STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525461	A. Building B. Wing	11/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pavilion at Glacier Valley	1900 American Eagle Dr Slinger, WI 53086

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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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 32768 Based on observation, staff and resident interview, and record review, the facility did not ensure sufficient staffing was provided to meet the needs of 5 residents (R) (R30, R11, R17, R50, and R26) of 25 sampled residents with the potential to affect additional residents. The facility had low staffing on 4/14/24, 5/11/24, 5/12/24, and 6/23/24. On 11/10/24, R30 activated R30's call light for assistance with toileting on multiple occasions. Staff turned off R30's call light without providing assistance. On 11/10/24, R11 activated R11's call light for assistance to bed. Certified Nursing Assistant (CNA)-Y turned off R11's call light and left the room without assisting R11. On 11/10/24, R17 activated R17's call light for assistance to bed. CNA-Z turned off R17's call light and left the room without assisting R17. On 11/10/24, R50 activated R50's call light for an evening snack. Licensed Practical Nurse (LPN)-F turned off R50's call light and left the room without providing a snack. R26 did not consistently receive scheduled showers. Findings include: The facility's Staffing Policy, dated 5/5/23, indicates: The facility will implement strategies to mitigate staffing shortages during times of illness, pandemic, or additional situations that may lead to decreased numbers of available staff. The facility will adjust staffing needs to include day, evening, and night shifts based on changes in the resident population .1. The facility will collaborate with Human Resources and regional personal to implement staffing strategies to mitigate staffing shortages in any department. 2. The facility will attempt to ascertain reasons or root causes for staff unavailability for work and address as practicable and able. Low Staffing: (continued on next page)

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

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility calculates the number of CNAs and Registered Nurses (RNs) by the following formula: 3.08 times the census = total hours to schedule per day divided by 8 = number of staff to schedule per shift On 11/12/24, Surveyor reviewed the facility's staffing schedules from 4/1/24 to 6/30/24. Surveyor identified 4 weekend days in April, May, and June where the facility was low on staff. On 4/14/24, the facility had a census of 78 and required 240 staffing hours for the day. The facility had 199.8 hours scheduled and was down 4 CNAs due to call-ins and/or no-shows. On 5/11/24, the facility had a census of 73 and required 224 staffing hours for the day. The facility had 186.4 hours scheduled and was down 4 CNAs due to call-ins and/or no-shows. On 5/12/24, the facility had a census of 72 and required 221 staffing hours for the day. The facility had 201.8 hours scheduled and was down 3 CNAs due to call-ins and/or no-shows. On 6/23/24, the facility had a census of 77 and required 237 staffing hours for the day. The facility had 192.5 hours scheduled and was down 2 CNAs due to call-ins and/or no-shows. On 11/12/24 at 3:08 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A who indicated the facility had low staffing on the above mentioned days and couldn't get coverage. NHA-A indicated the facility tries to call agency, other staff, or have nurse managers cover, but they couldn't find anyone on those days. Call Lights: On 11/10/24 (Sunday) at 2:46 PM, Surveyor observed a CNA enter R30's room, turn off the call light, and exit the room. On 11/10/24 at 3:36 PM, Surveyor interviewed R30 who indicated R30 activated the call light to use the bathroom, but a CNA turned off the call light and left to get another staff and a lift. R30 indicated it was the fourth call R30 had made since 12:00 PM; the first and second calls were on the AM shift and the third and fourth calls were on the PM shift. R30 did not know the CNAs' names. R30 indicated R30 was incontinent of a small amount of urine due to the wait and felt like a second-class citizen. On 11/10/24 at 3:40 PM, Surveyor observed Medication Technician (MT)-T enter R30's room, ask about R30's concern, and turn off R30's call light to address another resident's fall. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/10/24 at 6:40 PM, Surveyor observed R11 enter the hallway from R11's room in a wheelchair. R11 was visibly upset and stated, For cripes sake, he turned my light out and said he needs to find a lift, but the lift is sitting right there. Surveyor observed a mechanical lift in the hallway near R11's room. R11 indicated a male CNA entered R11's room, turned off R11's call light, went to help a resident across the hall, and did not return. R11 indicated the lift needed to transfer R11 had been in the same spot for 15 minutes, however, that was the excuse given why R11 was not assisted. R11 stated, I am not dumb. R11's roommate (R57) then exited the room and stated to CNA-Y, You guys need to realize when they (residents) turn their lights on it is because they need someone to help them, and you should not turn it (call light) off. R11 indicated staff frequently turn call lights off and don't provide timely care on the weekends. On 11/10/24 at 6:47 PM, Surveyor interviewed CNA-Y who confirmed CNA-Y turned off R11's call light without assisting R11. CNA-Y indicated CNA-Y needed a second staff to assist with the transfer and a second staff was not available. On 11/10/24 at 7:20 PM, Surveyor observed R17 in a recliner and noted R17's call light was activated. Surveyor interviewed R17 who stated R17 wanted to go to bed. R17 said R17's call light had been on for an hour now. On 11/10/24 at 7:21 PM, Surveyor observed CNA-Z turn off R17's call light and exit the room. Surveyor also observed CNA-Z turn off a call light across the hall and exit the room. Surveyor interviewed CNA-Z who confirmed CNA-Z turned off R17's call light without providing assistance because CNA-Z needed to get a lift. Surveyor observed CNA-Z go to the 500 wing and start to move a lift in the hallway. When Surveyor turned to leave, CNA-Z stopped moving the lift and went to do something else. On 11/10/24 at 7:31 PM, Surveyor observed R17 still sitting in the recliner. R17's head was down and R17 appeared to be asleep. R17 had not been assisted to bed yet. On 11/11/24 at 11:39 AM, Surveyor interviewed NHA-A who was not aware of the incidents and indicated NHA-A would start an investigation. Showers: On 11/10/24 at 12:44 PM, Surveyor interviewed R26 who indicated R26 was supposed to receive two showers per week but did not consistently receive them. Surveyor reviewed R26's shower documentation for the past three months which was in the form of weekly skin checks and shower sheets that were not consistently completed and didn't always indicate if R26 had a shower or a bed bath. Documentation indicated showers were given or refused by R26 on 10 of 26 opportunities since 8/1/24. On 11/12/24 at 3:32 PM, Surveyor interviewed Director of Nursing (DON)-B who indicated showers were a problem for awhile and the facility was working to restructure them. DON-B indicated the facility was going trial a shower aide the following week. Staff Interviews: (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/11/24 at 10:34 AM, Surveyor interviewed CNA-DD who indicated staffing was a concern at times and CNA-DD sometimes had to care for a wing of 13 residents. CNA-DD indicated when the census is low on the rehab unit, there is no CNA on the night (NOC) shift. CNA-DD indicated CNA-DD has found that residents were not changed during the night. On 11/11/24 at 10:41 AM, Surveyor interviewed RN-E who indicated the facility had enough staff to care for residents unless there was a call in. RN-E indicated call light response times become longer when many residents make requests at the same time. On 11/11/24 at 10:49 AM, Surveyor interviewed Med Tech (MT)-G who indicated there were not enough staff to care for residents and indicated the facility did not find replacements for call ins. MT-G indicated there was turnover at the facility because CNAs quit when they felt they could not give good care. On 11/11/24 at 10:53 AM, Surveyor interviewed CNA-AA who indicated it is hard to find a replacement if someone calls in. CNA-AA indicated residents frequently complain about call light response times especially on the PM and NOC shifts.

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42423 Based on staff and resident interview and record review, the facility did not ensure medications were administered within the ordered timeframe for 1 resident (R) (R1) of 6 sampled residents. R1's medications were administered late on 7/29/24, 8/2/24, 10/28/24, 10/30/24, and 11/7/24. Findings include: The facility's Medication Management Program policy, with a revision date of 5/5/23, indicates: .7. Medications are administered no more than one hour before to one hour after the designated medication pass time .11. Immediately after administering the medication to the resident, the authorized staff or licensed nurse will return to the medication cart and document medication administration with initials on the MAR (Medication Administration Record). From 11/10/24 to 11/12/24, Surveyor reviewed R1's medical record. R1 was admitted to the facility on [DATE] and had diagnoses including traumatic brain injury (TBI), non-pressure chronic ulcer of skin of other sites limited to breakdown of skin, pain, and dysphagia (difficulty swallowing). R1's Minimum Data Set (MDS) assessment, dated 10/18/24, had a Brief Interview for Mental Status (BIMs) score of 15 out of 15 which indicated R1 was not cognitively impaired. On 11/11/24, Surveyor reviewed the facility's grievance file which included a grievance from R1's Power of Attorney (POA) (POA-J) that indicated R1's 8:00 PM medications were given at 10:00 PM on 8/2/24. R1's medical record indicated R1's medications were also administered late on 10/30/24, 11/4/24, and 11/7/24. On 11/11/24, Surveyor interviewed Director of Nursing (DON)-B who provided the following information: ~ On 7/29/24, R1's 8:00 AM medications (Abilify, amiloride, Breo Ellipta, buspirone, calcium antacid, Eliquis, eye drops, fluticasone propionate nasal spray, gabapentin, levetiracetam, levocarnitine, Lexapro, metoprolol succinate, Miralax, olopatadine drops, oxybutynin, phenobarbital, potassium chloride, Senna-S, topiramate, and UTI-Stat) were not administered until after 10:10 AM. Per DON-B, an agency nurse arrived one hour late and needed a password reset in order to access residents' medical records. DON-B indicated the nurse also did not follow the direction to administer (R1's) medications first. ~ On 8/2/24, R1's 4:00 PM medications (Acidophilus, eye drops, methimazole, multiple vitamins and potassium chloride) were administered at 5:37 PM. A note in R1's MAR indicated the medications were administered, however, they were charted late. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	~ On 8/2/24, R1's 8:00 PM medications (buspirone, calcium antacid, Eliquis, eye drops, gabapentin, levetiracetam, levocarnitine, melatonin, olopatadine drops, oxybutynin, phenobarbital, Senna-S, and topiramate) were not administered until 10:02 PM. A note in R1's MAR indicated the medications were administered, however, they were charted late. A grievance submitted by POA-J on 8/2/24 had a summary of findings that noted, Medication was given late by agency nurse. Nurse failed to follow facility protocol for medication administration and med error occurrence. Despite having been given verbal direction by administration. ~ On 10/28/24, R1's 5:00 AM medication (omeprazole) was not administered until 8:01 AM. No information was provided for the medication. ~ On 10/30/24, R1's 12:00 PM medications (busiprone, calcium antacid, ergocalciferol, eye drops, fexofenadine, gabapentin, levocarnitine, and topiramate) were not administered until 2:55 PM. Per DON-B, the medication administration delay was due to a resident in respiratory distress at 12:00 PM and three room moves that occurred between 10:30 AM and 2:00 PM. ~ On 11/4/24, R1's 8:00 AM medications (Abilify, amiloride, Breo Ellipta, buspirone, calcium antacid, Eliquis, eye drops, fluticasone propionate nasal spray, gabapentin, levetiracetam, levocarnitine, Lexapro, metoprolol succinate, Miralax, olopatadine drops, oxybutynin, phenobarbital, potassium chloride, Senna-S, topiramate, and UTI-Stat) were administered late. Per DON-B, R1 was picked up at 6:45 AM for an early morning appointment and returned at 9:45 AM. ~ On 11/7/24, R1's 4:00 PM medications (Acidophilus, eye drops, methimazole, multiple vitamins and potassium chloride) were not administered until 5:05 PM. Per DON-B, another resident was sent to the emergency room (ER) at 3:10 PM. R1 returned from an appointment at 3:30 PM and another resident fell at 3:40 PM. ~ On 11/7/24, R1's 8:00 PM medications (buspirone, calcium antacid, Eliquis, eye drops, gabapentin, levetiracetam, levocarnitine, melatonin, olopatadine drops, oxybutynin, phenobarbital, Senna-S, and topiramate) were documented as administered at 9:18 PM. R1's medical record indicated charted late. On 11/10/24 at 6:51 PM, Surveyor interviewed R1 who indicated R1's medications were administered late at times. On 11/11/24 at 9:45 AM, Surveyor interviewed POA-J who indicated POA-J had concerns with R1's medications being administered late. On 11/12/24 at 9:42 AM, Surveyor interviewed DON-B who indicated medication pass had gotten better since the facility had Med Techs and nurses pass medication. DON-B indicated staff were educated to not interrupt Med Techs and nurses during medication pass and to go to their supervisors instead. DON-B indicated the facility had the pharmacy review all residents' medication and DON-B adjusted medication times for medication scheduled at 7:00 AM and 8:00 AM to make them uniform. DON-B indicated the facility added an early morning med pass and indicated Med Techs arrived at 5:00 AM to help with the long-term care unit. DON-B indicated the medication review and changes began in mid-July and took approximately a week to complete. The pharmacy review was requested at the beginning of August and had started on the long-term care unit. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/12/24 at 12:56 PM, Surveyor interviewed Registered Nurse (RN)-E who indicated RN-E administered R1's medication late once because R1 had an early dentist appointment. RN-E indicated R1 wanted medication prior to the appointment, however, RN-E was not comfortable administering the medication because R1 had not eaten yet and there were multiple medications. RN-E administered R1's 8:00 AM medication when R1 returned from the appointment and administered R1's 12:00 PM medication later. RN-E indicated sometimes medications were administered late when agency staff were in the facility.