor observed medi-honey applied with border gauze placed on the stage 3 ischium pressure wound. DON-B applied skin prep to the 1st and 2nd right toes. Surveyor noted that DON-B completed the wrong treatment to the 2nd hammer toe.</p> <p>On 11/26/24 at 9:10 AM, Surveyor observed R5 in wheelchair, eating breakfast. R5 did not have heel boots on.</p> <p>On 11/26/24 at 10:28 AM, Surveyor observed R5 in wheelchair, no heel boots on, in common area in front of the television.</p> <p>On 11/26/24 at 11:15 AM, Surveyor observed R5 in wheelchair, no heel boots on, in common area in front of the television.</p> <p>On 11/26/24 at 12:10 PM, Surveyor observed R5 in wheelchair, no heel boots on, in common area in front of the television.</p> <p>On 11/26/24 at 12:56 PM, Surveyor observed R5 in wheelchair, no heel boots on, eating lunch in the dining room.</p> <p>Surveyor has not observed R5 to be repositioned at least every 2 hours during the survey process.</p> <p>On 11/26/24 at 9:30 AM, Surveyor interviewed Certified Nursing Assistant (CNA)-F. CNA-F stated that R5 wears heel boots when in bed. CNA-F knows this because I usually take the heel boots off in the morning.</p> <p>On 11/26/24 at 10:20 AM, Surveyor interviewed WD-H. WD-H explained that the left inner thigh area that is healed started as a scratch. WD-H stated that the left ischium is a stage 3 pressure ulcer, and that bone can be felt. WD-H stated the left inner thigh and the left ischium are considered 2 different areas. WD-H explained that WD-H's company policy does not allow for staff to leave the facility until all documentation including orders are completed and communicated with the facility. WD-H usually rounds with DON-B but did not on 11/21/24. However, WD-H cannot remember who WD-H rounded with on that date. WD-H confirmed there is a problem in the treatment of a pressure injury when there is a delay of treatment.</p> <p>On 11/26/24 at 10:38 AM, DON-B informed Surveyor that Licensed Practical Nurse (LPN)-C was the LPN that rounded with WD-H. Surveyor interviewed LPN-C. LPN-C explained it was LPN-C's first time rounding with WD-H. LPN-C stated that WD-H enters the information into WD-H's computer. WD-H assesses the wound and completes the treatment. LPN-C stated that the particular bandage WD-H wanted for R5 was on order at this time. LPN-C stated LPN-C did not take any verbal orders from WD-H because it was LPN-C's first time rounding.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Menomonee Falls Health Services		STREET ADDRESS, CITY, STATE, ZIP CODE  N84 W17049 Menomonee Ave Menomonee Falls, WI 53051	
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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 11/26/24 at 11:37 AM, Surveyor interviewed DON-B regarding R5's current open wounds. Surveyor and DON-B reviewed R5's comprehensive care plan addressing R5's open areas. Surveyor shared the concern that R5's care plan was revised on 11/25/24 and has no new interventions with the development of the 3 open areas. DON-B agreed R5's care plan should have been updated with new person-centered interventions when first identified. Surveyor shared that a documented root cause analysis of the open areas is not in R5's EMR. DON-B stated she is not sure completely how R5 developed the open areas. DON-B stated that WD-H does not verbally give treatment orders. The facility gets a print out on the rounding. DON-B confirmed DON-B did not do the rounding with WD-H on 11/21/24. DON-B stated the floor nurse does not know how to put in the treatment orders and that DON-B is the only person who puts in new treatment orders. DON-B stated that is the disconnect. DON-B agreed that R5's treatment orders from 11/21/24 did not get processed by the facility and DON-B realized it when Surveyor brought it to the facility's attention.</p> <p>Surveyor discussed with DON-B that a surveyor from the team observed DON-B complete the wrong treatment on the second hammer toe in which DON-B applied skin prep instead of betadine. DON-B confirmed DON-B put the wrong treatment on R5's second hammer toe pressure injury and forgot the treatment order had been switched. DON-B informed Surveyor that DON-B believes that the left inner thigh wound identified on 10/30/24 started as a scratch and is now currently healed. DON-B believes the left inner thigh open area is the same area of the stage 3 left ischium pressure area. Surveyor informed DON-B that no new interventions have been put in place once the stage 3 pressure wound was identified on the left ischium. Surveyor informed DON-B that Surveyor has observed R5 to not have bilateral heel boots on at all times per R5's physician orders during the survey. DON-B stated that R5 sometimes doesn't keep the boots on, but agreed this is not addressed in R5's care plan and that R5's care plan did not include interventions on how staff can reapproach R5 with encouragement to wear the bilateral heel boots.</p> <p>Surveyor informed DON-B that Surveyor has had observations of R5 not being repositioned during the survey process. Surveyor shared with DON-B that WD-H requested an upgrade to R5's off loading chair cushion. DON-B informed Surveyor that R5 has not received a new off loading chair cushion and has not followed up with therapy regarding R5 getting a new chair cushion. DON-B stated it was discussed that R5 needed a spare chair cushion because R5 soils the chair cushion. DON-B was unaware that WD-H recommended a new upgrade off loading chair cushion.</p> <p>On 11/26/24 at 1:30 PM, Surveyor shared the concern with Nursing Home Administrator (NHA)-A that R5 has had new open areas identified with no root cause analysis. Surveyor informed NHA-A that R5's person-centered care plan focus for the new areas on the toes and ischium was not initiated until 11/25/24 and contained no new interventions. Surveyor shared with NHA-A that R5 has not had R5's bilateral heel boots on at all times and has not been repositioned every 2 hours during the survey process per physician orders and R5's care plan. Surveyor shared that WD-H recommended a new off loading chair cushion appropriate for R5's stage 3 ischium which has not been implemented by the facility. NHA-A informed Surveyor that NHA-A understood the concerns and had no further information at this time.</p> <p>On 11/26/24 at 1:55 PM, Surveyor spoke with Rehabilitation Director (RD)-I regarding R5's chair cushion. RD-I stated that R5 is not on current caseload. RD-I was asked to get a new cushion because R5 had soiled R5's current chair cushion. RD-I informed Surveyor that R5 currently has a Stage 2 Comfort Support Pro 16x16 wheelchair cushion. RD-I confirmed RD-I did not receive a referral for an upgrade for an off loading cushion for R5 and was not aware that WD-H had recommended the upgrade. RD-I stated that R5's current cushion is not appropriate for a Stage 3 pressure wound on the ischium.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>No additional information was provided as to why the facility did not ensure that R5 received the necessary treatment and services consistent with professional standards of practice to promote healing and prevent new pressure injuries from developing.</p> <p>38253</p> <p>2.) R7 was admitted to the facility on [DATE] with diagnoses of open wound to the left lower leg, morbid obesity, diabetes, lymphedema, unstageable pressure ulcer of the left heel, cellulitis of the left lower leg, and anxiety.</p> <p>R7's Admission Minimum Data Set (MDS) assessment dated [DATE] documented R7 was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 14 and impairment to the lower extremity. The assessment documented R7 had a Stage I pressure injury, one venous or arterial ulcer, and a surgical wound. The Pressure Ulcer/Injury Care Area Assessment (CAA) that is associated with this MDS assessment documented R7 had a potential for pressure ulcers. The CAA did not document where the current Stage I pressure injury was located or the individualized characteristics of R7 to help develop a Care Plan to address R7's needs.</p> <p>R7's discharge paperwork from the long-term acute care facility dated 10/16/2024 had orders to treat the left heel pressure injury with skin prep daily. Wound notes were included in the discharge paperwork. The wound note dated 9/23/2024 documented the left heel pressure injury developed on 8/26/2024 and was a Deep Tissue Injury (DTI) that measured 3.2 cm x 3.7 cm with no visible necrotic tissue and a distinct outline of the wound. The wound was being treated at that time with betadine and open to the air daily.</p> <p>On 10/16/2024 on the Admission Evaluation form, nursing documented R7 had a pressure injury to the left heel that measured 6 cm x 3 cm. No staging or description of the pressure injury were documented on the form.</p> <p>On 10/16/2024 at 8:46 PM, in the progress notes, a Registered Nurse (RN) documented R7 had a DTI to the heel that was not open.</p> <p>R7's Skin Integrity Care Plan for the DTI to the left heel was initiated on 10/16/2024.</p> <p>On 10/18/2024, an order was initiated to treat the deep tissue injury to the left heel: wash area with soap and water, pat dry, apply skin prep to area daily and as needed. Surveyor noted the treatment order was not started until two days after R7 was admitted to the facility.</p> <p>On 10/22/2024 at 9:49 AM, in the progress notes, the Registered Dietician documented R7 had a DTI to the left heel and recommended protein liquid 30 ml twice daily for wound healing. Surveyor noted that the order was initiated.</p> <p>On 10/23/2024 on the Skin Review-Weekly form, nursing documented R7 had yeast under the abdominal fold with a current order for antifungal in place.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>R7's Pressure Injury Weekly Tracker dated 10/16/2024 signed by RN-D on 10/23/2024, RN-D documented the left heel Stage I pressure injury measured 6 cm x 3 cm with 100% epithelial tissue. Surveyor noted the pressure injury was now classified as a Stage I pressure injury rather than following the previous documentation of a DTI.</p> <p>RN-D documented on the Pressure Injury Weekly Tracker form assessments on 10/22/2024 signed 10/23/2024, 10/29/2024 signed 10/30/2024, and 11/5/2024 signed 11/6/2024. Each assessment documented the Stage I pressure injury to the left heel was improving with the measurements on 10/29/2024 and 11/5/2024 having the same measurements of 3.3 cm x 2.7 cm closed with 100% skin. No other documentation was found of the pressure injury after 11/5/2024.</p> <p>On 11/26/2024, Surveyor requested from Director of Nursing (DON)-B all of R7's wound documentation for review. DON-B provided the Pressure Injury Weekly Tracker assessments dated 10/16/2024, 10/22/2024, 10/29/2024, 11/5/2024, and 11/14/2024. Surveyor noted the 11/14/2024 assessment had not previously been in R7's medical record. The 11/14/2024 Pressure Injury Weekly Tracker form was completed by DON-B and signed on 11/26/2024 documenting R7's Stage I pressure injury had healed.</p> <p>On 11/20/2024 on the Skin Review-Weekly form, Licensed Practical Nurse (LPN)-C documented R7 had a pressure injury. Surveyor noted DON-B had documented R7's pressure injury had healed on 11/14/2024.</p> <p>On 11/26/2024 at 10:36 AM, Surveyor observed R7 eating breakfast in bed. R7 had an air mattress in place and the left leg/foot was elevated on pillows. R7 stated the dressing to the left lower leg and left heel were done every day. R7 said the left lower leg wound had previously had a wound vacuum in place but R7 was sensitive to the adhesive and so the wound vac was discontinued, and a daily dressing is done. Surveyor asked R7 if R7 would agree to have Surveyor observe the dressing change to the left lower leg and left heel. R7 agreed.</p> <p>In an interview on 11/26/2024 at 11:30 AM, Surveyor asked RN-D why the pressure injury to R7's left heel had changed from a DTI to a Stage I pressure injury. RN-D stated RN-D did not do the initial assessment of R7's left heel so did not know why it was changed to a Stage I. RN-D had completed the Pressure Injury Weekly Tracker forms and Surveyor noted RN-D documented on the 10/16/2024 initial assessment form the left heel pressure injury to be a Stage I. RN-D stated RN-D did the weekly wound rounds but left the facility two weeks prior to work at a different facility so did not know anything currently about R7's heel wound.</p> <p>On 11/26/2024 at 2:01 PM, Surveyor observed R7's left heel with LPN-C. R7's left leg and heel were elevated on pillows. The left leg had a stretchy gauze wrap around the leg holding the dressing in place. No dressing was on the left heel. The left heel had a small black/purple area that measured approximately 0.75 cm x 0.75 cm to the lateral aspect of the heel that was not open and flush with the surrounding skin. LPN-C agreed there was discoloration to the area. LPN-C stated the heel had originally been completely open with red tissue that needed to be measured with a cotton-tipped swab, so the dark area looked much better than what had been there. LPN-C stated the treatment to the left heel had recently been discontinued.</p> <p>(continued on next page)</p>		

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F 0686  Level of Harm - Actual harm  Residents Affected - Few	<p>On 11/26/2024 at 2:24 PM, Surveyor shared with DON-B the concerns observed during R7's treatment to the left leg. Surveyor shared a dark area was observed on R7's left lateral heel and LPN-C had stated R7's left heel had been open and deep that they had to use a cotton-tipped swab to measure the wound. DON-B stated the wound had never been open. Surveyor shared the conflicting documentation of the pressure injury to be a DTI prior to and at admission and the staging got changed to a Stage I. Surveyor shared with DON-B that RN-D had changed the staging and then stated the wound had always been a DTI when that was not what RN-D had documented. Surveyor shared with DON-B the treatment to R7's left heel did not start until two days after admission and no assessment was documented after 11/5/2024 until Surveyor asked for the wound documentation. DON-B stated DON-B saw R7's left heel on 11/14/2024 and it was healed at that time; DON-B had not documented it until today, 11/26/2024 after realizing the assessment was not in R7's medical record.</p> <p>No additional information was provided at that time.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 38253</p> <p>Based on interview and record review, the facility did not ensure medication administration records were complete and accurate for 2 (R1 and R3) of 5 residents reviewed for medication administration.</p> <p>* R1's Medication Administration Record (MAR) had empty signature boxes for multiple medications from 9/2024 through 11/2024. The signature boxes indicate the medication was administered by a nursing professional assigned to R1.</p> <p>* R3's MAR had empty signature boxes for multiple medications from 9/2024 through 11/2024. The signature boxes indicate if the medication was administered by a nursing professional assigned to R3.</p> <p>Findings include:</p> <p>The facility policy and procedure titled Medication Administration General Guidelines dated 1/2024 document: Documentation: 1. The individual who administers the medication dose, records the administration on the resident's MAR immediately following the medication being given. In no case should the individual who administered the medications report off-duty without first recording the administration of any medications. 4. The resident's MAR/TAR is initialed by the person administering the medication, in the space provided under the date, and on the line for that specific medication dose administration and time. Initials on each MAR/TAR are verified with a full signature in the space provided or on the nursing care center's master employee signature log.</p> <p>1.) R1 was admitted to the facility on [DATE] with diagnoses of Alzheimer's disease, diabetes, epilepsy, depression, and anxiety.</p> <p>R1's Significant Change Minimum Data Set (MDS) assessment dated [DATE] documented R1 was severely cognitively impaired with a Brief Interview for Mental Status (BIMS) score of 1 and had hallucinations and delusions. R1 had a Guardian.</p> <p>R1's September 2024, October 2024, and November 2024 MARs were reviewed.</p> <p>R1's September 2024 MAR had the following medications not documented as administered at 7:00 AM on 9/1/2024, 9/3/2024, 9/15/2024, 9/19/2024, and 9/26/2024:</p> <ul style="list-style-type: none"> <li>-Amlodipine 5 mg for hypertension</li> <li>-Ferrous sulfate 325 mg for a supplement</li> <li>-Januvia 100 mg for diabetes</li> <li>-Omeprazole 20 mg for gastroesophageal reflux disorder</li> <li>-Polyethylene Glycol powder 17 Gm for constipation</li> </ul> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Potassium 20 mEq for a supplement</p> <p>-Zoloft 100 mg for anxiety</p> <p>-Senna plus 8.6-50 mg for anal fissure</p> <p>-Topiramate 25 mg for seizures</p> <p>-Acetaminophen 650 mg for pain; the Noon dose was not documented as administered for the same dates and the 7:00 AM dose was not documented as administered on 9/29/2024.</p> <p>-Depakote sprinkles delayed release 250 mg for impulsive behaviors; additionally, the 7:00 AM dose was not documented as administered on 9/12/2024 and the Noon doses were not documented as administered on 9/1/2024, 9/3/2024, 9/15/2024, 9/17/2024, 9/19/2024, and 9/26/2024.</p> <p>Insulin Glargine 18 units was not documented as administered at 7:00 AM on 9/1/2024, 9/3/2024, and 9/9/2024 and blood sugar readings were not documented. The order was changed on 9/10/2024 to be administered in the evening rather than in the morning.</p> <p>Insulin lispro sliding scale and blood sugars were not documented as administered at 11:00 AM on 9/15/2024, at 7:30 AM and 11:00 AM on 9/17/2024, 9/19/2024, and 9/26/2024.</p> <p>R1's October 2024 MAR had the following medications not documented as administered at 7:00 AM on 10/1/2024, 10/9/2024, 10/10/2024, 10/12/2024, 10/23/2024 and 10/25/2024:</p> <p>-Amlodipine 5 mg for hypertension</p> <p>-Ferrous sulfate 325 mg for a supplement</p> <p>-Januvia 100 mg for diabetes</p> <p>-Omeprazole 20 mg for gastroesophageal reflux disorder</p> <p>-Polyethylene Glycol powder 17 Gm for constipation</p> <p>-Potassium 20 mEq for a supplement</p> <p>-Zoloft 100 mg for anxiety</p> <p>-Senna plus 8.6-50 mg for anal fissure</p> <p>-Topiramate 25 mg for seizures</p> <p>-Acetaminophen 650 mg for pain; the Noon dose was not documented as administered for the same dates.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Depakote sprinkles 250 mg was not documented as administered at 7:30 AM and 11:00 AM on 10/1/2024 and 10/3/2024. The order was discontinued on 10/3/2024 and new order for valproic acid solution 250 mg three times daily for mood and impulsive behavior was initiated on 10/4/2024.</p> <p>The valproic acid solution was not documented as administered at 7:00 AM and Noon on 10/9/2024, 10/10/2024, 10/12/2024, 10/23/2024 and 10/25/2024.</p> <p>Insulin lispro sliding scale and blood sugars were not documented as administered at 7:30 AM and 11:00 AM on 10/1/2024, 10/9/2024, 10/10/2024, 10/11/2024, 10/12/2024, and 10/23/2024; and at 11:00 AM on 10/7/2024 and 10/25/2024.</p> <p>R1's November 2024 MAR had the following medications not documented as administered at 7:00 AM on 11/21/2024, 11/22/2024, and 11/24/2024:</p> <ul style="list-style-type: none"> <li>-Amlodipine 5 mg for hypertension</li> <li>-Ferrous sulfate 325 mg for a supplement</li> <li>-Januvia 100 mg for diabetes</li> <li>-Omeprazole 20 mg for gastroesophageal reflux disorder</li> <li>-Polyethylene Glycol powder 17 Gm for constipation</li> <li>-Potassium 20 mEq for a supplement</li> <li>-Zoloft 100 mg for anxiety</li> <li>-Senna plus 8.6-50 mg for anal fissure</li> <li>-Topiramate 25 mg for seizures</li> <li>-Acetaminophen 650 mg for pain; the Noon dose was not documented as administered for the same dates.</li> <li>-Valproic acid solution 250 mg for mood and impulsive behavior; the Noon dose was not documented as administered for the same dates and the 3:00 PM dose on 11/2/2024 was not documented as administered.</li> </ul> <p>Insulin glargine 22 units and blood sugars were not documented as administered at 7:00 PM on 11/2/2024, 11/7/2024, and 11/24/2024.</p> <p>Insulin lispro sliding scale and blood sugars were not documented as administered at 4:00 PM on 11/2/2024, 7:30 AM and 11:00 AM on 11/21/2024 and 11/22/2024, and 7:30 AM, 11:00 AM, and 4:00 PM on 11/24/2024.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2.) R3 was admitted to the facility on [DATE] with diagnoses of paralytic syndrome, diabetes, chronic obstructive pulmonary disease, morbid obesity, congestive heart failure, chronic kidney disease, anxiety, and depression. R3's Annual Minimum Data Set (MDS) assessment dated [DATE] documented R3 was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 15 and was administered anti-anxiety, antidepressant, diuretic, opioid, and hypoglycemic medications.</p> <p>R3's September 2024, October 2024, and November 2024 MARs were reviewed.</p> <p>R3's September 2024 MAR had the following medications not documented as administered at 7:00 AM on 9/15/2024 and 9/26/2024:</p> <ul style="list-style-type: none"> <li>-Metolazone 2.5 mg for congestive heart failure; additionally, the 7:00 AM dose was not documented as administered on 9/19/2024.</li> <li>-Metoprolol succinate extended release 75 mg for hypertension</li> <li>-Multivitamin for supplement</li> <li>-Vraylar 1.5 mg for depression</li> <li>-Bumex 3 mg for edema; additionally, the Noon dose was not documented as administered on 9/9/2024, 9/15/2024, 9/24/2024, and 9/26/2024.</li> <li>-Buspirone 10 mg for anxiety</li> <li>-Clonazepam 1 mg for anxiety; additionally, the 7:00 AM dose was not documented as administered on 9/9/2024.</li> </ul> <p>Advair diskus aerosol inhaler 100-50 mcg/act for shortness of breath was not documented as administered at 6:00 AM on 9/9/2024, 9/15/2024, and 9/26/2024.</p> <p>Lactobacillus capsule for probiotic was not documented as administered at 6:00 AM on 9/15/2024 and 9/26/2024.</p> <p>Sertraline 100 mg for depression was not documented as administered at 8:00 AM on 9/15/2024 and 9/26/2024.</p> <p>Lidocaine external cream 4% for shoulder pain was not documented as administered at 8:00 AM on 9/9/2024, 9/15/2024, 9/17/2024, and 9/26/2024.</p> <p>Methocarbamol 500 mg, a muscle relaxant, was not documented as administered at 8:00 AM on 9/9/2024, 9/15/2024, and 9/26/2024 and at Noon on 9/15/2024, 9/18/2024, 9/23/2024, 9/24/2024, and 9/26/2024.</p> <p>Pregabalin 75 mg for convulsions was not documented as administered at 8:00 AM on 9/9/2024 and 9/26/2024 and at 8:00 PM on 9/15/2024.</p> <p>Cholestyramine 4 gm packet for high cholesterol was not documented as administered at 8:30 AM on 9/9/2024, 9/15/2024, and 9/26/2024.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525415	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/26/2024
NAME OF PROVIDER OR SUPPLIER  Menomonee Falls Health Services		STREET ADDRESS, CITY, STATE, ZIP CODE  N84 W17049 Menomonee Ave Menomonee Falls, WI 53051	
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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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ciprofloxacin 500 mg for urinary tract infection was not documented as administered at 9:00 AM on 9/26/2024.</p> <p>Acetaminophen 1000 mg for pain was not documented as administered at 9:00 AM on 9/15/2024 and 9/26/2024 and at 2:00 PM on 9/15/2024.</p> <p>Insulin glargine 46 units for diabetes was not documented as administered at 7:00 PM on 9/26/2024.</p> <p>Insulin lispro sliding scale and blood sugars were not documented as administered at 7:30 AM and 11:00 AM on 9/15/2024, 9/17/2024, and 9/26/2024, and at 11:00 AM on 9/5/2024, 9/9/2024, 9/10/2024, 9/23/2024, and 9/30/2024.</p> <p>R3's October 2024 MAR had the following medications not documented as administered.</p> <p>Advair diskus aerosol inhaler 100-50 mcg/act for shortness of breath was not documented as administered at 6:00 AM on 10/9/2024, 10/12/2024, and 10/23/2024.</p> <p>Lactobacillus for probiotic was not documented as administered at 6:00 AM on 10/9/2024 and 10/12/2024.</p> <p>Bumex 3 mg for edema was not documented as administered at 7:00 AM and Noon on 10/3/2024.</p> <p>Metolazone 2.5 mg for congestive heart failure was not documented as administered at 7:00 AM on 10/9/2024.</p> <p>Metoprolol succinate extended release 75 mg was not documented as administered at 7:00 AM on 10/3/2024, and 50 mg was not documented as administered at 7:00 AM on 10/9/2024, 10/12/2024, 10/23/2024, and 10/25/2024.</p> <p>Multivitamin for supplement, clonazepam 1 mg for anxiety, and buspirone 10 mg for anxiety was not documented as administered at 7:00 AM on 10/9/2024, 10/12/2024, and 10/23/2024, buspirone 10 mg for anxiety was not documented as administered at Noon on 10/23/2024, 10/25/2024, and 10/26/2024, and clonazepam 1 mg for anxiety was not documented as administered at 7:00 PM on 10/9/2024.</p> <p>Cariprazine (Vrylar) 1.5 mg for depression was not documented as administered at 7:00 AM on 10/23/2024.</p> <p>Metformin 1000 mg for diabetes was not documented as administered at 7:30 AM on 10/23/2024.</p> <p>Insulin aspart sliding scale and blood sugars were not documented as administered at 7:30 AM on 10/8/2024, 10/12/2024, 10/23/2024 and 10/25/2024, and at 11:00 AM on 10/8/2024, 10/9/2024, 10/10/2024, 10/12/2024, 10/23/2024 and 10/25/2024.</p> <p>Lidocaine external cream 4% for shoulder pain was not documented as administered at 8:00 AM on 10/9/2024 and 10/12/2024.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Menomonee Falls Health Services		STREET ADDRESS, CITY, STATE, ZIP CODE  N84 W17049 Menomonee Ave Menomonee Falls, WI 53051	
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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Bumetanide 2 mg for congestive heart failure, sertraline 100 mg for depression, methocarbamol 500 mg for muscle relaxant, and pregabalin 75 mg was not documented as administered at 8:00 AM on 10/9/2024, 10/12/2024, and 10/23/2024, methocarbamol 500 mg was not documented as administered at Noon on 10/9/2024, 10/10/2024, 10/23/2024, 10/25/2024, and 10/26/2024, and pregabalin 75 mg was not documented as administered at 8:00 PM on 10/9/2024.</p> <p>Acetaminophen 100 mg for pain was not documented as administered at 8:00 AM on 10/23/2024, 9:00 AM on 10/9/2024 and 10/12/2024, 1:00 PM on 10/23/2024, 10/25/2024, and 10/26/2024 and at 9:00 PM on 10/9/2024 and 10/10/2024.</p> <p>Potassium chloride extended release 20 mEq for supplement was not documented as administered at 8:00 AM on 10/12/2024 and 10/23/2024.</p> <p>Doxycycline hyclate 100 mg for skin infection and lactobacillus for supplement was not documented as administered at 8:00 AM on 10/23/2024.</p> <p>Insulin glargine 25 units for diabetes was not documented as administered at 8:00 AM on 10/8/2024, 10/9/2024, and 10/12/2024.</p> <p>Trulicity 3 mg injection for diabetes was not documented as administered at 8:00 AM on 10/8/2024.</p> <p>Vraylar 1.5 mg for depression was not documented as administered at 8:00 AM on 10/9/2024 and 10/12/2024.</p> <p>Cholestyramine packet 4 gm for high cholesterol was not documented as administered at 8:30 AM on 10/9/2024, 10/12/2024, and 10/23/2024.</p> <p>Cetirizine 10 mg for cold symptoms was not documented as administered at 7:00 PM on 10/13/2024.</p> <p>R3's November 2024 MAR had the following medications not documented.</p> <p>Bumetanide 2 mg for chronic kidney disease and cholestyramine 4 gm packet for cholesterol was not documented as administered at 6:00 AM on 11/19/2024, 11/21/2024, and 11/22/2024, and was not documented as administered at 3:00 PM on 11/7/2024 and 11/24/2024.</p> <p>Clonazepam 1 mg for anxiety was not documented as administered at 7:00 AM on 11/19/2024, 11/21/2024, and 11/22/2024, at 3:00 PM on 11/7/2024 and 11/24/2024, and at 7:00 PM on 11/7/2024 and 11/24/2024.</p> <p>Cariprazine (Vraylar) 1.5 mg for depression, metoprolol succinate extended release 50 mg, and multivitamin for supplement was not documented as administered at 7:00 AM on 11/19/2024, 11/21/2024, and 11/22/2024, and metoprolol succinate extended release 50 mg was not documented as administered at 7:00 AM on 11/24/2024.</p> <p>Advair diskus inhaler for chronic obstructive pulmonary disease (COPD) was not documented as administered at 7:00 AM on 11/19/2024, 11/21/2024, and 11/22/2024, and was not documented as administered at 3:00 PM on 11/7/2024 and 11/24/2024.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Metolazone 2.5 mg for edema was not documented as administered at 7:00 AM on 11/19/2024 and 11/21/2024.</p> <p>Metformin 1000 mg for diabetes was not documented as administered at 7:30 AM on 11/19/2024 and at 4:00 PM on 11/24/2024.</p> <p>Insulin aspart sliding scale and blood sugars were not documented as administered at 7:30 AM on 11/18/2024, 11/19/2024, 11/22/2024 and 11/24/2024, and at 11:00 AM on 11/18/2024, 11/19/2024, and 11/2/2024, and at 4:00 PM on 11/6/2024, 11/7/2024, and 11/24/2024.</p> <p>Methocarbamol 500 mg for muscle relaxant was not documented as administered at 8:00 AM on 11/19/2024, at Noon on 11/19/2024 and 11/21/2024, at 4:00 PM on 11/24/2024, and at 8:00 PM on 11/7/2024 and 11/24/2024.</p> <p>Potassium chloride 20 mEq for heart failure and Trulicity 3 mg injection for diabetes was not documented as administered at 8:00 AM on 11/19/2024.</p> <p>Lactobacillus capsule for supplement, pregabalin 75 mg for pain, and sertraline 100 mg for depression was not documented as administered at 8:00 AM on 11/19/2024 and at 8:00 PM on 11/7/2024 and 11/24/2024.</p> <p>Buspirone 10 mg for anxiety was not documented as administered at 8:00 AM on 11/19/2024, at Noon on 11/19/2024, and at 4:00 PM on 11/24/2024.</p> <p>Acetaminophen 1000 mg for pain was not documented as administered at 8:00 AM on 11/19/2024, at 1:00PM on 11/19/2024 and 11/21/2024 and at 8:00 PM on 11/7/2024 and 11/24/2024.</p> <p>Dulaglutide 3 mg injection for weight loss was not documented as administered at 3:00 PM on 11/12/2024.</p> <p>Amitriptyline 25 mg for depression was not documented as administered at 7:00 PM on 11/7/2024.</p> <p>Insulin glargine 25 units for diabetes was not documented as administered at 7:00 PM on 11/7/2024 and 11/12/2024.</p> <p>On 11/25/2024 at 1:12 PM, Surveyor asked R3 if R3 had any concerns about getting medications late or not at all. R3 stated all medications and shots have been provided.</p> <p>On 11/25/2024 at 2:01 PM, Surveyor asked Licensed Practical Nurse (LPN)-C when nurses document medications and blood sugar results into the resident's MAR. LPN-C stated they should be put in the MAR right away, but that depends on what is going on in the facility at the time. LPN-C stated LPN-C will write down blood sugars on a piece of paper and then will chart when LPN-C has time if it was busy. LPN-C states LPN-C tries to write everything in the chart right when it happens, like passing meds and blood sugar results.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 11/25/2024 at 3:36 PM, Surveyor asked Director of Nursing (DON)-B what the expectation was for nurses documenting in the MAR medications being administered. DON-B stated the nurse should sign out the medication as soon as it is given and the same for when a blood sugar is obtained. Surveyor shared with DON-B the concern R1 and R3 had multiple medications and blood sugar results that were not documented as administered or obtained. DON-B stated audits are done daily by DON-B to make sure medications are signed out.</p> <p>No additional information was provided as to why the facility did not ensure that medication administration records were complete and accurate for R1 and R3.</p>		