

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525435	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/22/2024
NAME OF PROVIDER OR SUPPLIER Abbotsford Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 600 E Elm St Abbotsford, WI 54405	

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 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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41945</p> <p>Based on interview and record review, the facility failed to provide needed service to maintain the resident's highest practicable physical, mental, and psychosocial well-being for 1 of 3 residents (R)2 reviewed for transportation service for medical necessity.</p> <p>R2 was transferred by ambulance to the hospital on 07/08/24 at 4:15 p.m. Transportation was not provided for R2 to return to the facility from the hospital. R2 had to remain at the hospital from 9:00 p.m. on 07/08/24 until 9:08 a.m. on 07/09/24.</p> <p>Findings include:</p> <p>On 07/17/24 at 1:00 p.m., Surveyor reviewed R2's medical record. R2 was admitted to the facility on [DATE] with diagnoses of atrial fibrillation, cognitive disorder, type 2 diabetes mellitus, hypertension, obesity, hypercholesterolemia, hepatocellular carcinoma, and sleep apnea.</p> <p>R2's Minimum Data Set (MDS) admission assessment, dated 07/08/24, documents R2 is independent with eating, toileting hygiene, dressing, personal hygiene, bed mobility, transfers, and walking.</p> <p>R2's Brief Interview for Mental Status (BIMS) dated 07/08/24 documents a score of 6 out of 15, which indicates severe cognitive impairment.</p> <p>R2 is a member of a managed care organization and receives services at the facility.</p> <p>On 07/08/24 at 4:15 p.m., facility documentation states R2 complained of chest pain and shortness of breath. The facility assessed R2, notified physician and obtained an order to send R2 to the emergency room (ER) for an evaluation and treatment.</p> <p>On 07/16/24 at 12:15 p.m., Surveyor interviewed R2 about the ER visit and waiting for a ride back to the facility. R2 stated that it was a long time to wait, but R2 couldn't do anything else. R2 stated R2 was glad to get back to the facility. Surveyor asked if the wait was upsetting and caused R2 distress. R2 stated that it was fine.</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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 07/16/24 at 1:26 p.m., Surveyor interviewed Assistant Director of Nursing (ADON) O and asked about R2's transportation back to the facility from the hospital ER. ADON O stated R2 was sent to the hospital and the ER called the facility when R2 was able to return. The facility and another transport service did pick up the resident at the hospital. ADON O stated it is confusing if a resident has a managed care organization because transportation is set up through them. ADON O stated ADON O was unsure of specifics with R2 but would check on it and get back to Surveyor.</p> <p>On 07/16/24 at 2:27 p.m., Surveyor interviewed Registered Nurse (RN) U from the managed care organization and asked about R2's transportation from the hospital back to the facility. RN U stated RN U nor RN U's supervisor knew R2 was sent to the hospital until 07/09/24 when a quarterly assessment visit was conducted at the facility for R2. RN U stated normally the facility sets up transportation for the residents.</p> <p>On 07/16/24 at 2:25 p.m., ADON O provided Surveyor with R2's ER documentation and a note with a timeline of transportation notifications. Note documented:</p> <p>R2 left Abbotsford facility on 07/08/24 at 4:15 p.m.</p> <p>R2 had labs drawn at hospital on 07/08/24 at 5:41 p.m.</p> <p>ER documentation from physician noted to discharge R2 at 8:57 p.m.</p> <p>ER nursing note regarding transportation and managed care unable to provide transportation dated 07/08/24 at 11:46 p.m.</p> <p>Van driver called on 07/09/24 at 7:15 a.m. to get van.</p> <p>Van driver picked up R2 at the hospital for transportation back to the facility on [DATE] at 9:08 a.m.</p> <p>Surveyor reviewed ER documentation on 07/08/24. Documentation from ER states: Contacted nursing home staff, per staff at nursing home, managed care organization unable to obtain a ride back to the nursing home until AM. Patient (R2) placed back in room, given food and drink at bedside per patient (R2) request. Warm blankets provided and television channel picked by patient (R2). Patient (R2) informed of delay on ride back to nursing home until AM.</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 07/16/24 at 2:45 p.m., Surveyor interviewed Nursing Home Administrator (NHA) A and asked about R2's transportation from the hospital to the nursing home after the ER visit. NHA A stated that NHA A got a call that the managed care organization could not get transport. NHA A stated the hospital contacted the managed care organization. By morning, 07/09/24, R2's managed care organization set up transport and it was on its way to pick up R2 at the hospital and the facility van was in transport to pick up R2 at the hospital. NHA A stated it wasn't known both transports were in route until they arrived at the hospital around 9:00 a.m. Surveyor asked who is responsible for setting up transportation for the resident. NHA A stated the managed care organization sets up transportation if they have a resident in service at the facility, otherwise the facility sets up the transportation. NHA A stated the facility transport is available Monday through Friday during the daytime hours, otherwise the facility does call other transportation services for the residents, but they too operate during daytime hours. NHA A stated it is difficult to obtain transportation in off hours. The transportation services don't run after hours and NHA A stated the facility van driver is only during the day and again is Monday through Friday. NHA A stated this type of situation has happened in the past. NHA A stated it is common in the rural areas not to have the needed transportation, especially in off hours. NHA A stated the ambulance was contacted and they would not provide non-emergent transport even though the facility stated they would pay for the transport. NHA A stated since the ambulance services will not provide non-emergent transport, it has left the facilities at a loss for transportation options. The facility does not have a system in place to utilize the facility's van during off hours to assist with resident transfers.</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41945</p> <p>Based on interview and record review, the facility failed to ensure a resident utilizing a Hoyer lift for transfers received adequate supervision and assistance devices to prevent accidents for 1 of 3 residents (R1) reviewed.</p> <p>Certified Nursing Assistant (CNA) transferred R1 utilizing a Hoyer lift from the bed to the chair without assistance from another staff member. Facility policy states all mechanical lift transfers require 2 people. R1 slipped out of the Hoyer lift sling, fell to the floor, and struck R1's head sustaining a subarachnoid hemorrhage, subdural hematoma, a right posterior scalp laceration and hematoma, and required hospitalization . R1's condition declined as a result. R1 was verbal, but nonsensical prior to the fall, and is now nonverbal. R1's code status changed from Full Code to Do Not Resuscitate (DNR). R1 is now residing in a hospice facility.</p> <p>The facility's failure to follow the policy for 2 staff assistance for Hoyer lift transfers created a finding of immediate jeopardy that began on 07/02/24. Nursing Home Administrator (NHA) A and Director of Nursing (DON) B were notified of the immediate jeopardy on 07/17/24 at 9:30 a.m. The facility took steps on 07/02/24, immediately after the incident, to correct the deficient practice and ensure compliance. The immediate jeopardy was removed on 07/07/24 and corrected on 07/07/24. Based on this determination, the citation issued is past non-compliance.</p> <p>Findings include:</p> <p>The facility policy titled, Mechanical Lift Transfers, not dated, states in part:</p> <p>Policy:</p> <p>8. Position the sling extending from the resident's shoulder to the thigh.</p> <p>19. The other nursing assistant should hold the sling back in the hip area and help lower the resident slowly into the position in the chair while you slowly release the hydraulic and lower the lift. Monitor the location of the resident's feet and arms when lowering the lift.</p> <p>The facility policy titled, Mechanical Lift Transfers: Sit to Stand, not dated, states in part:</p> <p>Policy:</p> <p>2. All mechanical lift transfers require 2 persons.</p> <p>On 07/16/24 at 9:58 a.m., Surveyor reviewed R1's medical record. R1 was admitted to the facility on [DATE] with diagnoses including unspecified dementia-unspecified severity with other behavioral disturbance and anxiety disorder-unspecified.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>R1's Minimum Data Set (MDS) discharge assessment, dated 07/02/24, indicated R1 required total assistance with all activities of daily living (ADLs.) R1 is a fall risk with a score of 13. A score over 10 indicates at risk for falls. R1's Brief Interview for Mental Status (BIMS) score was 99, which indicates nonsensical responses. Facility documentation states R1 is disoriented to person, place, and time always.</p> <p>R1 has a Guardian (Guardian-P.) R1's code status is Full Code.</p> <p>R1's care plan:</p> <p>FOCUS</p> <p>Resident has diagnosis of Alzheimer's or related dementia. Due to cognitive loss, diminished decision-making capabilities and safety and security issues, placement in the secure Alzheimer's Care unit with programs designed for this population is needed as evidenced by: Vascular dementia.</p> <p>Date Initiated: 11/03/2021.</p> <p>GOAL</p> <p>Resident will maintain cognitive level as long as possible within the disease process as measured by the BIMS.</p> <p>Date Initiated: 11/03/2021 Revision on: 01/10/2024 Target Date: 09/24/2024.</p> <p>INTERVENTIONS:</p> <p>I have a physical functioning deficit related to: Mobility impairment.</p> <p>Date Initiated: 11/03/2021.</p> <p>Hoyer lift for transfers.</p> <p>Date Initiated: 06/08/2023.</p> <p>Resident to have a high back, reclining wheelchair, and calf pad.</p> <p>Date Initiated: 11/04/2021.</p> <p>On 07/02/24 at 6:00 a.m., CNA C was transferring R1 from the bed to the wheelchair using a Hoyer lift. CNA C lifted the sling with R1 in it, turned the Hoyer to pivot toward the wheelchair. CNA C lowered the sling and R1 started to slide forward out of the sling. CNA C was unable to stop R1 from sliding and R1 fell on the floor and struck R1's head.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>R1's medical record progress note dated 07/02/24 at 6:45 a.m. documents Registered Nurse (RN) D was called to R1's room and when RN D entered the room, R1 was on the floor next to the bed. R1 had slid out of the mechanical lift during transfer from the bed to the chair. R1 hit R1's head, and a laceration was noted on the back of R1's head. R1's physician was updated and ordered to send R1 to the emergency room (ER) for evaluation and treatment. Facility notified DON B and R1's guardian. R1's vital signs after the incident: blood pressure 139/78, pulse 83, respirations 12, temperature 97.4, and O2 (oxygen) saturation was 92% at room air.</p> <p>Facility documentation states an investigation was initiated immediately. Facility documentation states the following:</p> <p>R1 was sent to the ER for an evaluation and treatment.</p> <p>The facility contacted the police department to file a report.</p> <p>CNA C was suspended pending investigation.</p> <p>Facility investigation concluded the following factors:</p> <p>CNA C did not request a second person for the lift transfer. A nurse was available nearby.</p> <p>Facility had conducted an education on Hoyer use on 04/29/24.</p> <p>Care plan did not state to cross the straps between the legs.</p> <p>CNA C used the appropriate size sling for R1.</p> <p>CNA C had no complaints from staff or residents about CNA C's care, and had no similar events happen, and was not in a current disciplinary process.</p> <p>Facility had recently purchased and implemented the use of walkie talkies for the purpose of allowing CNAs to request assistance when needed.</p> <p>Facility had recently adjusted staffing up to ensure that enough staff are available for the safe, timely, and effective provision of care.</p> <p>Facility documentation includes an interview with CNA C. CNA C stated CNA C was transferring R1 from the bed to the wheelchair and had placed the sling and connected it to the Hoyer in an uncrossed fashion. CNA C stated the sling was raised up and CNA C turned the Hoyer lift to move it toward the wheelchair. As the sling was lowered, R1 began to slide out of the sling and fell out onto the floor. CNA C stated it happened so quickly that CNA C was unable to stop it. CNA stated the nurse was called immediately.</p> <p>NHA A interviewed CNA C and CNA C's responses were as follows:</p> <p>NHA A: Was it normal to complete the lift with the straps uncrossed? CNA C: The straps were not crossed between R1's legs because it was the normal way to lift R1.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>NHA A: What sling was used? CNA C: The sling used was the sling that was kept in R1's room for R1's individual use.</p> <p>NHA A: Was the Hoyer functioning normally? CNA C: Hoyer was functioning properly.</p> <p>NHA A: Did the Hoyer wheel hit anything? CNA C: Hoyer wheels did not hit anything.</p> <p>NHA A: Was there anyone else in the room at the time? CNA C: No one else was in the room at the time of the transfer/incident.</p> <p>NHA A: Was assistance requested? CNA C: CNA C did not ask for assistance.</p> <p>NHA A: Did CNA C know that all lifts required 2 people? CNA C stated CNA C knew.</p> <p>NHA A: Was the floor nurse nearby? CNA C stated a nurse was nearby for assistance.</p> <p>NHA A: Was the nurse asked to assist with the lift? CNA C stated the nurse was not asked to assist.</p> <p>On 07/17/24, Surveyor reviewed the hospital documentation from 07/02/24. Hospital performed a CT scan of the head which revealed a small multifocal acute subarachnoid hemorrhage (bleeding in the space between the brain and the surrounding membrane), a new small subdural hematoma (blood collection between the skull and the surface of the brain) overlying the right frontal lobe anteriorly and new ill-defined subdural blood products (old collection of blood and blood breakdown products) anterior and medial to the anterior frontal lobes found on the second CT performed, and right scalp hematoma (collection of blood) with overlying skin staples. A CT of the chest/abdomen/pelvis was performed, and the results were negative.</p> <p>Documentation states given resident's (R1's) age (95), neurosurgery does not recommend any acute surgical interventions.</p> <p>On 07/16/24 at 11:51 a.m., Surveyor called R1's elder care agency to speak with R1's guardian. Representative of elder care agency (ECA) T stated Guardian-P was out of the office. Surveyor asked if agency received any information on R1 from the hospital as to R1's condition. Representative stated R1 was residing in a hospice facility.</p> <p>On 07/16/24 at 12:05 p.m., Surveyor interviewed RN D and asked about R1's incident. RN D stated CNA C came out of R1's room and called RN D. RN D stated R1 fell out of the Hoyer lift sling. RN D stated R1 was assessed and found to have a laceration on the back the head. RN D stated RN D took R1's vital signs. RN D stated R1's physician was called, guardian was called, ambulance was called and transported R1 to the ER. Surveyor asked if CNA C asked for assist to transfer with the Hoyer lift. RN D stated CNA C had not asked for assistance. Surveyor asked what the facility policy is regarding Hoyer lift transfers. RN D stated all lift transfers are to be done with 2 people. Surveyor asked what type of sling was used for R1's transfers. RN D stated RN D was unsure.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 07/17/24 at 10:00 a.m., Surveyor interviewed DON B and asked about R1's fall out of the Hoyer lift sling. DON B stated an in-service had been completed 04/29/24 on Hoyer lift transfers. DON B stated staff was aware that Hoyer lifts/all mechanical lifts require 2 people to operate. DON B stated staff have walkie talkies to call other staff for assistance when needed and the licensed nursing staff know they are required to assist the CNAs if needed. DON B stated R1's care plan wasn't updated until 07/02/24 stating straps were to be crossed in between R1's legs. Surveyor questioned the type of sling used for R1's transfers. DON B stated DON B would clarify. Surveyor asked what the facility plan is to ensure this type of incident does not reoccur. DON B stated the facility is going to continue to do spot check audits with lift transfers, and care plans of residents who use mechanical lifts have been reviewed and updated as needed.</p> <p>On 07/17/24 at 10:22 a.m., Surveyor called the police department and inquired about the facility calling regarding R1's fall from a Hoyer lift. Police department representative (PD) S stated the police department has documentation of the facility calling, but the officer has not written a report as of this date and time.</p> <p>On 07/19/24 at 10:52 a.m., Surveyor received a phone call from R1's guardian. Surveyor asked about R1's incident at facility, and current condition. Guardian P stated the last time Guardian P saw R1 was on 06/24/24 and R1 was verbal but nonsensical, which was R1's normal. Guardian P stated since the incident of falling from the Hoyer lift at the nursing home facility, R1 has been nonverbal. Guardian P stated R1's condition has declined, is considered in a vegetative state. Guardian P stated R1's code status has been changed to Do Not Resuscitate (DNR). Guardian P stated per R1's living will, R1 did not want tube feedings or any heroic measures if in a vegetative state. Guardian P stated the decision was made for no feeding tube. Guardian P stated R1 is currently residing in a hospice facility.</p> <p>On 07/22/24 at 3:52 p.m., Surveyor reached out to NHA A with an email to clarify the size and type of sling the facility used for R1's transfers. Surveyor received no reply from NHA A.</p> <p>The facility's failure to ensure a resident utilizing a Hoyer lift for transfers received adequate supervision and assistance devices to prevent accidents created a reasonable likelihood for serious harm, thus leading to a finding of immediate jeopardy that began on 07/02/24. On 07/02/24, the facility identified the deficient practice that occurred when the facility staff did not follow facility policy for 2 staff to be present during all mechanical lift transfers and R1 fell out of Hoyer lift sling sustaining a major head injury. The facility took steps to correct the deficient practice and ensure compliance starting on 07/02/24. The immediate jeopardy was removed on 07/07/24 and corrected on 07/07/24 when the facility completed the following:</p> <p>The facility completed resident care plan reviews for the residents who require mechanical lift transfers.</p> <p>The facility provided reeducation on mechanical lift use, requirement for 2 staff to be present during the entire transfer, and use walkie talkies to ask for assistance, and if unsure how to transfer a resident, staff is to seek clarification from a nurse.</p> <p>Licensed nursing staff educated on updating a resident care plan if the straps are to be crossed for the transfer.</p> <p>(continued on next page)</p>		

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<p>F 0837</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Establish a governing body that is legally responsible for establishing and implementing policies for managing and operating the facility and appoints a properly licensed administrator responsible for managing the facility.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41945</p> <p>Based on record review and staff and vendor interview, the Bedrock corporation governing body did not ensure adequate funds were made available to provide for the safe and efficient management of the facility. The failure to maintain current payment status with service providers and vendors has the potential to affect all 51 residents in the facility.</p> <p>The Bedrock corporate governing body failed to maintain current payment status with several service providers and vendors that resulted in vendors refusing to provide or providing discontinuation notices until payment is received, the governing body has not paid State bed tax and the facility pharmacy provider was abruptly terminated after a past due notice was issued including potential of disruption of service. The failure of the Bedrock governing body to maintain current contract payments has resulted in loss of service. Bedrock's corporation's failure to provide sufficient funding to maintain service/vendor contracts resulted in decreased options for services to the facility and has the potential to negatively impact resident quality of care and quality of life.</p> <p>Findings include:</p> <p>The facility Governing Body policy implemented 03/01/23 states:</p> <p>The facility will have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility.</p> <p>Policy Explanation and Compliance Guidelines:</p> <ol style="list-style-type: none"> 1. The governing body will appoint an administrator who is: <ol style="list-style-type: none"> a. Licensed by the state where required. b. Responsible for management of the facility. c. Reports to and is accountable to the governing body. 2. The governing body is responsible and accountable for the Quality Assurance Performance Improvement (QAPI) program. 3. The governing body refers to individuals such as facility owner(s), Chief Executive Officer(s), or other individuals who are legally responsible to establish and implement policies regarding the management and operations of the facility. 4. The governing body will have a process in place by which the administrator: <p>(continued on next page)</p>		

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<p>F 0837</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>a. Reports to the governing body.</p> <p>b. Method of communication between administrator and governing body.</p> <p>c. How the governing body responds back to the administrator.</p> <p>d. What specific types of problems and information (i.e., survey results, allegations of abuse or neglect, complaints, etc.) are reported or not reported.</p> <p>e. How the administrator is held accountable and reports information about the facility's management and operation (i.e., audits, budgets, staffing supplies, etc.)</p> <p>f. How the administrator and the governing body are involved with the facility-wide assessment.</p> <p>On 07/17/24 at 11:45 a.m., Surveyor received an aging vendor report, which was 13 pages long with multiple vendors listed. The aging vendor report, dated 07/17/24, indicated invoices being owed from 45 days to invoices dating back 3 years 8 months.</p> <p>On 07/17/24 at 1:12 p.m., Surveyor placed a call to [NAME] Plumbing, Heating, and Electric to verify account balance per aging vendor report of \$2,524.65 and payments. Surveyor spoke to [NAME] Representative (JR) V. JR V stated facility owes \$2,932.53 and company has not contacted them about payments.</p> <p>On 07/17/24 at 1:19 p.m., Surveyor placed a call to Town & Country Lawn and Landscape. Spoke with Town and Country Representative (TCR) W about balance owed and payments from facility. Aging vendor report states facility owes \$5015.63. TCR W stated facility owes \$5015.63 and they have not paid in quite some time. TCR W stated TCR W has been in contact with Nursing Home Administrator (NHA) A, but no payment yet. TCR W stated they have been doing work for the facility for a few years and payment has always been slow, but it is getting worse.</p> <p>On 07/17/24 at 2:10 p.m., Surveyor placed a call to Constellation, which is a gas supplier and spoke with Constellation Representative. Facility has not made a payment since 01/11/23. No contact with Constellation via phone calls or emails since 2022 for set-up of payments. Balance owed is \$26,499.64, not \$9,147.97 as per aging vendor report.</p> <p>On 07/17/24 at 2:53 p.m., Surveyor placed a call to Sysco Baraboo (Food Supplier). Spoke to Sysco Representative who stated Bedrock made payments on 07/01/24 \$4,119.16, 07/08/24 \$2,943.33, 07/11/24 \$26,463.38, 07/12/24 \$5,397.00, 07/12/24 \$5,306.60. Balance owed is \$54,766.03, not \$39,450.41 as per aging report.</p> <p>On 07/18/24 at 3:24 p.m., Surveyor received an email from A Touch of Hope Transportation service. Email states the current balance due is \$4,231.66 and services have been stopped due to non-payment.</p> <p>On 07/19/24 at 10:31 a.m., Surveyor received email from Point Click Care Accounts Receivable (AR) Y. AR Y stated the open balance as of 07/19/24 for facility is \$18,869.38, not \$14,412.16 as per aging vendor report. AR Y states no payments have been received from this facility.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525435	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/22/2024
NAME OF PROVIDER OR SUPPLIER Abbotsford Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 600 E Elm St Abbotsford, WI 54405	
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 0837</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On 07/19/24 at 11:38 a.m., Surveyor interviewed M & L Transport about current balance. M & L Transport indicated an old outstanding balance from 10/19/23 of \$160.00 and have sent notices to the facility and have not received a response. Service to Abbotsford is on hold until payment is made.</p> <p>On 07/22/24 at 8:23 a.m., Surveyor interviewed Metro Fire Protection about current balance owed by the facility. Metro Fire Protection indicated the invoices on 10/19/23 services for \$236.52, 12/20/23 services \$108.67, 04/09/24 services for kitchen and fire extinguishers \$139.26 for a total of \$484.45 outstanding. Abbotsford is due in October for service of the kitchen and fire extinguishers and will not be serviced if balance is not paid.</p> <p>On 07/22/24 at 2:44 p.m., Surveyor sent an email to Northwest Environment, which is the garbage removal service, inquiring on balance owed by the facility and if any payments have been received. Surveyor received an email from Northwest Environment on 07/23/24 at 9:27 a.m., from the Director of Accounts Receivable (DAR) Z stating Bedrock-Abbotsford breached their contract with them effective 07/01/24. Balance owed is \$7,758.93, which is from May 2024 services through July 2024 plus Liquidated Damages. The last payment made was on 05/14/24. No other payment has been made as of recent. The facility had different hauler cans delivered back in June 2024, without notifying Northwest Environment. Northwest Environment placed the account in collections for legal action to be pursued.</p> <p>On 07/24/24 at 2:41 p.m., Surveyor received a return fax from Marshfield Clinic Financial Service stating, The Abbotsford Healthcare Center is significantly delinquent on their services. We do not show payments since we switched to our billing partner in 2021. The have agreed to a payment plan [sic] to get this account caught up. In \$2000 increments over the next several weeks. They owe approximately \$7000 for lab at this time. If they do not uphold the payment agreement we will begin to looking to suspend services.</p> <p>Bedrock Abbotsford owes the Wisconsin Department of Health Services for Bed Taxes in the amount of \$636,403.00.</p> <p>Bedrock Abbotsford owes Civil Money Penalties in the amount of \$72,662.00, date due 03/07/24.</p> <p>According to the facility's aging vendor report dated 07/17/24 the facility currently has outstanding total balance of \$274,216.47 and is greater than 151 days past due for Alixa Pharmacy. The facility is no longer doing business with Alixa and this account is currently in litigation.</p> <p>The facility's aging vendor report dated 07/17/24 the facility currently has outstanding total balances:</p> <p>\$17,179.50 and is greater than 151 days past due for Comprehensive Therapy Specialists.</p> <p>\$252.69 and is greater than 91-120 days past due for Securitas Healthcare which provides the facility's wanderguard service.</p> <p>\$21,667.25 and is greater than 151 days past due for Comfort Carriers.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525435	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/22/2024
NAME OF PROVIDER OR SUPPLIER Abbotsford Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 600 E Elm St Abbotsford, WI 54405	

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 0837</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On 07/17/24 at 5:35 p.m., Surveyor interviewed NHA A and asked about the balances owed to the vendors and payments. NHA A stated NHA A only sees the invoice for the service/supplies and NHA A approves the invoice and then it is sent to corporate. NHA A states NHA A does not see the past due amounts and doesn't know what is owed. Surveyor asked if NHA A is informed when the invoices are paid. NHA A stated NHA A is not informed when the invoices are paid.</p> <p>Surveyor asked if any utilities or internet has had disruption in services. NHA A stated there have been no disruptions. Surveyor asked if there have been any delays/disruptions with Sysco food service. NHA A stated there have been no issues with Sysco. Surveyor asked if there have been any disruptions with Point Click Care service. NHA A stated there have been no issues with Point Click Care service. Surveyor asked about the change in Pharmacy service and why. NHA A stated the company switched providers but NHA A stated NHA A unaware as to why.</p>