STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525447	A. Building B. Wing	07/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillside Manor	803 S University Ave Beaver Dam, WI 53916

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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that each resident received treatment and care in accordance with professional standards of practice (N6, Wisconsin Nurse Practice Act) for 1 out of 4 sampled residents (R1) by failing to serve R1 the correct diet and failing to administer first aid (Heimlich Maneuver) timely when R1 experienced a choking episode. R1 experienced a choking episode that required the Heimlich maneuver to clear R1's airway. The facility did not complete all assessments of Vital Signs (VS) and respirations over the next 24 hours. At supper the following day, the facility did not ensure that R1 received the proper downgraded diet of bite sized and soft food items. R1's meal card indicated R1 could be served a dinner roll, which was served. R1's new downgraded diet does not allow dinner rolls. R1 experienced another choking episode prior to leaving the dining room from supper. First aid (Heimlich maneuver) was not administered immediately and R1 expired. The facility's failure to complete frequent and thorough assessments, failure to provide the proper diet, and failure to administer first aid immediately created a finding of immediate jeopardy that began on 6/24/25. INHA A (Interim Nursing Home Administrator) and INHA B were notified of the immediate jeopardy on 7/9/25 at 3:35 PM. The immediate jeopardy was removed on 7/21/25, however, the deficient practice continues at a scope severity of a D (Potential for more than minimal harm/isolated) as the facility continues to implement its action plan.Findings include: According to the Wisconsin Nurse Practice Act, N6.03(1), An R.N. (Registered Nurse) shall utilize the nursing process in the execution of general nursing procedures in the maintenance of health, prevention of illness or care of the ill. The nursing process consists of the steps of assessment, planning, intervention, and evaluation. This standard is met through performance of each of the following steps of the nursing process: (a) Assessment. Assessment is the systematic and continual collection and analysis of data about the health status of a patient culminating in the formulation of a nursing diagnosis. (b) Planning. Planning is developing a nursing plan of care for a patient which includes goals and priorities derived from the nursing diagnosis. (c) Intervention. Intervention is the nursing action to implement the plan of care by directly administering care or by directing and supervising nursing acts delegated to L.P.N.s (Licensed Practical Nurse) or less skilled assistants. (d) Evaluation. Evaluation is the determination of a patient's progress or lack of progress toward goal achievement which may lead to modification of the nursing diagnosis.The International Dysphagia Diet Standardization Initiative (IDDSI) website's (https://www.iddsi.org/) IDDSI Framework and Detailed Level Definitions, dated July 2019, states, in part: 6 Soft and Bite-Sized Description/characteristics.soft, tender and moist throughout but with no separate thin liquid.Food Specific or Other Examples: .Bread No regular dry bread, sandwiches, or toast of any kind. The website's Frequently Asked Questions page, (USIRGFAQExceptionsBreadsMixedConsistencyJan2025.pdf), dated January 2025, states, in part: . Part 1: Bread.Soft and Bite-Size, Level 6 and Minced and Moist, Level 5 do not include regular dry bread, sandwiches, or toast of any kind, even if they are cut-up to the appropriate size indicated for each diet level. Use pre-gelled soaked breads that are very moist and gelled through the entire product. The facility's Life Support Certifications and Course Requirements policy, dated 2/17/25, states, in part: .The purpose of this document is to establish and outline standards for facility's American Heart Association (AHA) Training Center and facility life support requirement. This policy is complimentary to the AHA Center standards. 3.1 Managing Certifications a. Certifications in BLS (Basic Life Support) .are recognized solely from the AHA.The facility's first aid training, Basic Life Support Provider Manual eBook, undated, states, in part: Choking Relief in a Responsive Adult or Child: Abdominal Thrusts Use abdominal thrusts to relieve choking in a responsive adult or child.Choking Relief in an Unresponsive Adult or Child. A choking victim's condition may worsen, and the victim may become unresponsive. If you are aware that a foreign-body airway obstruction is causing the victim's condition, you will know to look for a foreign body in the throat. To relieve choking in an unresponsive adult or child, follow these steps: 1. Shout for help. If someone is available, send that person to activate the emergency response system. 2. Gently lower the victim to the ground if you see that they are becoming unresponsive. 3. Being CPR, starting with chest compressions. Do not check for a pulse. Each time you open the airway to give breaths, open the victim's mouth wide. Look for the object. A. if you see an object that looks easy to remove, remove it with your fingers. B. If you do not see an object, continue CPR. 4. After about 5 cycles or 2 minutes of CPR, activate the emergency response system if someone has not already done so Heimlich Maneuver works by using the air in the lungs to push an object

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not ensure that each resident receives adequate supervision to prevent accidents for 1 of 2 Residents (R3) reviewed for dining supervision.R3 is care planned for feeding assistance and direct supervision with meals and was observed eating in dining room with no staff seated at table.Evidenced by:Surveyor requested dining / meal supervision policy. NHA A (Nursing Home Administrator) indicated that the facility does not have a separate policy, but follows state and federal regulations for adequate supervision for residents as denoted on the individual care plan.R3 was admitted to the facility on [DATE] and has diagnoses that include Parkinson's disease with dyskinesia (a progressive neurological disorder that primarily affects movement, causing symptoms like tremors); dementia in other diseases classified elsewhere, unspecified severity, with mood disturbance (a decline in mental ability severe enough to interfere with daily life); dysphagia, unspecified (difficulty swallowing foods or liquids, ranging from mild difficulty to complete and painful blockage); essential tremor (a neurological condition causing involuntary rhythmic shaking, most commonly in the hands).R3's most recent quarterly Minimum Data Set (MDS) indicates a Brief Interview of Mental Status (BIMS) score of 4, indicating moderate to severe cognitive impairment.R3's care plan states, in part; *4/10/25 Nutritional Problem: I have a significant tremor which is now worsening which places limitations on my ability to feed myself independently. I now require feeding assistance by staff.general set up assistance as well as direct supervision and cuing and feeding assistance. *4/20/25 Nurse aide-monitor me for any increase difficulty with my chewing and/or swallowing abilityR3's Speech Therapy Discharge summary, dated [DATE], states, in part: Pt (patient) and care staff will utilize safety of swallow guidelines including upright positioning, slow rate, small bites, alternating liquids and solids, clearing mouth before next bite, cues to remain on task, continue with meal; assistance in drinking and eating if patient demonstrates weakness or difficulty. Discharge 1/30/25.with support from care staff for safety of swallow guidelines.On 7/8/25 at 8:48 PM, Surveyor observed R3, seated at dining room table alone, feeding himself mandarin oranges and drinking Glucerna (liquid supplement). CNA J (Certified Nursing Assistant) was seated with her back towards R3, at another table, assisting 2 residents with their meals. CNA T entered the dining room at 9:03 AM with another resident and served that resident their meal. On 7/8/25 at 9:03 AM, Surveyor interviewed CNA T and asked if R3 needed assistance with meals. CNA T stated, I don't think so. CNA T then left the dining room.On 7/8/25 at 9:12 AM, CNA J approach Surveyor indicating her departure from the dining room. Surveyor asked CNA J if CNA J was allowed to leave the dining room as no staff members would be in the room and 2 residents were still eating. CNA J stated that the residents in the dining room were from another hall and that hall's staff should be returning to the dining room. Surveyor asked CNA J to remain in dining room. Surveyor asked CNA J if any residents in the dining room needed assistance with meals. CNA J stated that R3 needed assistance when his blood sugar was low. CNA J stated that CNA J would assist R3 if working on his hall. Surveyor asked CNA J how a CNA is aware that someone needs assistance with meals. CNA J stated when a resident is sluggish or not awake/not feeding themselves; a CNA can see that they need help. Surveyor asked if there is any documentation that tells the CNA that a resident needs assist. CNA J stated that in the computer charting it would say assistance with meals. Surveyor asked if there was anything in R3's charting stating that R3 needed assistance. CNA J stated not in the CNA charting, as far as I know.On 7/8/25 at 4:34 PM, Surveyor reviewed R3's care plan with ADON D (Assistant Director of Nursing) and asked about the meaning of direct supervision, cuing, and feeding assistance. ADON D stated that it meant that someone should be sitting at the table with R3 and assisting R3 with eating.

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the resident and his/her doctor meet face-to-face at all required visits. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure residents were seen by a physician every 30 days for the first 90 days after admission and every 60 days thereafter for 1 of 1 residents (R1) reviewed for physician visits. R1 was not seen by a provider at least once every 30 days for the first 90 days after admission.This is evidenced by:Facility policy, titled Physician Visits Policy, reviewed 12/31/24, includes: The physician needs to see a newly admitted resident at a minimum of once every 30 days for the first 90 days and then at least every 60 days thereafter.R1 was admitted to the facility on [DATE] with diagnoses that include, in part: unspecified dementia, severe, with mood disturbance (a condition with a decline in mental ability severe enough to interfere with daily life); unspecified dementia, severe, with anxiety; other persistent atrial fibrillation (a heart rhythm disorder which leads to the heart beating irregularly and rapidly); muscle weakness-generalized.R1 was seen by his physician on 3/12/25.There is no evidence of R1 being seen by a physician in April, therefore missing a 60-day visit after admission.On 7/21/25 at 10:00 AM, ADON D (Assistant Director of Nursing) stated, There should be a physician's visit and signed orders for April, but they were missed.On 7/21/25 at 11:21 AM, INHA B (Interim Nursing Home Administrator) indicated R1 should have had a physician visit at 30 days, 60 days, and 90 days from her admission, but the 60 days visit was missed.