STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525443	A. Building B. Wing	05/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Onalaska Care Center	1600 Main St Onalaska, WI 54650

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49353 Based on interview and record review, the facility did notify the resident representative of a change in condition for 1 of 3 residents (R) reviewed (R1). R1 had multiple syncopal episodes resulting in one fall, and R1's family/representative was not notified for each occurrence. This is evidenced by: Facility policy titled, Change in Condition, with a revised date of 08/12/24, states in part: Purpose: To assure appropriate medical intervention in the event of significant change in resident's physical or mental condition. Procedure: .3. The Charge Nurse will assess the resident and will immediately consult with the provider and notify the family/HCPOA when a deviation occurs, including: i. An accident, which results in an injury and has potential for requiring physician intervention. 2. The provider and family/HCPOA will be notified immediately if the resident has a significant change in status relating to a previous accident that had originally resulted in no change. (i.e. increased pain, bruising, deformity, swelling, etc.) ii. A significant change in physical, mental or psychological status. (i.e. a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications.) R1 was admitted to the facility on [DATE] with pertinent diagnoses of atrial fibrillation, congestive heart failure, hypotension, and syncope and collapse. R1's admission Minimum Data Set (MDS) assessment dated [DATE] noted a Brief Interview for Mental Status (BIMS) score of 14/15 indicating cognition intact, able to be understood, and understands others. Surveyor reviewed R1's admission documentation and noted R1's son was the designated healthcare power of attorney (HCPOA) which is not activated. R1's HCPOA was designated as R1's emergency contact. R1's daughter-in-law was also noted as a family contact. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor reviewed R1's social worker notes and noted on 01/14/25 they state R1 is cognitively intact, own decision maker, and states preference to notify family/representative of incidents. On 05/12/25, Surveyor reviewed R1's nursing notes and noted the following: -03/22/25 at 2:43 PM, R1 had an unwitnessed fall. R1 was assessed and noted no injuries, no pain, and no musculoskeletal deformities. Provider notified. R1 declined family notification. -03/23/25 at 11:45 AM, R1 had syncopal episode during transfer resulting in a skin tear on left inner forearm. Wound was cleansed, steri-strips and gauze applied. R1 was assessed and noted no injuries, no pain, and no musculoskeletal deformities. -03/24/25 at 12:32 PM, R1 had syncopal episode after repositioning. R1 complained of moderate pain in left leg with lifting leg and knee flexion. No musculoskeletal deformity noted. No documentation of provider or family/HCPOA notification at this time. -03/25/25 at 12:34 PM, R1 was assessed and noted to have left foot externally rotated, left lower extremity range of motion loss, Activity of Daily Living (ADL) interference, and/or risk of injury present. Provider and family notified. R1 was sent to hospital for evaluation. On 05/12/25, Surveyor reviewed R1's hospital summary and noted R1 was admitted to the hospital on 03/25/25. Hip/pelvis x-ray confirmed acute left femoral neck fracture. Chest x-ray noted non-acute, healing, nondisplaced fractures of anterior or lateral left 4th, 5th, 6th, 7th, 8th, 9th ribs. Due to increased risk, R1 was not a surgical candidate. R1 and family agreed to palliative care. R1 was discharged from hospital on 03/27/25 on hospice and returned to facility. On 05/12/25 at 1:41 PM, Surveyor interviewed R1's Family Member (FM) G, who stated not being notified of a fall or a syncopal episodes that occurred between 03/22/25-03/24/25. FM G stated family was notified mid-afternoon on 03/25/25 of R1 having a possible leg/hip fracture and would be transferred to the hospital for evaluation. On 05/12/25 at 4:13 PM, Surveyor interviewed Licensed Practical Nurse (LPN) C regarding notifications. LPN C stated if a fall or a significant change is assessed in a resident, charge nurse is notified, who will be responsible for notifying the provider and/or family. On 05/12/25 at 4:38 PM, Surveyor interviewed Registered Nurse (RN) E regarding notifications. RN E stated being charge nurse role and would have the responsibility of notifying the provider and family with changes or concerns. RN E stated if a resident is their own decision maker, they are asked if they would like their family notified. RN E stated they notify family based on resident preference. On 05/12/25 at 4:47 PM, Surveyor interviewed Director of Nursing (DON) B regarding notifications. DON B stated if a resident has an activated HCPOA, notification is always made immediately after incidents or change in condition. If a resident is their own decision maker, then they are asked their preference on notification to family. Surveyor asked DON B about R1's preference for notifying family. DON B stated being aware that R1 wanted family notified, but that R1 was asked after each incident if family should be notified. Surveyor asked DON B if this would be documented asking R1 on notification. DON B stated yes, it should. DON B stated that R1 was likely asked if family should be notified but was unable to provide the documentation of this.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49353 Based on interview and record review, the facility did not ensure residents received care and treatment in accordance with professional standards of practice for 1 of 3 residents (R) reviewed (R1). Staff did not complete comprehensive and focused respiratory, skin and pain assessments after R1 had a fall and complained of rib pain. This is evidenced by: Facility policy titled, Resident Fall, with a revised date of 01/06/25, states in part: .After immediate/emergent needs have been addressed, head-to-toe assessment of resident to be performed by the RN/Charge LPN including assessment for head trauma, any obvious injury, pain, possible fracture, ability to move all extremities, any deformity/shortening/rotation of legs. According to the American Journal of Nursing, When a fall occurs, a comprehensive assessment must be completed to include visual observation of skin to assess for bruising, pallor, and trauma; note any pain and points of tenderness. Be aware of the following warning signs: numbness or tingling in the extremities, back pain, rib pain, or an externally rotated or shortened leg .Focused assessments should be completed frequently when any abnormalities are assessed to monitor for changes and efficacy of treatment. Current professional standards for pain assessment include pain intensity, location, quality, functional impairment, onset, and duration to evaluate for efficacy of interventions and changes that may indicate a need for further evaluation or worsening of condition. R1 was admitted to the facility on [DATE] with pertinent diagnoses of atrial fibrillation, congestive heart failure, hypotension, and syncope and collapse. R1's admission Minimum Data Set (MDS) assessment, dated 01/22/25, noted a Brief Interview for Mental Status (BIMS) score of 14/15 indicating cognition intact, able to be understood, and understands others. R1 was noted to have chronic pain occasionally present in left and right hip rated 3/10. Surveyor reviewed R1's electronic medical record and noted: On 02/12/25 at 12:05 AM, R1 was found on floor. No injuries assessed. R1 denied pain. Vital signs, musculoskeletal system, and neurological assessments completed with no abnormalities noted. No documentation of a head to toe skin assessment noted. On 02/12/25 at 11:00 PM, fall occurred due to weakness/dizziness during transfer. No injuries assessed. R1 denied pain. Vital signs, musculoskeletal system, and neurological assessments completed with no abnormalities noted. No documentation of head to toe skin assessment noted. On 02/13/25 at 1:56 PM, R1 complained of dizziness/vertigo, syncope, weakness, shortness of breath with exertion and at rest, respirations noticeably quick and short, lung sounds clear upper bilaterally and diminished lower bilaterally, and had 3+ pitting edema of R1's bilateral lower extremities. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Of note: Provider and family notified. R1 declined transfer to hospital for evaluation. No skin assessment documented. No further comprehensive respiratory assessment noted. On 02/16/25 at 2:00 PM, R1 found on floor and stated sliding out of wheelchair. No injuries assessed at this time. R1 denied pain. Vital signs, musculoskeletal system, and neurological assessments completed with no abnormalities noted. No documentation of skin assessment noted. No documentation of comprehensive respiratory assessment noted. On 02/17/25, R1 complained of left rib pain rated 6/10. Of note: Comprehensive respiratory assessment not completed. Comprehensive pain assessment to include quality, functional impairment, onset, and duration was not completed. On 02/18/25, R1 complained of painful coughing and left rib pain following recent fall. R1's respirations elevated, shallow. Congested cough, non-productive. Lungs clear throughout. Left side chest tender to touch/palpation. No skin assessment noted. Comprehensive pain assessment to include quality, functional impairment, onset, and duration was not noted. On 02/20/25, R1 complained of left hip pain going up left side rated 8/10. Of note: Comprehensive respiratory assessment not completed. Comprehensive pain assessment to include quality, functional impairment, onset, and duration was not completed. On 03/22/25 at 2:43 PM, R1 found on floor with wheelchair on top of R1's body. R1stated losing balance when trying to move wheelchair. R1 denied pain. Vital signs, musculoskeletal system, and neurological assessments completed with no abnormalities noted. No documentation of skin assessment noted. No documentation of comprehensive respiratory assessment noted. On 03/22/25 at 8:15 PM, R1 complained of left hip pain rated 8/10. Of note: Comprehensive pain assessment to include quality, functional impairment, onset, and duration was not completed. On 03/25/25 at 12:03 AM, R1 complained of pain that was aching, almost constantly Night shift documented in musculoskeletal note, mild to moderate pain in left leg, but did not complete a comprehensive pain assessment to include functional impairment, onset or duration. On 03/25/25 at 12:34 PM, R1 complained of pain to left hip while lying at rest in bed. Assessment noted left foot was externally rotated. Skin assessment noted no abnormalities. At 4:11 p.m., R1 was transferred to the hospital for evaluation. All falls documented included fall investigation to determine root cause, identify risk, and contributing factors. Safety interventions were appropriately implemented. Provider was appropriately notified and assessed. Surveyor reviewed R1's hospital discharge summary and noted: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/25/25, CT of chest noted non-acute, healing, nondisplaced fractures of lateral left 4th, 5th, 6th, 7th, 8th, 9th ribs. Chest x-ray noted left pleural effusion, suspected pulmonary edema, potentially with infectious/inflammatory or aspiration pneumonitis. Hip/pelvis x-ray noted acute fracture of the left subcapital femoral neck. On 05/12/25 at 4:13 PM, Surveyor interviewed Licensed Practical Nurse (LPN) C regarding post-fall assessments. LPN C stated residents are to be assessed head-to-toe, which includes skin, respiratory status, pain, and cognition. LPN C stated if any abnormalities are assessed, the charge nurse is notified, and follow-up focused assessments would be completed. On 05/12/25 at 4:27 PM, Surveyor interviewed Registered Nurse (RN) D regarding post-fall assessments. RN D stated residents should be assessed head-to-toe. RN D stated that if a resident complains of rib pain, then a focused respiratory assessment should be completed to include lung sounds, respirations, shortness of breath, muscle use, and skin color. RN D stated pain assessment should include location, severity, and duration. Surveyor asked if this was documented in a resident's chart. RN D stated if it was assessed, then it should be documented in a nursing note. On 05/12/25 at 4:47 PM, Surveyor interviewed Director of Nursing (DON) B regarding post-fall assessments. DON B stated staff are expected to assess residents head-to-toe and document findings. DON B stated nursing is expected to monitor pain using location and severity and complete follow-up assessments for efficacy. Surveyor asked DON B how pain is monitored for changes. DON B stated interventions are assessed for efficacy to determine if pain is worsening. Surveyor asked DON B if this practice would be effective in monitoring for changes in pain, as R1 was noted to have hip pain on admission. DON B acknowledged staff did not assess for changes or worsening in R1's hip pain. Surveyor asked DON B if a focused lung assessment should have been completed with R1 after noting rib pain. DON B stated yes.