

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525440	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/08/2025
NAME OF PROVIDER OR SUPPLIER Plum City Care Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 301 Cherry Avenue West Plum City, WI 54761	

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 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47657</p> <p>Based on observations, interviews and record reviews, the facility did not ensure 4 of 4 residents (R5, R34, R28 and R3) reviewed for moderate to high risk of Pressure Injury (PI) development received the necessary treatment and services to promote healing of existing skin impairments or prevent new pressure injuries from developing.</p> <p>-R5 is at moderate risk for the development of PIs. R5 was observed for 5 hours and 13 minutes sitting in a Broda chair without staff offering or attempting to offload body surface.</p> <p>-R34 was admitted with multiple PIs and was at risk for PI development. The facility did not reposition R34 for several hours and did not provide repositioning to off-load the coccyx and hip as ordered.</p> <p>-R28 was at risk for PI development. The facility failed to evaluate the effectiveness of current interventions R28 had in place. The facility did not apply prevalon boot to R28's right heel as ordered to off-load heels.</p> <p>-R3 was at moderate risk for PI development. R3 was not repositioned for 5.5 hours and did not have pressure relieving cushion in Broda chair as ordered.</p> <p>This is evidenced by:</p> <p>According to the National Pressure Injury Advisory Panel (NPIAP) 2019, page 115, . Repositioning and mobilizing individuals is an important component in the prevention of pressure injuries. The underlying cause and formation of pressure injuries is multifaceted; however, by definition, pressure injuries cannot form without loading, or pressure, on tissue. Extended periods of lying or sitting on a particular part of the body and failure to redistribute the pressure on the body surface can result in sustained deformation of soft tissues and, ultimately, in tissue damage .</p> <p>According to Wound Care Education Institute (WCEI), 2018 states in part: there are three levels to skin breakdown . The second phase of skin breakdown is tissue ischemia, which begins within 2-6 hours of sustained pressure, depending on various factors (shearing, friction, moisture or incontinence, immobility, medical conditions, nutrition, mental status, etc.). and age. Tissue ischemia is marked by deep redness over the skin surface. It takes approximately 36 hours to dissipate once the pressure is removed.</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 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The facility Policy and Procedure titled: Skin Care Management, last revised on 09/24, states: It is the policy of this nursing home to provide skin care to residents that includes assessment, prevention of skin breakdown, management of pressure injury and other skin integrity concerns.</p> <p>Under section Protocol Section 3 states in part, The Braden Scale pressure injury risk assessment will be completed to identify risk factors . the risk assessment scoring, along with comprehensive clinical evaluation, will assist the interdisciplinary team for the development of the care plan.</p> <p>.#5. The tissue tolerance protocol will be completed to determine which repositioning interval best reduces resident risk for developing pressure injuries. This test will be completed upon new admission, readmission if a problem exists, annually, and if there is a significant change in the resident's condition, acuity or alterations to their skin.</p> <p>#7. When a resident is admitted with or develops a pressure injury or any other open area, immediate treatment will be initiated.</p> <p>d. A weekly assessment will be done by the nurse and all ongoing wound documentation will be entered into the pressure-injury assessment folder in ECS.</p> <p>f. The nurse will notify the residents responsible party of any skin integrity issues and/or changes in treatment and document this in the nursing progress notes .</p> <p>Example 1</p> <p>R5 was admitted to the facility on [DATE] and has diagnoses that include but are not limited to Alzheimer's disease and venous insufficiency.</p> <p>R5's Minimum Data Set (MDS) assessment, dated 10/23/24, indicated:</p> <p>-R5 is totally dependent on staff to meet the most basic daily tasks of bed mobility, transfer, dressing, toilet use and personal hygiene.</p> <p>-R5 is non-ambulatory and is transferred with the use of a mechanical lift.</p> <p>-R5 is always incontinent of bladder function and bowel function.</p> <p>-R5 has short-term and long-term memory impairment and severely impaired daily decision-making abilities.</p> <p>On 07/24/24, the facility completed a Braden Scale for Predicting Pressure Sore Risk Assessments for R5 indicating a score of 14 (moderate risk).</p> <p>On 07/24/24, the facility completed a Tissue Tolerance Protocol per policy which indicated R5 requires repositioning at an interval of every 2 hours.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>R5's care plan, dated 01/06/25, with a target date of 3 months, states: Problem: Tissue integrity impairment r/t impaired mobility, urinary incontinence, cognitive deficits . manifested by dependent on others for position changes and personal hygiene . intervention includes: assist with position changes every 2-3 hour.</p> <p>On 01/07/25, Surveyor observed the following:</p> <p>-7:40 AM, Surveyor observed R5 sitting in Broda chair at 45-degree position at breakfast table.</p> <p>-8:04 AM, R5 repositioned by staff to 90-degree position to eat.</p> <p>-8:35 AM, R5 brought to room and remained sitting at a 90-degree position.</p> <p>-9:45 AM, R5 observed continuing sitting in room at a 90-degree position.</p> <p>-10:39 AM, R5 brought to dining room for church service remaining at a 90-degree position.</p> <p>-11:17 AM, R5 placed in dining room in front of television after church service.</p> <p>-11:51 AM, R5 wheeled to dining table for lunch.</p> <p>-12:29 PM, R5 brought out of dining room into hallway across from nurses station.</p> <p>-12:53 PM, R5 transferred to bed. Surveyor observed 2 staff members conducting check and change peri care, noting R5's buttocks to be reddened after removing wet incontinent product (taking approximately 2-3 minutes).</p> <p>On 01/07/25 at 12:55 PM, Surveyor interviewed Certified Nursing Assistant (CNA) C who stated R5 was transferred to bed for a check and changed for incontinence before church.</p> <p>On 01/07/25 at 3:13 PM, Surveyor interviewed Director of Nursing (DON) B regarding expectation of turning, repositioning and offloading residents who have pressure injury or are at moderate to high risk for pressure injuries. DON B stated, The expectation would be to turn and reposition approximately every 2 hours and should be off loaded for at least 1/2 hour to 1 hour. DON B also stated that R5 should probably have been laid down after breakfast and gotten back up to go to church service.</p> <p>48793</p> <p>Example 2</p> <p>On 01/06/25, Surveyor reviewed R34's medical record. R34 was admitted to the facility on [DATE] with diagnoses including unspecified Alzheimer's disease, failure to thrive, chronic kidney disease stage 3, type 2 diabetes mellitus with hyperglycemia, overactive bladder, and encounter for palliative care. R34's Minimum Data Set (MDS) assessment, dated 01/09/24, had a Brief Interview for Mental Status (BIMS) score of 5 out of 15 which indicated R34 had severe impaired cognition. R34's MDS section GG for functional ability indicated R34 is totally dependent on staff for transfers, repositioning, and personal hygiene. MDS indicated that R34 was admitted with three stage 1 PIs and one stage 2 PI, and no stage 3 PIs noted.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>R34 is currently on hospice care.</p> <p>Surveyor reviewed R34's physician orders, which stated in part:</p> <ul style="list-style-type: none"> -Check drive air mattress set at 200 and marked with a sticker. Air mattress set on normal pressure, static. Check 3 times a day. <p>Surveyor reviewed R34's tissue integrity impairment care plan dated 01/05/25:</p> <ul style="list-style-type: none"> -needs 2 assist and slip sheet for position changes every 2 hours. -keep off left hip as much as possible -float heels while in bed -air mattress on bed check every shift -heel protectors on at all times -dressing on both hips -document on coccyx PI area weekly <p>On 01/07/25 at 7:15 AM, Surveyor observed R34 lying in bed on back slightly leaned to right side, sleeping. Surveyor observed lower back and coccyx flat against R34's bed, not offloading the PI.</p> <p>On 01/07/25 at 9:23 AM, Surveyor observed R34 lying in bed on back with slight lean towards right side and a pillow behind R34's upper back. Surveyor observed lower back and coccyx flat against R34's bed, not offloading the PI.</p> <p>On 01/07/25 at 10:35 AM, Surveyor observed CNA D and CNA G go into R34's room. CNA D and CNA G pulled covers down to R34's waist. Surveyor observed R34 on R34's right side slightly leaned to the right but with lower back and coccyx touching the mattress. Surveyor did not observe CNA D and CNA G reposition R34 off R34's coccyx.</p> <p>On 01/07/25 at 11:58 AM, Surveyor observed R34 lying on back in bed with lower back and coccyx against the mattress, not offloading the PI. Surveyor observed CNA D and CNA G transfer R34 out of bed into wheelchair for lunch.</p> <p>On 01/07/25 at 12:52 PM, Surveyor interviewed CNA G and asked how often is R34 to be repositioned and is R34 supposed to be completely off R34's coccyx. CNA G indicated that every resident should be repositioned for the most part every 2 hours. CNA G indicated that all staff try to reposition R34 off coccyx and off left hip as much as possible.</p> <p>On 01/07/25 at 1:13 PM, Surveyor started to observe R34 when placed in bed via Hoyer lift. CNA D and CNA G placed R34 on left side with pillow between legs.</p> <p>Surveyor did continuous observation of R34.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 01/07/25 at 3:53 PM, Surveyor observed R34 lying in bed on left side with pillow between legs. Surveyor did not observe staff reposition R34 during 1:13 PM-3:53 PM observation.</p> <p>On 01/08/25 at 11:33 AM, Surveyor interviewed Director of Nursing (DON) B and asked about expectations for staff to reposition R34. DON B indicated that CNAs should be repositioning R34 within 2 hours of being in bed since R34 is at high risk and has stage 3 PI on coccyx.</p> <p>On 01/13/25 at 3:30 p.m., Surveyor interviewed Regional Director of Operations (RDO) I asking if the PI was unavoidable. RDO I provided physician documentation that R34 has severe aortic stenosis, and audible severe heart murmur that affects circulation and healing. Physician stated that the area was not expected to heal due to R34's end of life condition.</p> <p>Example 3</p> <p>On 01/06/25, Surveyor reviewed R28's medical record. R28 was admitted to the facility on [DATE] with diagnoses including acute on chronic systolic heart failure, chronic atrial fibrillation, and nonrheumatic mitral valve insufficiency. R28's Minimum Data Set (MDS) assessment, dated 09/25/24, had a Brief Interview for Mental Status (BIMS) score of 8 out of 15 which indicated R28 had moderate impaired cognition. R28's MDS section GG for functional ability indicated R28 needs substantial/maximal assistance from staff for transfers, repositioning, and personal hygiene.</p> <p>Admission MDS indicated that R28 was admitted with unstageable pressure injury to the right heel but current MDS from 09/25/24 indicates right heel PI healed.</p> <p>Surveyor reviewed R28's physician orders, which stated in part:</p> <ul style="list-style-type: none"> -Apply foam boot and float right heel when in bed every shift. <p>Surveyor reviewed R28's tissue integrity impairment care plan dated 01/04/25:</p> <ul style="list-style-type: none"> -Encourage to lift off surfaces to prevent shearing -Geo ultra gel mattress on bed -Encourage frequent positions changes 2-3 hours -Prevalon boots in bed and elevate feet <p>Surveyor reviewed R28's skin assessments:</p> <ul style="list-style-type: none"> -On 09/25/24, Braden scale assessment score was 17, indicating at risk for pressure injury. <p>On 01/06/25 at 11:19 AM, Surveyor observed R28 sleeping in bed. Surveyor observed prevalon boot in wheelchair and not on R28's feet.</p> <p>On 01/08/25 at 9:48 AM, Surveyor observed R28 lying in bed without prevalon boot on right heel. Surveyor did not observe pillow under right heel to off-load. Surveyor observed prevalon boot lying in recliner beside the bed.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 01/08/25 at 10:16 AM, Surveyor interviewed CNA D and asked why R28's prevalon boot was in recliner in room instead of on R28's right heel. CNA D indicated that prevalon boot should be on while R28 is lying in bed. CNA D indicated to Surveyor that CNA D is unsure who laid R28 down in bed after breakfast.</p> <p>On 01/08/25 at 10:18 AM, Surveyor interviewed CNA C and asked if CNA C laid R28 down after breakfast. CNA C indicated that CNA C laid R28 down in bed after breakfast around 8:50 AM. Surveyor asked CNA C if CNA C applied prevalon boot on R28's right heel when CNA C laid R28 down after breakfast. CNA C indicated that CNA C did not apply the prevalon boot to R28's right heel and CNA C should have.</p> <p>On 01/08/25 at 11:33 AM, Surveyor interviewed DON B and asked about expectations for staff to apply prevalon boot to R28's right heel. DON B indicated that CNAs should always apply R28's prevalon boot to right heel whenever R28 is in bed.</p> <p>Example 4</p> <p>On 01/06/25, Surveyor reviewed R3's medical record. R3 was admitted to the facility on [DATE] with diagnoses including Alzheimer's disease with early onset, contracture right and left hand, contracture right and left elbow, contracture right and left wrist, contracture left shoulder, and Post Traumatic Stress Disorder (PTSD). R3's Minimum Data Set (MDS) assessment, dated 10/01/24, indicated Brief Interview for Mental Status (BIMS) could not be completed due to R3 being nonverbal. R3's MDS section GG for functional ability indicated R3 is totally dependent on staff for transfers, repositioning, and personal hygiene.</p> <p>Surveyor reviewed R3's care plan dated 01/06/24, which stated in part:</p> <ul style="list-style-type: none"> -Dependent on staff for all cares, and transfers with 2 assists and Hoyer lift -Lay down between meals -Up in Broda chair with pommel wedge cushion for locomotion -Currently is unable to make any position changes independently <p>Surveyor reviewed R3's Braden scale assessment, which stated in part:</p> <ul style="list-style-type: none"> -On 12/27/24, Braden scale score 14 which indicates R3 is at moderate risk of skin breakdown. <p>On 01/07/25 at 7:35 AM, Surveyor observed R3 in Broda chair sitting up at a 90-degree angle. Surveyor did not observe R3's pommel wedge cushion in place under R3.</p> <p>On 01/07/25 at 8:26 AM, Surveyor observed staff assisting R3 with breakfast. R3 was sitting in Broda chair at 90-degree angle. Surveyor did not observe R3's pommel wedge cushion in place under R3.</p> <p>On 01/07/25 at 8:50 AM, Surveyor observed Certified Nurse Assistant (CNA) E propel R3 in Broda chair to R3's room. CNA E parked R3 in room to watch television and attached call light to R3's chair. Surveyor did not observe CNA E reposition R3 in Broda chair and Surveyor did not observe R3's pommel wedge cushion in place under R3.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 01/07/25 10:05 AM, Surveyor observed R3 in Broda chair sitting up at a 90-degree angle. Surveyor did not observe R3's pommel wedge cushion in place under R3. Surveyor did not observe any staff members go into R3's room to assist in repositioning R3.</p> <p>On 01/07/25 at 11:03 AM, Surveyor observed R3 sleeping in Broda chair sitting up at a 90-degree angle. Surveyor did not observe R3's pommel wedge cushion in place under R3. Surveyor did not observe any staff members go into R3's room to assist in repositioning R3.</p> <p>On 01/07/25 at 12:02 PM, Surveyor observed CNA E wheel R3 out of R3's room and to the dining room. Surveyor observed R3 in Broda chair sitting up at a 90-degree angle. CNA E parked R3 at the dining room table and placed clothing protector on R3. Surveyor did not observe R3 repositioned. Surveyor did not observe R3's pommel wedge cushion in place under R3.</p> <p>On 01/07/25 at 1:15 PM, Surveyor observed CNA D and CNA G lift R3 into Hoyer lift and transfer to bed. CNA D and CNA G performed peri cares on R3. Surveyor observed golf ball size red mark on R3's right outer elbow where R3's elbow was pressed against the side of the Broda chair for a length of time. Surveyor observed wrinkle creases in skin on R3's lower back and coccyx area. Surveyor interviewed CNA D and CNA G and asked what time CNA D and CNA G transferred R3 out of bed this morning for breakfast. CNA D indicated around 6:40 AM. CNA D indicated that CNA D and CNA G were going to lay R3 down in bed after breakfast, but CNA G was waiting to offer a snack since R3 was pocketing food at breakfast and did not eat breakfast. CNA D and CNA G indicated that CNA D and CNA G decided to just keep R3 up for the day. Surveyor asked if R3 had been repositioned or position changed since R3 did not lay down in bed to off-load. CNA G indicated R3's Broda chair has been repositioned back a little earlier this morning but unsure what time. CNA G indicated that CNA G should have probably laid R3 down earlier.</p> <p>On 01/07/25 at 3:41 PM, Surveyor interviewed DON B and asked about repositioning R3. DON B indicated that all residents should be repositioned every 2 hours if at risk of skin breakdown. Surveyor asked DON B about R3's pommel wedge cushion that is ordered for R3 to be placed in wheelchair. DON B indicated that DON B would need to look into the cushion for R3.</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48793</p> <p>Based on record review and interview, the facility did not ensure that 1 of 1 resident (R) reviewed received appropriate respiratory care during administration of respiratory therapy (R32).</p> <p>Facility did not perform pre and post respiratory assessments for R32 when administering nebulizer treatments.</p> <p>Findings include:</p> <p>On 01/06/25, Surveyor reviewed R32's medical record. R32 was admitted to the facility on [DATE] with diagnoses including Chronic Obstructive Pulmonary Disease (COPD), anxiety disorder, pneumonia, and chronic respiratory failure with hypoxia. R32's Minimum Data Set (MDS) assessment, dated 11/20/24, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R32 had intact cognition.</p> <p>Surveyor reviewed R32's physician orders, stated in part:</p> <ul style="list-style-type: none"> -Albuterol Sulfate HFA 90 mcg, give two puffs inhalation every four hours as needed for COPD and breathing comfort. -Ipratropium-Albuterol neb 0.5mg/3ml give every six hours with pre-neb and post-[NAME] assessment. -May take medications whole. Do not leave at bedside. Observe taking all medications. <p>On 01/06/25 at 11:35 AM, Surveyor observed R32 sitting in recliner. Surveyor observed R32 start R32's own nebulizer machine. Surveyor interviewed R32 and asked if the normal process was for R32 to start R32's own nebulizer for treatment. R32 indicated R32 started own nebulizer machine and that staff will bring nebulizer medication in and leave on bedside table if not ready to take medication. Surveyor did not observe a nurse go in and complete pre nebulizer treatment assessment.</p> <p>On 01/07/25 at 10:55 AM, Surveyor observed nebulizer machine on bedside table with some medication in the nebulizer compartment. Surveyor interviewed R32 and asked who manages the nebulizer machine such as filling the nebulizer compartment with medication, cleaning, rinsing, and drying it for the next use. R32 indicated it stays on bedside table and it is R32's personal nebulizer machine that R32 manages.</p> <p>On 01/07/25 at 12:35 PM, Surveyor heard nebulizer going and Registered Nurse (RN) F in R32's room sitting on bed conversing with R32. Surveyor observed RN F exit R32's room and walk down the hallway. Surveyor did not observe RN F complete pre nebulizer treatment assessment. Surveyor interviewed RN F and asked what RN F's process is for administering nebulizers to R32. RN F indicated that RN F will sometimes bring the nebulizer medication down to R32 and place in nebulizer machine. RN F indicated that RN F sometimes assesses oxygenation saturation with oximeter. RN F indicated RN F should auscultate lungs as well. Surveyor asked RN F if RN F assessed R32's lungs pre nebulizer treatment and RN F indicated that RN F did. Surveyor did not observe RN F perform pre nebulizer treatment or observe a stethoscope in R32's room or around RN F's neck.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 01/07/25 at 12:41 PM, Surveyor observed R32 shut nebulizer machine off and set the nebulizer on the bedside table. Surveyor did not observe RN F go back into R32's room to confirm nebulizer medication was finished accurately. Surveyor interviewed R32 and asked if RN F had listened to R32's lungs pre nebulizer treatment. R32 indicated that RN F did not listen to R32's lungs before R32 started R32's own nebulizer treatment. R32 indicated that R32 manages R32's own nebulizer treatments.</p> <p>On 01/07/25 at 12:41 PM-1:11 PM, Surveyor observed continuous observation that RN F did not perform post nebulizer respiratory assessment.</p> <p>On 01/07/25 at 1:53 PM, Surveyor interviewed Director of Nursing (DON) B and asked DON B's expectations for nursing staff to complete pre and post nebulizer assessments if R32 is self-administering the nebulizer treatment. DON B indicated that nursing staff should still be auscultating R32's lungs and performing the respiratory assessment pre and post nebulizer treatment. Surveyor asked DON B's expectation of time frame post nebulizer treatment for assessment of respiratory status. DON B indicated within 15-30 minutes post nebulizer treatment a respiratory assessment should be completed. Surveyor requested documentation of respiratory assessment pre and post nebulizer treatment for 01/07/24.</p> <p>Surveyor reviewed nurse progress notes and could not find consistent respiratory assessments pre and post nebulizer administrations.</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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48793</p> <p>Based on observation and interview, the facility did not ensure the accurate receiving and dispensing of all drugs and biologicals. Expired medications were observed in 1 of 4 medication storage areas medicine carts/rooms inspected. The facility did not administer medications accurately for 1 resident (R) (R32) of 1 sampled resident observed.</p> <p>-Facility did not destroy R15's Lorazepam after medication was discontinued.</p> <p>-Facility did not destroy R35's Lorazepam after medication was discontinued.</p> <p>-R32 had medications left at bedside and did not have an assessment to self-administer medication.</p> <p>Findings include:</p> <p>Example 1</p> <p>The facility policy, titled Destruction of Medications, reviewed July 2024, states:</p> <p>.3. Disposal of all drugs will occur within 72 hours of a physician's order discontinuing its use, the resident's death or passage, its expiration date or as outlined in state specific policy .</p> <p>Surveyor reviewed R15's physician orders, which stated in part:</p> <p>-On 11/14/24, ordered Lorazepam 2mg/ml Give 0.25ml orally every four hours as needed for anxiety.</p> <p>Surveyor reviewed R35's physician orders, which stated in part:</p> <p>-On 12/17/24, ordered Lorazepam 2mg/ml Give 0.25ml orally every two hours as needed for anxiety.</p> <p>On 01/07/25 at 9:36 AM, Surveyor toured medication storage room with Director of Nursing (DON) B.</p> <p>On 01/07/25 at 9:43 AM, Surveyor observed two Lorazepam 2mg/ml bottles unopened labeled for R15 and R35 for use as needed. R15's bottle was prescribed 11/14/24. R35's bottle was prescribed to R35 12/17/24. DON B indicated the two bottles of lorazepam are not supposed to be in fridge anymore as the physician orders were only good for 14 days and both orders have been discontinued for a while. Surveyor interviewed DON B and asked why the bottles were still in fridge and who is responsible for auditing and removing controlled medications that are no longer in use. DON B indicated that DON B is the one who audits controlled medications and makes sure controlled medications that are discontinued are no longer in the facility. DON B apologized and stated DON B would remove controlled policy medications right away.</p> <p>Example 2</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525440	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/08/2025
NAME OF PROVIDER OR SUPPLIER Plum City Care Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 301 Cherry Avenue West Plum City, WI 54761	
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>On 01/06/25, Surveyor reviewed R32's medical record. R32 was admitted to the facility on [DATE] with diagnoses including Chronic Obstructive Pulmonary Disease (COPD), anxiety disorder, pneumonia, and chronic respiratory failure with hypoxia. R32's Minimum Data Set (MDS) assessment, dated 11/20/24, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R32 had intact cognition.</p> <p>Surveyor reviewed R32's physician orders, which stated in part:</p> <ul style="list-style-type: none"> -Albuterol Sulfate HFA 90 mcg, give two puffs inhalation every four hours as needed for COPD and breathing comfort. -Ipratropium-Albuterol neb 0.5mg/3ml give every six hours with pre-neb and post-[NAME] assessment. -May take medications whole. Do not leave at bedside. Observe taking all medications. <p>On 01/06/25 at 11:35 AM, Surveyor observed R32 sitting in recliner. Surveyor observed R32's nebulizer medication in nebulizer machine on bedside table. Surveyor observed R32 start R32's own nebulizer machine. Surveyor interviewed R32 and asked if the normal process was for R32 to start R32's own nebulizer for treatment. R32 indicated R32 started own nebulizer machine and that staff will bring nebulizer medication in and leave on bedside table if not ready to take medication. During interview Surveyor observed two Ventolin HFA inhalers with tops off located on bedside table near R32's recliner.</p> <p>On 01/07/25 at 10:55 AM, Surveyor observed R32 sitting in recliner after transferring from commode to recliner. R32 was short of breath and had a red inhaler in left hand shaking getting ready to use the inhaler. Surveyor interviewed R32 and asked if R32 was ok and once done using the inhaler, may Surveyor see the inhaler to read the label. R32 indicated to Surveyor that the inhaler is fine, and R32 manages own medication with the rescue inhalers in R32's room. R32 indicated that R32 always keeps inhalers at bedside in R32's room. Surveyor observed nebulizer machine on bedside table with some medication in the nebulizer compartment. Surveyor interviewed R32 and asked who manages the nebulizer machine such as filling the nebulizer compartment with medication, cleaning, rinsing, and drying it for the next use. R32 indicated it stays on bedside table and it is R32's personal nebulizer machine that R32 manages.</p> <p>On 01/07/25 at 12:35 PM, Surveyor heard nebulizer going and Registered Nurse (RN) F in R32's room sitting on bed conversing with R32. Surveyor observed RN F exit R32's room and walk down the hallway. Surveyor interviewed RN F and asked what RN F's process is for administering nebulizers to R32. RN F indicated that RN F will sometimes bring the nebulizer medication down to R32 and place in nebulizer machine. RN F indicated that R32 does not always want the nebulizer right away so RN F will leave nebulizer medication on bedside table until R32 is ready to use. RN F indicated the facility has deemed R32 to be ok to administer nebulizer to self.</p> <p>On 01/07/25 at 12:41 PM, Surveyor observed R32 shut nebulizer machine off on R32's own and set the nebulizer on the bedside. Surveyor did not observe RN F go back into R32's room to confirm nebulizer medication was finished accurately.</p> <p>On 01/07/25 at 1:53 PM, Surveyor interviewed Director of Nursing (DON) B and asked DON B's expectations for staff leaving medications with residents.</p> <p>(continued on next page)</p>		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/07/25 at 2:17 PM, DON B indicated to Surveyor that R32 did not have an assessment to self administer medications so the nurse should not have left the medication at bedside.		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48793</p> <p>Based on observation and interview, the facility did not ensure all drugs and biologicals were stored in accordance with currently accepted professional principles. This occurred for 1 of 7 resident (R32) medication administration/storage observed.</p> <p>During the three-day survey, 1 of 7 observations were made of medications left unattended and out of view of staff.</p> <p>Findings include:</p> <p>On 01/06/25, Surveyor reviewed R32's medical record. R32 was admitted to the facility on [DATE] with diagnoses including Chronic Obstructive Pulmonary Disease (COPD), anxiety disorder, pneumonia, and chronic respiratory failure with hypoxia. R32's Minimum Data Set (MDS) assessment, dated 11/20/24, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R32 had intact cognition.</p> <p>Surveyor reviewed R32's physician orders, which stated in part:</p> <p>-Ipratropium-Albuterol neb 0.5mg/3ml give every six hours with pre-neb and post-[NAME] assessment.</p> <p>-Do not leave at bedside. Observe taking all medications.</p> <p>On 01/06/25 at 11:35 AM, Surveyor observed two Ventolin HFA inhalers with tops off located on bedside table near R32's recliner.</p> <p>On 01/07/25 at 10:55 AM, Surveyor observed R32 sitting in recliner after transferring from commode to recliner. R32 was short of breath and had a red inhaler in left hand shaking getting ready to use the inhaler. Surveyor interviewed R32 and asked if R32 was ok and once done using the inhaler, may Surveyor see the inhaler to read the label. R32 indicated to Surveyor that the inhaler is fine, and R32 manages own medication with the rescue inhalers in R32's room. R32 indicated that R32 always keeps inhalers at bedside in R32's room.</p> <p>On 01/07/25 at 1:53 PM, Surveyor interviewed Director of Nursing (DON) B and asked DON B's expectations for R32 self-administering Ventolin inhalers and storage of R32's inhalers. DON B indicated that all medications are to be stored in medication carts or medication storage room. DON B indicated that R32 should not be using Ventolin inhalers freely in room without supervision from nursing staff.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>47807</p> <p>Based on observation, interview and record review, the facility did not ensure that food was stored, prepared, distributed, and served food in accordance with professional standards for food service safety. The facility did not label opened dry goods with an open date to ensure food safety for residents. This has the potential to affect all 37 of 37 residents (R) residing in the facility.</p> <p>Findings include:</p> <p>Facility policy titled, Food Storage Standards revised November 2024, states, The dietary director shall ensure that standards for refrigerated, frozen, and dry foods are followed . Policy: follow the criteria below for all types of food storage . 3. Criteria for Dry Food Storage: . A dry food storage timeline chary is available and followed. (http://www.ag.ndsu.edu/pubs/yff/foods/fn579.pdf) . Dry food stock rotation follows the FIFO [First In First Out] principle . Staff receive training on the proper dry food storage time and temperature.</p> <p>North Dakota State University (NDSU), FN579 titled, Food Storage Guide reviewed January 2023, states, Many staples and canned foods have a relatively long shelf life, but buy only what you can expect to use within the time recommended in the chart. Date food packages and use the oldest first .Cupboard Storage Chart . - spaghetti, macaroni, etc. unopened stored for 2 years opened stored for 1 year . egg noodles unopened stored for 2 years and opened stored for 1-2 months. Once opened, store in an airtight container.</p> <p>On 01/07/25 at 11:52 AM, Surveyor observed dry storage area and noted that some products had open dates and some products did not. Surveyor observed three bags of noodles that were opened and did not have open dates; other bags of noodles in the same area were also opened and did have open dates. The three bags of noodles were open and still in original packaging, not in an airtight container.</p> <p>On 01/07/25 at 12:00 PM, Surveyor interviewed Dietary Manager (DM) H regarding food storage procedure. DM H would expect that staff put an open date on the noodles, so they know if they need to be thrown out. DM H said they planned to toss the noodles now because they did not know when they were opened and did not feel comfortable serving the noodles after not seeing open dates.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>51804</p> <p>Provide and implement an infection prevention and control program.</p> <p>Based on observation, record review and interview, the facility staff did not conduct hand hygiene during resident (R) cares for 1 out of 5 (R34) observations.</p> <p>Certified Nursing Assistant (CNA) E did not perform hand hygiene when warranted when providing peri care to R34.</p> <p>This is evidenced by:</p> <p>The facility policy, titled Infection Prevention and Control dated 2/2024 states:</p> <p>5. Hand Hygiene</p> <p>a. The World Health Organization (WHO) guidelines are followed for hand hygiene for all employees.</p> <p>The WHO Guidelines, titled WHO Guidelines on Hand Hygiene in Health Care dated 01/15/2009 states on page 92 under the section Indications for hand hygiene:</p> <p>My five moments for hand hygiene.</p> <p>Moment 1- Before touching a patient.</p> <p>Moment 2- Before a procedure.</p> <p>Moment 3- After a procedure or body fluid exposure risk.</p> <p>Moment 4- After touching a patient.</p> <p>Moment 5- After body fluid exposure risk</p> <p>The WHO Leaflet, titled Glove Use Information Leaflet states under section Inappropriate glove use:</p> <p>The use of contaminated gloves caused by inappropriate storage, inappropriate moments, and techniques for donning and removing, may also result in germ transmission.</p> <p>On 01/07/2025 at 9:02 AM, Surveyor observed CNA E conduct hand hygiene before transferring R34 via Hoyer lift to R34's bed. CNA E donned gloves, and no hand hygiene was observed prior to donning gloves. CNA E proceeded to remove urine wet brief, conducted peri care and placed new brief. CNA E proceeded with contaminated gloves to pull up and adjust R34's pants, adjust pillow under head, place pillow behind back for support and adjust blanket.</p> <p>On 01/08/2025 at 12:40 AM, Surveyor interviewed Director of Nursing (DON) B regarding expectation of hand hygiene. DON B stated the expectation would be to conduct hand hygiene after contact with residents, personal items, or equipment used to care for them.</p>		