STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525452	A. Building B. Wing	11/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elroy Health Services	307 Royall Ave Elroy, WI 53929

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40824 Based on interviews, record review, and facility policy reviews, the facility failed to ensure that privacy was maintained for one resident (R1) of 14 residents reviewed. Specifically, R1's positive COVID status was announced in front of residents and a hospice staff member. Additionally, the Social Services Director (SSD) discussed R1 not following the facility's smoking protocol in the common area making R1 feel scared and uncomfortable. Findings include: Review of the undated facility's policy titled, Rights of Residents in Wisconsin Nursing Facilities included .The facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality .The resident has a right to personal privacy and confidentiality of his or her personal and medical records .The facility must respect the resident's right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications . Review of the facility's policy titled, Protecting & Ensuring Resident Rights revised 07/2022 stated .3. All staff will be advocates for resident rights 4. All staff will receive training on resident rights prior to assignment as well as at least annually . Review of R1's Admission Record located in the Electronic Medical Record (EMR) under the Resident tab indicated that she was admitted to the facility on [DATE] with a primary diagnosis of cervical disc disorder at C4-C5 (cervical spine) level with myelopathy (spinal cord compression resulting in weakness, numbness, and tingling). Review of R1's Care Plan located in the EMR under the Care Plan tab revised 06/17/24 included smoking status and a revision on 10/22/24 indicating R1 had been COVID positive requiring quarantine for ten days (10/20/24-10/30/24). Review of R1's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 09/11/24 located in the EMR under the MDS tab included a Brief Interview for Mental Status (BIMS) score of 15 out of 15 indicating that she was cognitively intact. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R1's Order Summary located in the EMR under the Orders tab confirmed that she was diagnosed with COVID and required contact and droplet isolation from 10/22/24-10/31/24. Review of Certified Nursing Assistant's (CNA1) Relias training provided by the facility included Health Insurance Portability and Accountability Act (HIPAA) training on 06/30/24. Review of Social Services Director (SSD) Relias training provided by the facility included Communicating Effectively on 09/03/24, HIPAA on 05/31/24, Customer Service 08/15/24, and Resident Rights on 03/04/24. During an interview on 11/07/24 at 1:59 PM with CNA1 confirmed that she had gone outside to look for another resident and R1 asked her why she couldn't have a shower herself. CNA1 responded you can't be showered because you have COVID. CNA1 confirmed that there were at least two other residents outside. R1 seemed to be upset with her that another resident was going to be showered and not her. CNA1 confirmed that she should not have discussed her health status in front of other residents but didn't think about it until after she had already said it. During an interview on 11/07/24 at 5:15 PM with R1 she stated that when she had COVID in October 2024, she was outside smoking and CNA1 came outside looking for R15. R1 told CNA1 she hadn't had a shower in 13 days and asked why she couldn't go to the shower room, that's when CNA1 told her because R15 doesn't have COVID and you do. There was a lady in her car (CNA7) that heard this comment. R1 said it offended her that CNA1 voiced her personal health information in front of residents and the hospice CNA. R1 confirmed that she was not on hospice services and that CNA7 did not provide care for her. CNA7 told R1 that CNA1 should not have discussed her COVID status in front of other residents and herself. On another occasion, she had returned from a doctor's appointment and needed to use the restroom. Instead of stopping and turning in her smoking materials, she went straight to her room to use the restroom. The SSD and DON came up to her, began yelling at her for not turning in the smoking materials immediately. The SSD kept getting closer and closer to her wheelchair, he kept yelling at her and would not stop. R1 stated that she felt afraid of him, yelled back at him, and then went outside to get away from him. R1 stated that SSD was verbally attacking her, but did not feel this was abuse. The UC (Unit Clerk) approached her once she returned into the building and offered to give her a hug and told her she didn't deserve that, meaning the SSD did should not have spoken to her in that way. During an interview on 11/08/24 at 9:30 AM with CNA7 confirmed that in October 2024 she recalled sitting in her car outside the facility when she heard CNA1 tell R1 that she couldn't have a shower because she had COVID. There were other residents sitting outside and were able to hear her say this. During an interview on 11/08/24 at 2:30 PM with Unit Coordinator (UC) confirmed that the DON and SSD caught R1 at the front door telling her that she knew the smoking rules and SSD was badgering R1. R1 said leave me alone and he kept going and going. SSD was being stern about smoking and how she needed to give her cigarettes back. R1 did not seem scared, but did seem mad. R1 yelled at SSD to leave me the f*** alone! The incident occurred at the front entrance of the facility where other residents, visitors, and staff could hear the incident. UC stated she did not feel that R1 should have been reprimanded in front of visitors, residents, and other staff. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/08/24 at 3:25 PM with SSD stated that on the day in question, R1 had returned from a doctor appointment when one of the nurses reported to him that R1 had not turned in her smoking materials. The SSD approached her, and she began swearing at him, was belligerent and then went outside to smoke. The SSD denied raising his voice to R1 and did not touch her or the wheelchair. During an interview on 11/08/24 at 3:35 PM, the Director of Nursing (DON) confirmed that she recalled the day that R1 came in the building after returning from a doctor appointment and did not immediately turn in her smoking materials. She did not recall the SSD yelling at R1 but did confirm that R1 yelled at the DON and SSD. Herself and the SSD did have to raise their voice so that R1 could hear them while she was yelling. The DON did not confirm or deny the conversation was inappropriate. The DON's expectation was that all resident's medical information be kept confidential and she was not aware that CNA1 had announced R1's COVID status in front of other residents and a hospice staff member. The DON confirmed that CNA1 should not have voiced R1's medical status in front of other residents or visitors.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40824 Based on interviews, record review, and facility policy reviews, the facility failed to ensure that activities of daily living (ADL) assistance was provided for 1 resident (R1) of 15 residents reviewed for ADLs. Specifically, R1 was not provided assistance with showering/bathing for 21 days while on COVID quarantine. Findings include: Review of the facility's policy titled, Activities of Daily Living (ADLS) revised 07/26/24 stated The facility will, based on the resident's comprehensive assessment and consistent with the resident's needs and choices, ensure a resident's abilities in ADLs do not deteriorate unless deterioration is unavoidable. Care and services will be provided for the following activities of daily living: 1. Bathing, dressing, grooming and oral care . Review of the facility's Shower Schedule provided by the facility indicated that R1 was to be showered on Monday's of each week. Review of Critical Event Analysis and Action Plan Worksheet provided by the Administrator and dated 11/06/24, indicated action was needed regarding bathing/showers. Education was to be provided to staff on appropriate documentation of bathing/showers. Additionally, audits were to be done twice weekly to ensure that residents received their scheduled showers. This was to continue for four weeks. The audit form provided was empty. Review of R1's Admission Record located in the Electronic Medical Record (EMR) under the Resident tab indicated that she was admitted to the facility on [DATE] with a primary diagnosis of cervical disc disorder at C4-C5 (cervical spine) level with myelopathy (spinal cord compression resulting in weakness, numbness, and tingling). Review of R1's Care Plan located in the EMR under the Care Plan tab revised 05/23/24 indicated that she had ADL self-care deficit as evidenced by weakness and required bathing/showering assist of one staff member as needed and as desired. Review of R1's 5-Day Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 09/11/24 located in the EMR under the MDS tab included a Brief Interview for Mental Status (BIMS) score of 15 out of 15 indicating that she was cognitively intact. Section G indicated that R1 was independent with oral hygiene and was dependent on showering/bathing. Set-up assistance was required with upper/lower body dressing and personal hygiene. Review of R1's Order Summary located in the EMR under the Orders tab confirmed that she was diagnosed with COVID and required contact and droplet isolation from 10/22/24-10/31/24. Review of R1's Documentation Survey Report v2 provided by the facility dated 10/2024 revealed R1 did not receive showering/bathing services from 10/09/24 to 10/29/24. No documentation was made to indicate the resident had refused showering/bathing services. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/07/24 at 1:59 PM with CNA1 stated that she was one of the shower aides and that residents received showers Monday through Friday based on the shower schedule. CNA1 confirmed that R1 was to receive showers on Mondays. CNA1 stated residents on COVID quarantine were to receive bed baths to reduce the risk of exposure to other residents. Sometimes the residents do not receive their showers on the designated days due to being short staffed. She will try to bathe them the following day but sometimes that is not possible. CNA1 did not recall R1 refusing any showers and could not recall if R1 was offered a shower/bath during her COVID quarantine. If a resident refused a shower that should be indicated in the CNA documentation also known as Documentation Survey Report v2. During an interview on 11/07/24 at 5:15 PM with R1 she stated that she had not received a shower/bath in over two weeks while she was on COVID quarantine in October 2024. Additionally, no one gave her any washcloths and no one helped her change her clothes for at least five days. R1 had reported this to multiple CNAs and no one assisted her. During an interview on 11/08/24 at 3:35 PM the Director of Nursing (DON) stated that the facility policy was for residents to receive a shower at least once weekly per the shower schedule, R1 was to have showers on Mondays. If a resident was on COVID quarantine, they could still receive a shower at the end of the shift so the shower stall could be disinfected. The DON stated that when there are call-in's she calls nurses/CNA's to cover the shifts, she had worked as a CNA multiple times over the past few months. Shower aides are sometimes pulled to the floor, when this happened they try to move the showers to other days. During COVID they were very low on staff and the last month and a half, they have been short staffed due to positive cases. The DON stated that R1 had been offered showers during COVID but the resident declined to be showered. Upon review of R1's shower documentation, the DON confirmed that R1's CNA documentation indicated that she had not been showered from 10/09/24 to 10/29/24. Her expectation was for residents to be showered at least once weekly and on non-shower days they should be given a bed bath daily. If a resident refused to be bathed/showered the CNA was expected to document refused as opposed to na (not applicable). During an interview on 11/09/24 at 6:25 PM with the Administrator, he stated that he was not aware of R1 not receiving showers and that the expectation was for residents to receive a shower at least once weekly and on non-shower days they should receive a bed bath. The facility had a past non-compliance plan in place regarding showers and CNA documentation. The expectation was for CNA's to document refused on the shower task documentation in the EMR rather than NA. The Administrator provided a copy of the document titled Critical Event Analysis and Action Plan Worksheet indicating that on 11/06/24 action was needed regarding bathing/showers. Education was to be provided to staff on appropriate documentation of bathing/showers. Additionally, audits were to be done twice weekly to ensure that residents received their scheduled showers. This was to continue for four weeks. The audit form provided was empty and the Administrator stated that they had not yet done any audits. Education was sent electronically to CNA's on 11/09/24 at 11:06 AM. The Administrator was informed this was part of his performance improvement plan due to implementation not starting until after the complaint investigations had began.

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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** 40824 Based on record reviews, interviews, and facility policy reviews, the facility failed to ensure that quality of care/treatment were provided to one resident (R6) of 12 sampled residents. Specifically, the facility failed to provide a timely assessment for R6 after she sustained a fall. Findings include: Review of the policy titled Fall Prevention and Management Guidelines revised on 07/18/24 and provided by the facility stated, .When a resident experiences a fall, the facility will: A. Complete a post-fall assessment and review: 1) Physical assessment with vital signs 2) Neuro checks for any unwitnessed fall or witnessed fall where resident hits their head: Initially, then hourly x 3 then continue neuro checks every 4 hours x 6, then continue neuro checks every 8 hours x 6 or as indicated by the physician. Alert MD [Medical Doctor] of any abnormal findings from neuro checks - do not wait until series is complete to notify MD of abnormal findings .B. Complete an incident report in Risk Management. C. Notify physician and family/responsible party. D. Review the resident's care plan and update with any new interventions put in place to try to prevent additional falls. E. Document all assessments and actions. F. Obtain witness statements from other staff with possible knowledge or relevant information . The facility did not provide a policy related to following physician's orders. Review of R6's Admission Record located in the EMR under the Profile tab revealed she was admitted to the facility on [DATE] with a primary diagnosis of seizures. Review of R6's Care Plan provided by the facility indicated she was at risk for falls, had a history of poor safety awareness and did not always call for staff assistance for transfers/ambulation. R6 required one person assist with a gait belt for all transfers. Review of R6's Quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 10/21/24 included a BIMS (Brief Interview Mental Status) score of nine out of 15 indicating she was moderately cognitively impaired and had two or more falls since admission and used a walker or wheelchair for ambulation. Review of R6's Fall Investigation, provided by the facility revealed she had an unwitnessed fall on 09/21/24 at 12:30 AM. No mention of the nurse assessing the resident was in the fall investigation. Unspecified CNAs (Certified Nursing Assistant) heard the resident yelling, upon entering her room, she was noted to be sitting on her buttocks next to her bed. R6 reported to staff that she had been transferring herself to her wheelchair. Review of R6's Telehealth Visit Note located in the EMR (Electronic Medical Record) under the Progress Notes tab by the physician dated 09/21/24 at 11:28 PM included reference to an unwitnessed fall over 24 hours ago that was never reported. R6 was noted with no injuries per physician report. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R6's Progress Note/SBAR (Situation/Background/Assessment/Recommendation) located under the Progress Notes tab and dated 09/22/24 at 12:06 AM stated On 09/21/24 at approximately 12:30 AM CNAs heard resident yelling at the nursing desk. Upon entering resident's room resident was sitting on butt next to bed. She said that she had been transferring herself to her w/c [wheelchair]. She denies hitting head . During an interview on 11/07/24 at 3:19PM with CNA2 confirmed that R6 fell out of bed a while back while Registered Nurse (RN3) was on duty. Herself and another CNA, she could not recall who it was, were instructed to get R6 up and into her wheelchair. CNA2 did not see RN3 assess the resident. When they found R6 on the floor the pressure pad alarm was not in the on position, the wheelchair was near the bed and was not locked, and the resident had a history of self-transferring with a lack of safety awareness. During an interview on 11/08/24 at 8:19 PM with RN3 confirmed that R6 had sustained a fall in September 2024 during the night shift, she had been busy with another resident when the aides reported the fall to her. The next thing she knew, she saw R6 in the bird room near the front entrance. RN3 confirmed that she failed to report the fall until the next day and the physician was upset with her. It was at that time [the next day] that she assessed the resident and started the fall investigation documentation. RN3 confirmed that all falls should be reported at the time of the fall or as soon as practicable. During an interview on 11/08/24 at 8:45 PM with CNA8 confirmed that R6 had sustained a fall in September 2024 on the night shift. CNA8 confirmed helping to get her up off the floor. He was unable to recall any further details regarding the falls. During an interview on 11/09/24 at 3:52 PM with the DON confirmed that RN3 was the nurse on duty on 09/21/24 night shift when R6 sustained a fall. Review of documentation confirmed that RN3 did not assess the resident until the next day. The DON's expectation was that all residents that sustain a fall be assessed at that time, the staff should not move the resident until assessed by the nurse, and the fall should be reported immediately to the family, physician, and administrative staff.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40824 Based on record reviews, interviews, and facility policy reviews the facility failed to ensure that qualify of care/treatment were provided to 1 residents (R3) of 12 sampled residents. Specifically, the facility failed to follow physician orders related to wound care for R3. Findings include: Review of the policy titled Pressure Injuries and Non pressure Injuries revised 07/20/22 and provided by the facility stated, .For those residents admitted with, or who subsequently developed a pressure injury or impaired skin integrity, they will receive care, treatment, and services that seek to promote healing, prevent infection, and prevent further development of pressure injuries/impaired skin integrity . The facility did not provide a policy related to following physician's orders. Review of R3's Admission Record located in the Electronic Medical Record (EMR) under the Profile tab revealed she was admitted to the facility on [DATE] with a primary diagnosis of heart failure. Review of R3's Care Plan provided by the facility indicated she required extensive assistance with repositioning, transferring, hygiene, and bathing. The care plan also included a status of multiple pressure ulcers requiring wound care assessment, monitoring, and treatment. R3 was incontinent of bowel and bladder and resistive to turning and repositioning. Review of R3's Significant Change in Status Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/04/24 included a Brief Interview for Mental Status (BIMS) score of 4 out of 15 indicating she was severely cognitively impaired and had multiple pressure ulcers. Review of R3's Order Summary, provided by the facility and dated 08/27/24, included cleansing the wound to the left hip with wound cleanser, apply skin prep to peri wound (allow to dry), apply calcium alginate (wound treatment to aide in healing) to wound bed, cover and secure with foam border twice daily unless soiled. Review of the Medication Admin Audit Report provided by the facility indicated that R3's wound care was performed by Registered Nurse (RN1) on 09/09/24 at 9:46 PM. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Investigation Summary, dated 09/09/24 and provided by the facility, revealed that the facility was made aware on 09/12/24 that on 09/09/24 RN1 did not complete wound treatment according to the most recent treatment orders for R3. A witness statement by Certified Nursing Assistant (CNA6) indicated that RN1 put medi honey on the wound and then wiped it off with gauze or paper towel. A witness statement by R3 indicated that RN1 .came in she went to use the medihoney [sic] & R3 told her we weren't using that anymore, it burns so she went and checked the computer and then wiped it off and put the new stuff on . Review of a witness statement by RN1, dated 09/09/24, stated she was called to R3's room, the dressing was saturated. She removed the dressing and used spray wound cleanser onto a piece of paper towel to clean up the peri-wound and pat the area dry. She took another piece of paper towel and sprayed it with wound cleanser and gently patted the wound noting a piece of dark slough, it stuck to the dry paper towel and the tissue came off. An abdominal pad and opsite (waterproof dressing) was applied to the wound. Additionally, RN1 reported that the facility was out of calcium alginate (a gelatinous, cream-colored substance that's used in wound dressings and in other application). Review of the facility document titled, Employee Disciplinary Form, dated 09/12/24, indicated that RN1 did not follow doctor orders. Specifically, the wrong medication was applied to the wound and she used paper towel to cleanse a wound. During an interview on 11/08/24 at 3:35 PM the Director of Nursing (DON) stated that during her investigation of R3's wound care indicated that CNA6 witnessed RN1 applying medi honey to R3's wound. CNA6 and RN1 had been in R3's room together for wound care. The DON confirmed that the facility investigation revealed RN1 did not follow physician orders by using medi honey and paper towels to clean the wound. RN1 was terminated in September 2024 after this incident and another incident where she did not assess residents being admitted to the facility. R3 refused to be interviewed 11/07/24-11/09/24. RN1 was not available for interview.