

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525482	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/03/2024
NAME OF PROVIDER OR SUPPLIER Burlington Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 677 E State St Burlington, WI 53105	

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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20483</p> <p>Based on interview and record review the Facility did not ensure 1 (R3) of 1 Resident's resident representative was notified when there was a need to alter treatment.</p> <p>R3's POA (Power of Attorney) was not notified when occupational therapy was discontinued on 6/26/24 and physical therapy was discontinued on 7/2/24.</p> <p>Findings include:</p> <p>The facility's policy titled, Notification of Changes and last reviewed/revised 8/27/24 under policy documents The purpose of this policy is to ensure the facility promptly informs the resident, consults the resident's physician; and notifies, consistent with his or her authority, the resident's representative when there is a change requiring notification.</p> <p>R3 was admitted to the facility on [DATE].</p> <p>R3's diagnoses includes congestive heart failure,diabetes mellitus, and end stage renal disease. R3's power of attorney for health care was activated on 7/19/23.</p> <p>Surveyor reviewed R3's medical record and was unable to locate therapy progress notes to determine when R3 had previously been discharged from occupational therapy & physical therapy and whether R3's POA had been notified of R3's therapies being discontinued.</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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 10/2/24, at 12:30 p.m., Surveyor met with DOR/COTA (Director of Rehab/Certified Occupational Therapy Assistant)-Q to discuss R3. DOR/COTA-Q informed Surveyor R3 has been off and on therapy. DOR/COTA-Q explained R3 is now on OT (occupational therapy) and speech therapy. DOR/COTA-Q informed Surveyor after R3 was admitted she had OT starting 5/15/24, PT (physical therapy) starting on 5/16/24, and speech therapy 5/16/24. DOR/COTA-Q informed Surveyor OT was discontinued on 6/26/24 & PT on 7/2/24. R3 received speech therapy until 8/1/24. DOR/COTA-Q informed Surveyor R3 was hospitalized and readmitted on [DATE]. DOR/COTA-Q informed Surveyor OT was started on 8/26/24, speech on 9/10/24, and PT was not started back up. Surveyor asked DOR/COTA-Q when a resident's therapy is discontinued is their POA notified of this. DOR/COTA-Q replied yes, sometimes the therapist and sometimes the DOR (Director of Therapy). Surveyor asked DOR/COTA-Q when R3's OT was discontinued on 6/26/24 & PT was discontinued on 7/2/24 is there a note documenting when R3's POA was notified of R3's therapy being discontinued. DOR/COTA-Q informed Surveyor she doesn't see a note regarding this for OT and informed Surveyor she will often hear the therapist calling but if it's not documented it doesn't mean anything. DOR/COTA-Q informed Surveyor the occupational therapist who wrote the discharge note not is not longer here. DOR/COTA-Q informed Surveyor for PT she sees the patient was discharged from PT and the patient agreed but doesn't see the POA was notified. Surveyor asked DOR/COTA-Q if she was the director when R3 was discharged from physical therapy. DOR/COTA-Q informed Surveyor [name], Prior DOR/PT-W, is no longer here.</p> <p>DOR/COTA-Q provided Surveyor with R3's occupational therapy discharge summary dated 6/26/24 and physical therapy discharge summary dated 7/2/24. Surveyor was unable to locate on these discharge summaries R3's POA was notified when OT & PT was discontinued.</p> <p>On 10/3/24, at 12:24 p.m., NHA (Nursing Home Administrator)-A was notified of the above. No information was provided to Surveyor as to why R3's POA was not notified when therapy was discontinued for R3.</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38829</p> <p>Based on interview and record review, the facility did not ensure 5 (R11, R15, R16, R3, and R7) of 12 Residents reviewed received a prompt resolution to grievances.</p> <p>*On 5/17/24, it is documented R11 answered yes to the question 'Do you have any concerns?' There is no evidence if the concerns were confirmed. The facility did not have any documentation the concerns/grievance was investigated promptly and resolved.</p> <p>*On 5/17/24, it is documented R15 answered yes to the question 'Do you have any concerns?' There is no evidence if the concerns were confirmed. The facility did not have any documentation the concerns/grievance was investigated promptly and resolved.</p> <p>*On 5/17/24, it is documented R16 answered yes to the question 'Do you have any concerns?' There is no evidence if the concerns were confirmed. The facility did not have any documentation the concerns/grievance was investigated promptly and resolved.</p> <p>*On 7/11/24, R3's representative filed a grievance with the facility and there is no evidence if the grievance was confirmed or not or if R3's representative was informed of the corrective actions taken by the facility and resolution. The facility did not have any documentation this grievance was investigated promptly and resolved.</p> <p>*Documentation refers to R7 having multiple concerns and there is no evidence if the concern/grievance was confirmed or not or if R7 was informed of the corrective actions taken by the facility and resolution. The facility did not have any documentation these concerns/grievances were investigated promptly and resolved.</p> <p>Findings Include:</p> <p>The facility's policy Grievance Guideline dated 10/3/22 and last revised on 5/31/2023 documents:</p> <p>.Purpose: To provide a process to voice grievances(such as those about treatment, care, management of funds, lost clothing, or violation of rights) and respond with prompt efforts to resolve while keeping the Resident and/or Resident representative appropriately apprised of progress toward resolution.</p> <p>-As necessary, taking immediate action to prevent further potential violations of any Resident right while the alleged violation is being investigated. -Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the Resident grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the Resident concern(s), a statement as to whether the grievance was confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued.</p> <p>(continued on next page)</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Taking appropriate corrective action in accordance with State law if the alleged violation of the Resident's rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these Residents' rights within its area of responsibility.</p> <p>-Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision.</p> <p>Response</p> <p>Any employee of this facility who receives a complaint shall immediately attempt to resolve the complaint within their role and authority. If a complaint cannot be immediately resolved the employee shall escalate that complaint to their supervisor and the facility Grievance Official. Grievances will be recorded and logged through Grievance Portal or written Grievance Form.</p> <p>Upon receipt of a grievance or concerns, the Grievance Official will review the grievance, determine immediately if the grievance meets a reportable complaint consistent with the facility Abuse Prevention Policy. The Grievance Official will immediately report all alleged violations involving neglect, abuse, including injuries of unknown sources and/or misappropriation of Resident property by anyone to the Administrator as required by State Law.</p> <p>The Grievance Official will initiate the appropriate notification and investigation processes per individual circumstance and facility guidelines. The investigation will consist of at least the following:</p> <ul style="list-style-type: none"> -A review of the completed complaint report -An interview with the person or persons reporting the grievance-Interviews with any witnesses to the concern -A review of the medical record if indicated -A search of Resident room(with Resident permission) -Interview with staff members having contact with the Resident during the relevant periods or shifts of the alleged incident-Interview with the Resident roommate, family members and visitors -Completion of a root cause analysis of all circumstances surrounding the concern <p>As necessary, the Grievance Official and the facility leadership will take immediate action prevent further potential continuations of any additional and like Resident concerns while the grievance is being investigated.</p> <p>Resolution</p> <p>The Grievance Official and/or designee will complete a response within 5 days of receipt to the Resident and/or Resident representative which includes:</p> <p>(continued on next page)</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<ul style="list-style-type: none"> -Date of grievance -Summary of grievance -Investigations steps -Findings -Resolution outcome and actions taken with date decision was determined <p>The Grievance Officer and/or designee will maintain a log of all grievances for a period of (3) years including:</p> <ul style="list-style-type: none"> -Date of grievance Tracking number or identification -Type of grievance -Location/Department -Person assigned to investigate -Date of resolution-Actions taken . <p>1.) R11 was admitted to the facility on [DATE] with diagnoses of Chronic Obstructive Pulmonary Disease, Type 2 Diabetes Mellitus, Alzheimer's Disease, Major Depressive Disorder, and Generalized Anxiety Disorder. R11 has an activated Health Care Power of Attorney (HCPOA).</p> <p>R11's Quarterly Minimum Data Set (MDS) completed on 8/8/24 documents R11's Brief Interview for Mental Status(BIMS) score of 6, indicating R11 demonstrates severely impaired skills for daily decision making. No mood or behavior issues were documented on R11's MDS.</p> <p>2) R15 was admitted to the facility on [DATE] with diagnoses of Cerebral Infarction, Type 2 Diabetes Mellitus, Chronic Kidney Disease, Stage 4 and Vascular Dementia.</p> <p>R15's Quarterly Minimum Data Set (MDS) completed on 8/31/24 documents R15's Brief Interview for Mental Status(BIMS) score of 15, indicating R15 is cognitively intact for daily decision making. No mood or behavior issues were documented on R15's MDS.</p> <p>3) R16 was admitted to the facility on [DATE] with diagnoses of Morbid Obesity, Chronic Kidney Disease, Stage 3, Pulmonary Hypertension, Major Depressive Disorder, and Anxiety Disorder. R16 is her own person.</p> <p>R16's Quarterly Minimum Data Set (MDS) completed on 8/24/24 documents R16's Brief Interview for Mental Status(BIMS) score of 15, indicating R16 is cognitively intact for daily decision making. No mood or behavior issues were documented on R16's MDS.</p> <p>(continued on next page)</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 10/1/24, at 11:23 AM, Surveyor reviewed a 5/17/24 self report involving an allegation of a Certified Nursing Assistant (CNA) being rough with cares involving Resident(10). In review, Surveyor notes there is documentation of interviews conducted with R11, R15, and R16 all of whom answered 'Yes' to the question 'Do you have any concerns?' Surveyor reviewed the grievance log provided by the facility and was unable to locate documentation that a concern/grievance had been documented with resolution for R11, R15, and R16.</p> <p>On 10/2/24, at 11:27 AM, Surveyor interviewed Social Worker (SW)-E regarding the grievance procedure. Surveyor discussed R11, R15, and R16's interviews where all 3 Residents indicated they had concerns. SW-E confirmed based on the grievance process, there should be documentation of R11, R15, and R16's concerns. Surveyor indicated, there is no documentation on the facility grievance log of what R11, R15, or R16's concerns may have been. SW-E stated SW-E will need to look for the grievances and get back to Surveyor.</p> <p>On 10/2/24, at 2:35 PM, Surveyor shared the concern with Nursing Home Administrator (NHA)-A, Director of Nursing (DON)-B, and Director of Operations (DO)-C the concern that R11, R15, and R16 expressed in an interview dated 5/17/24 that all 3 Residents had concerns. Surveyor shared that there is no documentation of steps taken to investigate R11, R15, and R16's concerns/grievance, a summary of pertinent findings, conclusion, statements as to whether the grievance was confirmed or not confirmed, corrective actions taken by the facility, and the date the written decision was issued. NHA-A, DON-B, and DO-C acknowledged the concern of no documentation that R11, R15, and R16's concerns were addressed. No further information was provided by the facility at this time.</p> <p>4.) R7's Admission Minimum Data Set (MDS), dated [DATE], documents R7 has a Brief Interview for Mental Status (BIMS) of 15, indicating R7 in cognitively intact. R7 did not exhibit any behaviors or rejection of care.</p> <p>Surveyor reviewed progress notes from R7's Electronic Health Record (EHR) and noted the following:</p> <ul style="list-style-type: none"> -a progress note dated 07/02/2024, documents Resident compliant with all cares and medications. His PICC line remains intact, and he has had no A/R (allergic reaction) to antibiotic. will continue to monitor. -a progress note dated 07/09/2024, documents Resident compliant with cares and medications. <p>Surveyor noted a progress note dated 07/11/2024, Resident complaint with cares and medications.</p> <p>Surveyor noted a progress note dated 07/16/2024, Resident compliant with cares and medications.</p> <p>Surveyor noted a progress note dated 07/23/2024, resident complaint with medications and cares.</p> <p>Surveyor noted, no documentation as to what exactly R7's complaints were, or if they were addressed.</p> <p>R7 was discharged from the Facility on 07/25/2024.</p> <p>(continued on next page)</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 10/03/2024, at 09:29 AM, Surveyor interviewed Director of Nursing DON-B. DON-B informed Surveyor that if a concern is made by a resident to a nurse, the expectation is the nurse would further investigate the concern and DON-B would expect to be notified. DON-B informed Surveyor that no concerns were brought to her attention aside from the issue with R7's Coban wrap.</p> <p>On 10/03/2024, at 12:30 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A. NHA-A informed Surveyor NHA-A spoke with R7 regarding concerns with service. NHA-A states no formal grievance was completed, communication with R7 regarding concerns were verbal.</p> <p>20483</p> <p>5.) R3's diagnoses includes congestive heart failure, diabetes mellitus, and end stage renal disease. R3's power of attorney for health care was activated on 7/19/23.</p> <p>On 10/1/24, at 1:01 p.m., Surveyor reviewed the facility's grievance summaries which is the grievance log. Surveyor noted there is a grievance summary for R3 with an incident & reported date of 7/11/24. The category documents care concern. Resolved Date - Resolved by documents 7/12/24. The resolved note documents [first name of] CNA (Certified Nursing Assistant)-X was given a teachable moment. Under grievance details documents [R3's first name] expressed concern regarding CNA being lazy. Under Summary of Investigation and Summary of findings documents [R3's first name] feels safe in the community. doesn't feel [CNA-X's first name] is abusive or neglectful. Just lazy. Under summary of actions taken documents [CNA-X's first name] was given a teachable moment.</p> <p>On 10/1/24, at 2:37 p.m., during the end of the day meeting Surveyor asked NHA (Nursing Home Administrator)-A and DON (Director of Nursing)-B for the complete grievance for R3 dated 7/11/24.</p> <p>On 10/2/24, at approximately 2:00 p.m., Surveyor noted the facility had provided Surveyor with R3's grievance summaries for incident date of 7/11/24. This was the same grievance summaries Surveyor had reviewed the previous day.</p> <p>On 10/2/24, at 2:36 p.m., during the end of the day meeting Surveyor informed NHA-A, DON-B and Director of Operations-C Surveyor still needed R3's complete grievance for 7/11/24.</p> <p>On 10/3/24, at 11:15 a.m., Surveyor reviewed R3's grievance investigation provided by the facility. Surveyor was provided with the same grievance summaries as previously provided, in addition there is CNA-X's employee teachable moment, and 15 resident interviews dated 7/12/24 with the questions do you feel safe here at (name of facility)? and do you have any concerns? There is no information as to what being lazy means or whether facility staff asked R3 what lazy means and the steps taken to investigate this grievance. There is not a summary of the findings other than R3 feels safe in the community, doesn't feel CNA-X is abusive or neglectful just lazy. There is no documentation as to whether the grievance is confirmed or not and the date of the written decision was provided to R3.</p> <p>(continued on next page)</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 10/3/24, at 11:37 a.m., Surveyor spoke with NHA-A and Director of Operations-C. Surveyor asked if there is anymore information for R3's grievance dated 7/11/24. NHA-A informed Surveyor CNA-X is a good aide. Director of Operations-C informed Surveyor they will have to look if they have additional information and then looked in her computer pulling up the grievance summaries. Surveyor informed Director of Operations-C this is the facility's grievance log. Surveyor then asked NHA-A if R3 voiced the concern or the POA (power of attorney) as they both have the same name. NHA-A informed Surveyor she thought it was the resident. Surveyor informed NHA-A & Director of Operations-C the investigation does not document what is being lazy mean and whether the facility asked about this. There is no documentation as to whether the grievance was confirmed and the date when the written decision was provided to R3. Director of Operations-C informed Surveyor there's not a thorough investigation. Surveyor asked NHA-A & Director of Operations-C if there is any additional information to let Surveyor know. Surveyor was not provided with any additional information regarding R3's grievance dated 7/11/24.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38829</p> <p>Based on record review and staff interviews, the facility did not ensure that 1 allegations of abuse involving 2 Residents (R10 and R8) of 5 allegations of abuse were reported immediately.</p> <p>*On 5/16/24, Certified Nursing Assistant (CNA)-V notified Registered Nurse (RN)-S that R10 voiced an allegation that CNA-V was rough with cares. RN-S informed CNA-V that was R10's behavior. CNA-V went back and continued cares for R10 and other Residents on CNA-V's assignment. On 5/17/24, Social Services notified Nursing Home Administrator (NHA)-A of the allegation.</p> <p>Findings Include:</p> <p>The facility's policy Abuse, Neglect, and Exploitation implemented 9/18/23 documents:</p> <p>.Policy: It the policy of this facility to provide protections for the health, welfare and rights of each Resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of Resident property.</p> <p>V. Investigation of Alleged Abuse, Neglect and Exploitation</p> <p>A. An immediate investigation is warranted when suspicion of abuse, neglect, or exploitation, or reports of abuse, neglect, or exploitation occur.</p> <p>VI. Protection of Resident The facility will make efforts to ensure all Residents are protected from physical and psychosocial harm, as well as additional abuse, during and after the investigation.</p> <p>A. Responding immediately to protect the alleged victim and integrity of the investigation</p> <p>B. Examining the alleged victim for any sign of injury, including a physical examination or psychosocial assessment if needed</p> <p>F. Providing emotional support and counseling to the Resident during and after the investigation</p> <p>G. Revision of the Resident's care plan if the Resident's medical, nursing, physical, mental, or psychosocial needs or preferences change as a result of an incident of abuse</p> <p>VII. Reporting/Response</p> <p>A. The facility will have written procedures that include:</p> <p>1. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies(law enforcement) within specified timeframe's:</p> <p>a. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in bodily injury</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>b. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury</p> <p>VIII. Coordination with QAPI</p> <p>A. The facility has written policies and procedures that define how staff will communicate and coordinate situations of abuse, neglect, misappropriation of Resident property, and exploitation with the QAPI program.</p> <p>1. Cases of physical or sexual abuse, for example by facility staff or other Residents, will be reviewed for and receive corrective action and tracking by QAA Committee. 1</p> <p>R10 was admitted to the facility on [DATE] with diagnoses of Paraplegia, Morbid Obesity, Chronic Respiratory Failure with Hypoxia, Anemia, Paroxysmal Atrial Fibrillation, Fibromyalgia, and Depression. R10 was her own person. R10 discharged from the facility on 6/4/24.</p> <p>R10's Admission Minimum Data Set (MDS) completed on 5/5/24 documents R10's Brief Interview for Mental Status (BIMS) to be 15, indicating R10 was cognitively intact for daily decision making. R10's MDS also documents that R10 was independent for eating, and dependent for showers, upper and lower dressing, mobility, and transfers.</p> <p>On 10/1/24, at 11:23 AM, Surveyor reviewed a self report that documents R10 reported CNA-V had been rough with cares. The Alleged Nursing Home Resident Mistreatment, Neglect, and Abuse Report dated 5/17/24 was submitted to the State Survey Agency. Surveyor reviewed CNA-V's statement which documents that CNA-V reported the allegation on the PM shift to Registered Nurse (RN)-S which was 5/16/24 around 6:30/7:00 PM. CNA-V's documented statement is that CNA-V reported R10's allegation to RN-S on 5/16/24. RN-S replied it was their behavior referring to R10 and CNA-V went back into R10's room to complete cares. CNA-V also provided ADL cares to other Residents during the shift. RN-S did not report the allegation from R10 immediately to a supervisor, Director of Nursing (DON)-B, or Nursing Home Administrator (NHA)-A.</p> <p>On 10/2/24, at 2:35 PM, Surveyor shared the concern with NHA-A, Director of Nursing (DON)-B, and Director of Operations (DO)-C that R10's allegation of abuse occurred on 5/16/24, was reported by CNA-V to RN-S who did not report it immediately and was not addressed until 5/17/24. Surveyor expressed that it is unclear how or by whom NHA-A was notified of the allegation on 5/17/24.</p> <p>On 10/3/24, at 12:07 PM, Surveyor was provided a grievance summary with an incident date of 5/17/24 and resolve date of 5/24/24. A post-it note was on top of the summary stating that NHA-A was notified in person by social services. Surveyor asked NHA-A at this time, if NHA-A recollects the conversation. NHA-A is not able to provide any further information at this time.</p>		

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NAME OF PROVIDER OR SUPPLIER Burlington Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 677 E State St Burlington, WI 53105	
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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22692</p> <p>Based on interview and record review, the facility did not ensure an allegation of abuse for 2 of 5 investigations reviewed, included steps that were taken by the facility to ensure safety of the facility residents.</p> <p>* Visitor-HH alleged facility housekeeper-N was sexual inappropriate to the visitor when visiting a resident in the facility. The facility did not complete a thorough investigation of the allegation/actions of housekeeper-N by ensuring current facility residents were interviewed to determine if they had concerns or similar allegations regarding housekeeper-N.</p> <p>*R10 made an allegation of rough care that was reported to a registered nurse. This was not thoroughly investigated by the facility.</p> <p>This deficient practice had the potential to affect 73 of 73 residents in the facility.</p> <p>Findings include:</p> <p>On 10/2/24, the facility's Abuse, Neglect and Exploitation policy and procedure implemented on 9/18/23 and notes the following in regards to reporting requirements:</p> <p>.Policy: It is the policy of this facility to provide protections for the health, welfare, and rights of each Resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of Resident property.</p> <p>V. Investigation of Alleged Abuse, Neglect and Exploitation</p> <p>A. An immediate investigation is warranted when suspicion of abuse, neglect, or exploitation, or reports of abuse, neglect, or exploitation occur.</p> <p>3. Investigating different types of alleged violations</p> <p>4. Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations</p> <p>5. Focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent, and cause</p> <p>6. Providing complete and thorough documentation of the investigation</p> <p>VI. Protection of Resident The facility will make efforts to ensure all Residents are protected from physical and psychosocial harm, as well as additional abuse, during and after the investigation.</p> <p>A. Responding immediately to protect the alleged victim and integrity of the investigation.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>B. Examining the alleged victim for any sign of injury, including a physical examination or psychosocial assessment if needed.</p> <p>F. Providing emotional support and counseling to the Resident during and after the investigation.</p> <p>G. Revision of the Resident's care plan if the Resident's medical, nursing, physical, mental, or psychosocial needs or preferences change as a result of an incident of abuse.</p> <p>VII. Reporting/Response</p> <p>5. Taking all necessary actions as a result if the investigation, which may include, but are not limited to the following:</p> <p>a. Analyzing the occurrence(s) to determine why abuse, neglect, misappropriation of Resident property or exploitation occurred, and what changes are needed to prevent further occurrences.</p> <p>b. Defining how care provision will be changed and/or improved to protect Residents receiving services.</p> <p>VIII. Coordination with QAPI (Quality Assurance Performance Improvement)</p> <p>A. The facility has written policies and procedures that define how staff will communicate and coordinate situations of abuse, neglect, misappropriation of Resident property, and exploitation with the QAPI program.</p> <p>1. Cases of physical or sexual abuse, for example by facility staff or other Residents, will be reviewed for and receive corrective action and tracking by QAA Committee. This coordinated effort results in the QAA Committee determining:</p> <p>a. If a thorough investigation is conducted</p> <p>b. Whether the Resident is protected</p> <p>1.) On 7/19/24 Visitor-HH reported to the facility an allegation of possible sexual assault involving housekeeper-N to visitor-HH. At that time the facility suspended housekeeper-N and the police were called and also initiated an investigation into the allegation. Housekeeper-N no longer is employed by the facility.</p> <p>On 10/3/24 at 11:33 AM, Detective-R was interviewed and indicated housekeeper-N admitted to inappropriate sexual behavior towards visitor-HH at the time and the facility was notified right away about what housekeeper-N admitted to.</p> <p>On 10/2/24, the Facility's investigation into the sexual assault allegations against housekeeper-N were reviewed and included interviews from 7 staff and 7 residents out of a census of 73 residents. Surveyor noted there was no summary of the results of the investigation were documented. Surveyor noted the investigation was not thorough as housekeeper-N had ben an employee since 2022 and the facility did not determine if residents beyond visitor-HH may have been subjected to housekeeper-N's sexually inappropriate behavior.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 10/3/24 at 12:36 PM, Director of Operations-C was interviewed and indicated that the facility did not do a thorough investigation into R4's allegations and should have.</p> <p>The above findings were shared with the Nursing Home Administrator-A and Director of Nursing-B on 10/2/24. Additional information was requested if available, but none was provided as to why a thorough investigation was not completed after the allegation of sexual abuse was made against housekeeper-N.</p> <p>38829</p> <p>2.) R10 was admitted to the facility on [DATE] with diagnoses of Paraplegia, Morbid Obesity, Chronic Respiratory Failure with Hypoxia, Anemia, Paroxysmal Atrial Fibrillation, Fibromyalgia, and Depression. R10 was her own person. R10 discharged from the facility on 6/4/24.</p> <p>R10's Admission Minimum Data Set (MDS) completed on 5/5/24 documents R10's Brief Interview for Mental Status (BIMS) to be 15, indicating R10 was cognitively intact for daily decision making. R10's MDS also documents that R10 was independent for eating, and dependent for showers, upper and lower dressing, mobility, and transfers.</p> <p>On 10/1/24, at 11:23 AM, Surveyor reviewed a self report that documents R10 reported CNA-V had been rough with cares. The Alleged Nursing Home Resident Mistreatment, Neglect, and Abuse Report dated 5/17/24 was submitted to the State Survey Agency. Surveyor reviewed CNA-V's statement which documents that CNA-V reported the allegation on the PM shift to Registered Nurse (RN)-S which was 5/16/24 around 6:30/7:00 PM. CNA-V's documented statement is that CNA-V reported R10's allegation to RN-S on 5/16/24. RN-S replied it was their behavior referring to R10 and CNA-V went back into R10's room to complete cares. CNA-V also provided cares to other Residents during the shift. RN-S did not report the allegation from R10 immediately to a supervisor, Director of Nursing (DON)-B, or Nursing Home Administrator (NHA)-A.</p> <p>The Misconduct Incident Report dated 5/24/24 submitted to the State Survey Agency contains a statement from CNA-V. There are no other documented statements from other staff members. There is no statement from RN-S. No statements from other staff members who worked the shift with CNA-V. Surveyor notes that CNA-V's assignment for 5/16/24 was Unit 5 and 6. All 6 of the provided Resident statements resided on units other than unit 5 and 6 so CNA-V would not have taken care of those Residents on the PM shift.</p> <p>On 10/2/24, at 2:35 PM, Surveyor shared the concern with NHA-A, DON-B, and Director of Operations (DO)-C that R10's allegation of abuse was not thoroughly investigated.</p> <p>On 10/3/24, at 12:07 PM, Surveyor was provided by NHA-A a text message print out from RN-S to central supply documenting the following: On May 16, CNA-V is stating that I refused to help her with R10. This is a false/untrue accusation Sent from iPhone. No additional explanation or information was provided.</p>		

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<p>F 0661</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38829</p> <p>Based on interview and record review the facility did not ensure 1 (R10) of 2 Residents reviewed for discharge received a complete discharge summary.</p> <p>*R10 was discharged to an adult living home on 6/4/24 without a completed discharge summary and list of medications to allow for coordination of care and to effectively transition R10 to post-facility care.</p> <p>Findings Include:</p> <p>The facility's policy Transfer and Discharge implemented 10/26/2022, and last revised on 1/2024 documents:</p> <p>14 Anticipated Transfers or Discharges -Resident -initiated discharges</p> <p>a. Obtain physicians' for transfer or discharge and instructions or precautions for ongoing care.</p> <p>b. A member of the interdisciplinary team(IDT) completes relevant sections of the Discharge Summary. The nurse caring for the Resident at the time of discharge is responsible for ensuring the Discharge Summary is complete and includes, but not limited to, the following:</p> <p>i. A recap of the Resident's stay that includes diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results.</p> <p>ii. A final summary of the Resident's status</p> <p>iii. Reconciliation of all pre-discharge medications with the Resident's post- discharge medications(both prescribed and over the counter)</p> <p>iv. A post discharge plan of care that is developed with the participation of the Resident, and the Resident's representative(s) which will assist the Resident to adjust to his/her new living environment.</p> <p>c. Orientation for transfer or discharge must be provided and documented to ensure safe and orderly transfer or discharge from the facility, in a form and manner that the Resident can understand. Depending on the circumstances, this orientation may be provided by various members of the IDT.</p> <p>d. Assist with transportation arrangements to the new facility and any other arrangements as needed.</p> <p>e. The comprehensive, person-centered care plan shall contain the Resident's goals for admission and desired outcomes and shall be in alignment with the discharge.</p> <p>(continued on next page)</p>		

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<p>F 0661</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>f. Residents who are sent to an acute care setting for routine treatment/planned procedure must be allowed to return to the facility.</p> <p>g. Supporting documentation shall included evidence of the Resident's or Resident representative's verbal or written notice of intent to leave the facility, a discharge plan, and documented discussions with the Resident and/or Resident representative.</p> <p>R10 was admitted to the facility on [DATE] with diagnoses of Paraplegia, Morbid Obesity, Chronic Respiratory Failure with Hypoxia, Anemia, Paroxysmal Atrial Fibrillation, Fibromyalgia, and Depression. R10 was her own person. R10 discharged from the facility on 6/4/24.</p> <p>R10's Admission Minimum Data Set (MDS) completed on 5/5/24 documents R10's Brief Interview for Mental Status (BIMS) to be 15, indicating R10 was cognitively intact for daily decision making. R10's MDS also documents that R10 was independent for eating, and dependent for showers, upper and lower dressing, mobility, and transfers.</p> <p>The following focused problems were part of R10's comprehensive care plan:</p> <ul style="list-style-type: none"> -Preferred activities -Activities of Daily Living (ADL) deficit -Behavior problem of false accusations -Wishes to return home -Potential for dehydration due to diuretic use -At risk for falls-Bowel incontinence -History of diarrhea-Uses antidepressant -Diuretic therapy-Anticoagulant therapy -Mood impairment-Antibiotic therapy -Nutritional problem -Chronic pain-Emphysema, asthma, chronic respiratory failure -History of Kidney Disease, stage 3 -Potential for impairment to skin integrity/moisture -MASD (moisture associated skin damage) to bilateral buttocks-Experienced trauma -Indwelling catheter <p>(continued on next page)</p>		

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<p>F 0661</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Surveyor notes that R10 had multiple care areas with interventions necessary for the adult living home to know in order for continuum of care to be implemented for R10 to ensure success of placement outside the facility.</p> <p>On 10/1/24, at 11:23 AM, Surveyor reviewed R10's physician orders, progress notes and 'Discharge Instructions and Review of Systems for Resident' dated 6/3/24. Surveyor noted, there is no discharge order for R10 to be discharged from the facility and there is no documentation in R10's progress notes of R10 being discharged from the facility on 6/4/24, as well as no documentation of the steps taken to coordinate a successful discharge from the facility.</p> <p>-R10's 'Discharge Instructions and Review of Systems' contains sections A-M.</p> <p>A-Discharge Location and Date is completed</p> <p>B-Discharge Summary Assessment documents vitals dated 6/3/24. It also documents that R10 is continent of bladder and incontinent of bowel, however, having an indwelling catheter is not documented for R10. Respiratory, skin evaluation, pain, vision and hearing, and ability to understand is not completed.</p> <p>C-Current Physical Status which includes Eating, Hygiene, Shower/Bathing Status, Dressing, Walking, Stair, Wheelchair, Bed Mobility, and Transfers is not completed.</p> <p>D-Diet Recommendations is not completed.</p> <p>E-Primary Care Information with Follow-up appointments is not completed.</p> <p>F-Referral for Care documents no referral has been made.</p> <p>G-Advance Care Planning is completed.</p> <p>H-Medications-Indicates a pharmacy the medications were called into, but then does not list R10's medications or when R10 last received a dose. It is also not documented if R10 received a current reconciled medication list or if one was given to the provider.</p> <p>I-Treatment-not completed</p> <p>J-Additional Instruction-not completed</p> <p>K-Person receiving the instructions-there is no name documented and no signature that either R10 received instructions and/or provider.</p> <p>L-BIMS and PHQ-0 (Patient Health Questionnaire) is completed.</p> <p>M-Education is not completed.</p> <p>(continued on next page)</p>		

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<p>F 0661</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 10/2/24, at 11:27 AM, Surveyor interviewed Social Worker (SW)-FF and Social Worker (SW)-E at the same time. SW-FF and SW-E explained to Surveyor that social services and nursing completes the discharge instructions prior to a Resident leaving the facility. Nursing has to close the discharge instructions, so it is likely that nursing would be the last to be working on the discharge instructions. SW-FF and SW-E stated that nursing gets it all together and completes the discharge packet. SW-FF and SW-E informed Surveyor that there is no designated person to make sure the discharge instructions with summary/recapitulation of a Resident's stay is completed.</p> <p>On 10/2/24, at 2:35 PM, Surveyor shared the concern with Nursing Home Administrator (NHA)-A, Director of Nursing (DON)-B, and Director of Operations (DO)-C that there is no documentation in R10's EMR of R10's discharge from the facility. Surveyor also shared that R10's discharge instructions include multiple sections that were not completed prior to R10 discharge from the facility that includes receiving a complete discharge summary including post discharge plans/instructions, follow up care necessary and medications provided to the Resident in order to communicate necessary information to the Resident, continuing care provider, and other authorized persons at the time of the anticipated discharge. No further information was provided by the facility at this time.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20483</p> <p>Based on interview and record review the facility did not ensure residents received treatment and care in accordance with professional standards of practice for 2 (R3 & R7) of 16 residents.</p> <p>* Staff did not place tubi grips on R3's bilateral lower extremities on 10/1/24 & 10/2/24.</p> <p>* R7's non pressure wounds were not comprehensively assessed for 7 days. There is no order for R7's PICC (peripherally inserted central catheter), the PICC dressing, & care of PICC line. Facility staff were wrapping R7's legs with ace bandages when the physician's orders documented Coban.</p> <p>Findings include:</p> <p>1.) R3's diagnoses includes congestive heart failure,diabetes mellitus, and end stage renal disease.</p> <p>The resident has an ADL (activity daily living) self-care performance deficit care plan initiated 5/17/24 includes an intervention of *DRESSING: The resident requires assistance by 1 staff to dress. Assist x (times) 1 with UB (upper body) and LB (lower body) dressing, Assist x1 with grooming, Tubi Grips to BLE (bilateral lower extremities), on in AM (morning), off at HS (hour sleep). Must have Hoyer Sling under/in place to W/C (wheel chair) during Dialysis Days. Initiated 5/17/24.</p> <p>The physician orders with an order date of 6/4/24 documents Tubi grips to BLE on AM off HS every morning and at bedtime for edema.</p> <p>The CNA (Certified Nursing Assistant) care card updated 9/27/24 under the ADL's section documents Assist x 1 with UB and LB dressing. Assist x 1 with groom, Tubi Grips to BLE, On in AM, off at HS. Must have Hoyer Sling under/in place to W/C during Dialysis Days.</p> <p>On 10/1/24, from 10:56 a.m. to 10:35 a.m., Surveyor observed CNA (Certified Nursing Assistant)-G and CNA-H provide morning cares for R3, dress R3, and transfer R3 from the bed into the wheel chair. During this observation at 11:08 a.m. CNA-G removed R3's gripper socks. Surveyor checked R3's feet and did not observe any open areas. At 11:24 a.m. CNA-G & CNA-H placed pants on R3 then positioned R3 from side to side to fasten the incontinence product and pull up R3's pants. CNA-G informed R3 she has two grippy socks. Surveyor observed there is a beige & gray gripper sock. R3 asked if they were mismatched. CNA-G replied yes. R3 asked why you got me looking like this. CNA-G informed R3 its only temporary. CNA-G placed the gripper socks and crocs on R3's feet. Surveyor noted during this observation neither CNA-G or CNA-H placed tubi grips on R3 nor did CNA-G or CNA-H ask R3 about the tubi grips.</p> <p>On 10/1/24, at 3:33 p.m., Surveyor observed R3 sitting in a wheelchair in the room. Surveyor observed R3's left pant leg is up. Surveyor observed R3 is still not wearing tubi grips.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 10/1/24, at 3:34 p.m., Surveyor reviewed R3's October TAR (treatment administration record) and noted on 10/1/24 there is a check & initials for tubi grips to BLE on AM off HS every morning and at bed time for edema for the morning scheduled time. A check & initials indicate the tubi grips have been applied.</p> <p>On 10/2/24, at 7:23 a.m., Surveyor observed R3 dressed for the day sitting in a wheel chair in her room. Surveyor observed R3 is wearing gray gripper socks and is not wearing tubi grips.</p> <p>On 10/2/24, at 7:37 a.m., Surveyor observed CNA-H wheeling R3 out of the room and down the hallway towards the front entrance for R3's dialysis appointment. Surveyor observed R3 is not wearing tubi grips.</p> <p>On 10/2/24, at 3:14 p.m., Surveyor noted R3 is still not back from dialysis and has not been wearing her tubi grips.</p> <p>On 10/3/24, at 10:47 a.m., Surveyor asked RN (Registered Nurse)-K if R3 should be wearing tubi grips. RN-K replied there should be an order. RN-K then reviewed R3's physician orders and replied yup, tubi grips BLE.</p> <p>On 10/3/24, at 10:51 a.m., Surveyor asked CNA-H if R3 wears tubi grips. CNA-H informed Surveyor she usually puts gray socks on her. Surveyor showed CNA-H the CNA care card with R3 listed for tubi grips and asked CNA-H if the CNA care card is what they follow. CNA-H replied yes.</p> <p>On 10/3/24, at 11:15 a.m., Surveyor reviewed R3's October TAR (treatment administration record) and noted on 10/2/24 there is a check & initials for tubi grips to BLE on AM off HS every morning and at bed time for edema for the morning scheduled time. A check & initials indicate the tubi grips have been applied.</p> <p>On 10/3/24, at 10:55 a.m., Surveyor informed DON (Director of Nursing)-B of the observations of R3 not wearing tubi grips during the first two days of survey as Surveyor had observed morning cares for R3 on 10/1/24 and staff did not place on the tubi grips. On 10/2/24 Surveyor observed R3 prior to going to dialysis without the tubi grips on.</p> <p>On 10/3/24, at 12:24 p.m., NHA (Nursing Home Administrator)-A was informed of the above. No information was provided to Surveyor as to why R3 was not wearing tubi grips on 10/1/24 & 10/2/24.</p> <p>*R7 was admitted to the facility on [DATE], to receive intravenous antibiotics due to a wound infection.</p> <p>R7's Admission Minimum Data Set (MDS), dated [DATE], documents R7 has a Brief Interview for Mental Status (BIMS) of 15, indicating R7 in cognitively intact. R7 did not exhibit any behaviors or rejection of care.</p> <p>Surveyor reviewed R7's document titled Discharge Summary, with a service date of 06/18/2024, and documents in part,</p> <p>Wound Care to BLE</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Burlington Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 677 E State St Burlington, WI 53105	
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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>1. Cleanse wound with Hibiclens and Water</p> <p>2. Pat area dry with gauze</p> <p>3. Apply Mepilex AG to posterior Knees</p> <p>4. Fan Wrap Viscopaste gauze</p> <p>5. Apply Coban 2 layer wrap to patients thighs</p> <p>6. WOCN to change twice a week, Monday/Thursday . Post-discharge IV ABX: Dx: MRSA bacteremia</p> <p>Rx: IV Vancomycin 1.5 g IV q18hr</p> <p>Duration: continue through 06/21/2024 to complete 2 week course. -10 mL of normal saline pre-infusion and post-infusion, and 3 mL of 10 units/mL of heparin post-infusion -please remove PICC line at end of IV ABX therapy.</p> <p>Surveyor reviewed R7's Medication Administration Record (MAR) and Treatment Administration Record (TAR), dated June 2024 and July 2024. Surveyor noted no orders to flush R7's Peripherally Inserted Central Catheter (PICC) with heparin, and no orders to change R7's PICC dressing. Surveyor noted multiple progress notes indicating R5 was using ace bandage wraps and the Facility did not have Coban available.</p> <p>Wound assessment</p> <p>Surveyor reviewed R7's document, titled Admission/Readmission/Routine Heat-to-toe Evaluation, dated 06/18/2024, and documents in part, . Coban wraps to BLE done twice weekly at hospital and d/t tomorrow, would like them to be done tomorrow vs assessing today.</p> <p>Surveyor reviewed the document titled, Weekly Wound Assessment- champion, dated 06/25/2024 and signed 07/01/2024 by DON-B, documents the first comprehensive wound assessment for R7 was 7 days after being admitted to the Facility.</p> <p>PICC Dressing change-</p> <p>Per the Center for Disease Control document titled, Summary of Recommendations from the Guidelines for the Prevention of Intravascular Catheter-Related Infections (2011), dated 02/28/2028, documents in part,</p> <p>6. Catheter Site Dressing Regimens . 1. Use either sterile gauze or sterile, transparent, semipermeable dressing to cover the catheter site. 3.</p> <p>Replace catheter site dressing if the dressing becomes damp, loosened, or visibly soiled. 6. Replace dressings used on short-term CVC sites every 2 days for gauze dressings. 7. Replace dressings used on short-term CVC sites at least every 7 days for transparent dressings, except in those pediatric patients in which the risk for dislodging the catheter may outweigh the benefit of changing the dressing.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Surveyor reviewed R7's Medication Administration Record (MAR) and Treatment Administration Record (TAR), dated June 2024 and July 2024. Surveyor noted no orders to change R7's PICC dressing.</p> <p>Surveyor noted a progress note, indicating PICC site was cleaned, and dressing changed on 06/21/2024. No further documentation of PICC dressing changes.</p> <p>R7 had PICC removed on 06/22/2024 while in the Facility, but PICC was reinserted while in the Facility on 06/28/2024, R7 was discharged from the Facility on 07/25/2024.</p> <p>Heparin Flush-</p> <p>The Facility's policy, titled Vascular Access Devices and Infusion Therapy Procedures Maintaining Patency of Peripheral and Central Vascular Access Devices, date 08/2021, documents in part, 12. Variations from recommended flush are based on physician orders.</p> <p>Surveyor reviewed R7's Medication Administration Record (MAR) and Treatment Administration Record (TAR), dated June 2024 and July 2024. Surveyor noted no orders to flush R7's Peripherally Inserted Central Catheter (PICC) with heparin.</p> <p>On 10/04/2024, at 03:07 PM, Surveyor received a document from NHA-A via confidential email. The document provided by NHA-A documents in part, . the risk of using Heparin outweighs the benefits. signed by MD-U, dated 10/04/2024.</p> <p>Coban-</p> <p>Surveyor reviewed R7's orders and noted an order documenting, Coban wraps to BLE twice weekly one time a day every Wed, Sat with a start date of 06/19/2024 and end date of 06/20/2024. Surveyor noted this was marked completed in R7's June 2024 Treatment Administration Record (TAR).</p> <p>Surveyor noted an order documenting, Per Dr. [NAME] wounds should be dressed with COBANZ MATERIAL instead of ACE wraps. Wrap feet with COBANZ first the escalate up the leg to prevent LE edema every shift with a start date of 06/28/2024 and end date 08/07/2024. Surveyor noted in R7's June and July TAR was marked as completed every shift (except not documented on 07/18/2024 evening shift and 07/19/2024 day shift).</p> <p>Surveyor noted a progress note on 06/23/2024, at 06:33 AM documents in part, . Has ace wrap to rt. leg. Has excoriated lt. leg .</p> <p>Surveyor noted a progress note, dated 06/23/2024, at 02:40 PM, documents in part, Situation: Resident c/o pain, burning and clear discharge from bilateral legs not relieved with analgesic given. Wants to go to ER.</p> <p>Surveyor noted a progress note, dated 06/23/2024, at 10:10 PM, documents in part, Resident returns from hospital ER, RN received report from [NAME], RN. Resident has had bilateral legs wrapped with xeroform, kerlix, and ace bandages. VSS obtained, 128/74, 18 respirations, 76 heart rate, 97% room air upon arrival to our facility. He reports he is in no pain at this time. will continue to monitor.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Surveyor noted on 06/24/2024, a progress note by NP-AA, documents resident was seen and examined today in his room at Burlington's rehabilitation center for follow-up on Leg wounds that are weeping. Resident is alert awake oriented x 4 sitting up on his comfortably with no acute distress no chest pain no shortness of breath stable vital signs, his pain level is 7-9 out of 10. On exam patient is wearing Ace wraps to bilateral legs from his knees down to his ankles.</p> <p>Surveyor noted a progress note on 06/29/2024, documents, Note Text: Per Dr. [NAME] wounds should be dressed with COBANZ MATERIAL instead of ACE wraps. Wrap feet with COBANZ first and escalate up the leg to prevent LE edema</p> <p>every shift no Coban available in facility, wrapped w/ kerlix f/b tubi grips.</p> <p>Surveyor noted a progress note by NP-AA, dated 07/02/2024, documents in part, . resident was seen and examined today in his room at Burlington's rehabilitation center for follow-up on Leg wounds that are weeping. Resident is alert awake oriented x 4 sitting up on his comfortably with no acute distress no chest pain no shortness of breath stable vital signs, his pain level is 7-9 out of 10. On exam patient is wearing Ace wraps to bilateral legs from his knees down to his ankles.</p> <p>Surveyor noted a progress note, dated 07/07/2024, documents, Per Dr. [NAME] wounds should be dressed with COBANZ MATERIAL instead of ACE wraps. Wrap feet with COBANZ first and escalate up the leg to prevent LE edema every shift</p> <p>COBANZ unavailable.</p> <p>Surveyor noted a progress note on 07/08/2024, by RN-K, documents Resident had ordered supplies from Amazon for his leg treatment. RN did treatment per order using these supplies. Coban wrap to be monitored for any circulation issues.</p> <p>Surveyor noted a progress not on 07/11/2024, by NP-AA documents in part, . resident was seen and examined today in his room at Burlington's rehabilitation center for follow-up on Leg wounds that are weeping. Resident is alert awake oriented x 4 sitting up on his comfortably with no acute distress no chest pain no shortness of breath stable vital signs, his pain level is 7-9 out of 10. On exam patient is wearing Ace wraps to bilateral legs from his knees down to his ankles.</p> <p>Surveyor noted a progress note on 07/13/2024, documents, Per Dr. [NAME] wounds should be dressed with COBANZ MATERIAL instead of ACE wraps. Wrap feet with COBANZ first and escalate up the leg to prevent LE edema</p> <p>every shift. Cobanz not available. Res. has legs wrapped in kerlix.</p> <p>Surveyor noted a progress note dated 07/15/2024 by NP-AA, documents in part, . resident was seen and examined today in his room at Burlington's rehabilitation center for follow-up on Leg wounds that are weeping. Resident is alert awake oriented x 4 sitting up on his comfortably with no acute distress no chest pain no shortness of breath stable vital signs, his pain level is 7-9 out of 10. On exam patient is wearing Ace wraps to bilateral legs from his knees down to his ankles.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Surveyor noted a progress note dated 07/22/2024 by NP-AA, documents in part, . Continue with wound care, follow-up with Dr. [NAME], per Dr. [NAME] and medical director follow-up with infectious diseases.</p> <p>Surveyor noted a progress note, dated 07/23/2024 documents, Clarification/Late entry for 7/23/2024; Wound care to BLE dressings completed, However, Resident declined to have Coban wraps applied, stating I don't need them right now, the swelling to my legs went down and I've been keeping my legs elevated MD updated, NNO sat this time.</p> <p>On 10/02/2024, at 03:07 PM, Surveyor interviewed RN-K regarding his progress note for R7's Coban. RN-K informed Surveyor that at the time the Facility did not have Coban, and the R7 ordered his own. RN-K informed Surveyor that he notified Medical Records/Central Supply-J to order Coban. RN-K informed Surveyor that the supply gets to the Facility quick.</p> <p>On 10/02/2024, at 01:25 PM, Surveyor interviewed Medical Records/Central Supply-J. Medical Records/Central Supply-J informed Surveyor that usually order requests are done verbally, no logs are kept of order requests. Medical Records/Central Supply-J informed Surveyor that the order for Coban arrived to the facility on [DATE]. Medical Records/Central Supply-J informed Surveyor that the week prior to the Coban arriving, 1 pack of Coban arrived due to error when ordering.</p> <p>On 10/02/2024, at 03:12 PM, UM-F informed Surveyor that UM-F bought Coban for R7 and informed R7 not to buy his own. UM-F informed Surveyor that the Coban was sent with R7 upon discharge.</p> <p>On 10/02/2024, at 03:55 PM, Surveyor received a printout of Coban in an online Walmart cart with an estimated total of \$18.38. Surveyor was also given a copy of document titled FREE CKG W/PLATINUM CARD indicating a charge of \$18.34 on July 20,2024.</p> <p>On 10/03/2024, at 09:29 AM, Surveyor interviewed DON-B. DON-B informed Surveyor the expectation is to follow policy regarding PICC line dressing changes and flushes. DON-B informed Surveyor that PICC line dressing should be changed every 7 days or as needed, and the site should be monitored every shift. DON-B informed Surveyor that flushing a PICC would include Saline flushes before and after, as well as a Heparin flush after. DON-B informed Surveyor that if a concern is made by a resident to a nurse, the expectation is the nurse would further investigate the concern and DON-B would expect to be notified. DON-B informed Surveyor that no concerns were brought to her attention aside from the issue with the Coban.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49845</p> <p>Based on observation, interview, and record review, the facility did not ensure residents received adequate assistance with devices to prevent accidents for 1 (R5) of 1 resident observed for accidents.</p> <p>R5 required assistance of 2 staff to be transferred using a Hoyer lift. Facility staff were observed walking away from R5 during the transfer process to address other issues leaving R5 suspended in the sling and creating a potential unsafe transfer.</p> <p>Findings include:</p> <p>R5's most recent admission to the Facility was on 05/16/2022. R5's annual Minimum Data Set (MDS), dated [DATE], documents R5 has a Brief Interview for Mental Status (BIMS) of 15 with a primary medical condition category of Traumatic Spinal Cord Dysfunction. R5 has functional limitations in bilateral upper and lower extremities, and is dependent with transfers from bed to chair.</p> <p>Surveyor reviewed R5's care plan and noted R5 requires the assist of 2 staff for transfer with a Hoyer. Full body sling / Xlarge. No Ambulation.</p> <p>On 10/01/2024, at 11:06 AM, Surveyor observed Hospice RN-CC ask RN-L for assistance transferring R5 from the bed to the wheelchair using a Hoyer lift. RN-L went into R5's room with Hospice RN-CC, the door to R5's room was left open. Surveyor observed from the hall. Surveyor observed RN-L controlling the Hoyer lift controls to maneuver the Hoyer. While R5 was attached to the Hoyer lift, in the air, a phone began ringing on the medication cart in the hallway outside of R5's room. Surveyor observed RN-L walk away to turn the ringer off on the phone. RN-L then went back into R5's room. R5 was then positioned in the air, over the wheelchair, RN-L and Hospice RN-CC attempted to lower R5 into the wheelchair a few times. On the last attempt to lower R5 to the wheelchair, Surveyor observed the front wheels of the wheelchair coming off the ground. Surveyor heard RN-L tell Hospice RN-CC he is going to fall. RN-L instructed Hospice RN-CC to assist R5 to position R5 better in the wheelchair. RN-L then indicated needing more help transferring R5 into the wheelchair. RN-L left R5's room to go get a certified nursing assistant (CNA), at the time RN-L left R5's room, R5 was suspended in the air with the Hoyer lift, with the wheelchair underneath R5. Hospice RN-CC stayed with R5 while RN-L left to get assistance. Hospice RN-CC informed Surveyor that Hospice RN-CC brought an XL sling today for R5's Hoyer transfers due to R5 having the wrong size sling, stating it was too small. R5 was suspended in the air for approximately 6 minutes until RN-L returned with Certified Occupational Therapy Aide (COTA)-Q and CNA-DD, they all went into R5's room and closed the door. Surveyor later observed R5 in his wheelchair with no concerns.</p> <p>On 10/03/2024 at 12:30 PM, Surveyor notified NHA-A of above findings.</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20483</p> <p>Based on observation, interview, and record review the facility did not ensure 1 (R3) of 1 resident was provided with appropriate food items for a renal/LCS (low concentrated sweets) diet as prescribed by the physician.</p> <p>R3 was served french fries and a tomato slice on 10/1/24.</p> <p>Findings include:</p> <p>The Renal Diet/Liberal Renal Diets/Renal LCS (low concentrated sweets) from [Name] Food Service not dated under description documents The renal/liberal renal diets regulate sodium, potassium, and fluid intake. The renal diet also regulates protein. These diets are primarily prescribed to patients with renal (kidney) disease. There are many stages of renal disease ranging from Acute Renal Failure to End-stage Renal Disease. However, a protein-restricted diet is generally only used for patients with acute or chronic renal failure who are not on dialysis. It is important to follow the appropriate individualized guidelines set by a physician and registered dietitian nutritionist knowledgeable in treating patients with kidney disease. The Renal/LCS diet combines the Renal diet and LCS diets.</p> <p>Under restricted foods for Vegetables documents High potassium/sodium vegetables such as baked beans, beets, potatoes, tomatoes, sweet potatoes.</p> <p>R3's diagnoses includes chronic kidney disease with heart failure and end stage renal disease. R3 receives hemodialysis three times weekly.</p> <p>The physician orders include with an order date of 9/26/24 Renal, LCS diet Regular texture, regular/thin consistency.</p> <p>On 10/1/24, at 12:16 p.m., Surveyor observed R3 sitting in a wheel chair in her room talking on the telephone. Surveyor observed there is an over bed table across R3 and R3 has not been served lunch.</p> <p>On 10/1/24, at 12:29 p.m., Surveyor observed the food truck being delivered to R3's unit.</p> <p>On 10/1/24, at 12:37 p.m., Surveyor informed CNA (Certified Nursing Assistant)-G Surveyor would like to see R3's lunch tray when they remove the tray from the food truck.</p> <p>On 10/1/24, at 12:38 p.m., CNA-G showed Surveyor R3's lunch meal which consisted of a chicken sandwich on a bun, french fries, pea salad, lettuce with a tomato, mayonnaise packet and green jello. R3's meal ticket listed Renal LCS, texture regular fluid thin. Surveyor noted R3 should not have received french fries & the tomato slice which is high in potassium.</p> <p>On 10/1/24, at 1:13 p.m., Surveyor telephone R3's POA (power of attorney). Surveyor asked R3's POA if there are any food concerns with R3. R3's POA informed Surveyor her mom doesn't like the food and they give her mom foods that are high in potassium such as potatoes and bananas.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 10/2/24, at 10:46 a.m., Surveyor interviewed RD (Registered Dietitian)-P. Surveyor asked RD-P if a resident is on a renal, LCS diet what does this mean. RD-P explained a renal diet is low potassium, low phosphorus, and LCS limits excessive sugar stating it's a pretty liberal diabetic diet. Surveyor asked for the renal diet is there any foods a resident should not receive. RD-P replied tomatoes, chocolate, bananas, potatoes, and soda drink. RD-P replied these are the main things to avoid. I would say those are the main trouble makers for a renal diet. Surveyor asked RD-P how the kitchen staff knows a resident is on a renal diet. RD-P explained when a resident comes in nursing gives the diet order to FSD (Food Service Director)-O, the diet order is put into menu matrix and is printed out on all the tickets. RD-P informed Surveyor if he makes any changes he notifies FSD-O. Surveyor inquired how the cooks would know a resident is on a renal diet. RD-P informed Surveyor the diet ticket would say renal diet and the cooks should be educated on the basic of a renal diet. Surveyor asked RD-P if he has had any communication with the dialysis dietitian. RD-P replied absolutely. RD-P informed Surveyor R3 was having high labs mainly potassium & phosphorus but the last labs were within normal limits. Surveyor informed RD-P of the food items R3 received for lunch on 10/1/24. RD-P replied that's not exactly compliant. RD-P stated he needs to go into the kitchen and do some education on a renal diet as they have new cooks.</p> <p>On 10/2/24, at 10:58 a.m., Surveyor asked FSD-O how the dietary staff know what diet a resident has ordered. FSD-O informed Surveyor nursing gives them a diet slip and she puts it on their diet cards. Surveyor asked how do the cooks know what foods they should not give a resident who is on a renal diet. FSD-O informed Surveyor they have a book in the kitchen that lists the foods the resident should not have like tomatoes, oranges, bananas, orange juice mostly. Surveyor asked FSD-O if a resident on a renal diet can the resident receive potatoes. FSD-O replied no can't get it. Surveyor informed FSD-O of the food items R3 received for lunch on 10/1/24. FSD-O informed Surveyor she'll have to check into that.</p> <p>On 10/3/24, at 12:24 p.m., NHA (Nursing Home Administrator)-A was informed of the above. No information was provided as to why R3 received food items which should not have been served on a renal diet.</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** 20483</p> <p>Based on observation, interview, and record review the facility did not provide the necessary respiratory care and services for 1 (R3) of 1 residents with a tracheostomy.</p> <p>The facility did not change R3's HME (heat moisture exchanger) trach valve daily according to physician orders.</p> <p>Findings include:</p> <p>R3 was admitted to the facility on [DATE].</p> <p>R3's diagnoses include chronic respiratory failure, morbid obesity, and paralysis of vocal cords and larynx.</p> <p>The physician orders include with an order date of 5/17/24 Change HME trach valve daily one time a day for tracheostomy care. An HME trach valve traps the moisture and heat from exhaled gas allowing it to be recycled on inspiration and also helps keep large particles out of the lung such as food particles.</p> <p>Surveyor reviewed R3's May 2024, June 2024, July 2024, August 2024, September 2024 & October 2024 MAR (medication administration record) and noted licensed staff are checking & initialing the HME trach valve is being changed daily with a scheduled time of 0800 (8:00 a.m.) when R3 is in the facility.</p> <p>On 10/1/24, at 9:44 a.m., LPN (Licensed Practical Nurse)-M informed Surveyor R3's ready and she will get the supplies ready. LPN-M had a suction catheter kit, T sponge, and inner cannula 6.5 mm (millimeter). LPN-M placed the appropriate PPE (personal protective equipment) on and entered R3's room. From 9:50 a. m. to 9:59 a.m. Surveyor observed LPN-M suction R3's trach, change the T sponge and inner cannula. Surveyor did not observe LPN-M change R3's HME trach valve.</p> <p>On 10/2/24, at 1:05 p.m., Surveyor asked LPN-M if she could show Surveyor the HME trach valve. LPN-M informed Surveyor she doesn't know what that is and will have to ask first name of DON (Director of Nursing)-B. Surveyor then accompanied LPN-M to the medication room to look for the HME trach valve. LPN-M stated it may be something different than what they call it. I need to Google it. LPN-M stated maybe it's in the box referring to a box with trach supplies. LPN-M was unable to locate the HME trach valve.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Burlington Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 677 E State St Burlington, WI 53105	
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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 10/2/24, at 1:11 p.m., Surveyor asked MR/CS (Medical Records/Central Supply)-J what she is responsible for ordering. MR/CS-J informed Surveyor wound care treatments, tube feeding, over the counter medications, Foley catheters, trach supplies, cups for med pass, and all personal care supplies such as shampoo & toothpaste. Surveyor asked MR/CS-J if the facility has HME trach valves. MR/CS-J replied I don't think I ever ordered them then stated wait I put an order in because [first name of] UM (Unit Manager)-I asked me to order them but then R3 went to the hospital. Surveyor asked MR/CS-J if the HME trach valves came in the building. MR/CS-J replied no. Surveyor then accompanied MR/CS-J down to the central supply room in the basement to observe trach supplies. Surveyor noted there are inner cannula's, trach ties, suction catheter kits, canisters, trach masks. MR/CS-J informed Surveyor upstairs there are tubing and she just put an order in for humidifier bags and Y connectors.</p> <p>On 10/2/24, at 1:27 p.m., LPN-M asked Surveyor if Surveyor was able to find out what the HME trach valve is. Surveyor informed LPN-M the facility has never had this in the building. LPN-M informed Surveyor she had checked the HME trach valve as being changed and will have to change it.</p> <p>On 10/3/24, at 8:02 a.m., Surveyor interviewed DON (Director of Nursing)-B regarding R3's HME trach valve. DON-B informed Surveyor after R3 was admitted she let MR/CS-J what needs to be ordered. DON-B stated I have no answer other than it was not ordered, referring to the HME trach valve. DON-B also stated nor did the nurses communicate, again referring to the HME trach valve. Surveyor informed DON-B the licensed nurses have been checking and initialing the HME trach valve is being changed daily. DON-B informed Surveyor when R3 was admitted RT (respiratory therapy) set up the equipment, education was provided to the nurses and MR/CS-J was sent a list of supplies that needed to be ordered.</p> <p>On 10/3/24, at 12:24 p.m., NHA (Nursing Home Administrator)-A was notified of the above. No information was provided to Surveyor as to why the facility did not provide the HME trach valve according to physician orders for R3.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</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** 20483</p> <p>Based on observation, interview, and record review the facility did not provide pharmaceutical services to assure accurate dispensing and administering medications to meet the needs of each resident. This has the potential to affect R3, R7, 17 residents who reside on the 400 unit & R17.</p> <p>* R3's Bisacodyl (Dulcolax) 10 mg (milligram) suppository was transcribed incorrectly on 8/20/24 when R3 was readmitted from the hospital.</p> <p>*The Facility did not provide R7 with the ordered Coban wraps, per the physician's order.</p> <p>* Medications were left on top of medication cart unattended.</p> <p>* R17's glucose monitor was not labeled to identify it was R17's glucose monitoring device.</p> <p>1.) R3 was readmitted to the facility on [DATE] with diagnosis which includes C Diff (clostridoides difficile).</p> <p>The after visit summary for date of discharge of 8/20/24 for discharge medications under continue taking these medications which have not changed includes Bisacodyl 10 mg (milligrams) suppository. Commonly known as: Dulcolax. Under details documents Place 10 mg rectally daily as needed for Constipation.</p> <p>R3's Bisacodyl 10 mg suppository was transcribed incorrectly on 8/20/24 to Insert 10 mg rectally every 24 hours for constipation. R3's Bisacodyl 10 mg suppository should have been transcribed as needed and not scheduled every 24 hours.</p> <p>Surveyor reviewed R3's August MAR (medication administration record) and noted R3 received the Bisacodyl suppository on 8/23/24. According to R3's bowel records on 8/23/24 R3 had 3 episodes of loose/watery stools.</p> <p>Surveyor reviewed R3's September MAR and noted R3 received the Bisacodyl suppository on 9/4/24 & 9/6/24. According to R3's bowel records R3 had one episode of loose/watery stools on 9/4/24 and on 9/6/24.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 10/3/24, at 7:54 a.m., Surveyor informed DON (Director of Nursing)-B Surveyor didn't understand why R3's Bisacodyl 10 mg suppository was transcribed to be administered every 24 hours when R3 was admitted on [DATE] with a diagnosis of C Diff and was having loose stools. DON-B replied me too and explained to Surveyor it was brought to her attention by R3's daughter who is the POA (Power of Attorney). DON-B informed Surveyor R3's daughter had emailed her asking why her mom was receiving a suppository. DON-B informed Surveyor this was brought to her attention on 9/9/24 and the scheduled suppository was discontinued on 9/7/24 and changed to PRN (as needed). DON-B informed Surveyor she spoke with the nurse who wrote the order, RN (Registered Nurse)-L. RN-L couldn't remember why she wrote the order. DON-B informed Surveyor she spoke with Nurse Tech-BB who gave the suppository during the period when R3 was having diarrhea. Nurse Tech-BB informed her she was following physician orders. Surveyor asked DON-B if she provided anyone with education following this incident. DON-B informed Surveyor she gave education to RN-L and Nurse Tech-BB. Surveyor asked DON-B if R3's Bisacodyl suppository order should have been PRN. DON-B replied should of been PRN.</p> <p>On 10/3/24, at 12:24 p.m., NHA (Nursing Home Administrator)-A was informed of the above.</p> <p>Coban</p> <p>*)R7 was admitted to the facility on [DATE], to receive intravenous antibiotics due to a wound infection.</p> <p>Surveyor reviewed R7's document titled Discharge Summary, with a service date of 06/18/2024, and documents in part,</p> <p>Wound Care to BLE</p> <ol style="list-style-type: none"> 1. Cleanse wound with Hibiclens and Water 2. Pat area dry with gauze 3. Apply Mepilex AG to posterior Knees 4. Fan Wrap Viscopaste gauze 5. Apply Coban 2 layer wrap to patients thighs 6. WOCN to change twice a week, Monday/Thursday <p>Surveyor reviewed R7's document, titled Admission/Readmission/Routine Heat-to-toe Evaluation, dated 06/18/2024, and documents in part, . Coban wraps to BLE done twice weekly at hospital and d/t tomorrow, would like them to be done tomorrow vs assessing today.</p> <p>Surveyor reviewed R7's orders and noted an order documenting, Coban wraps to BLE twice weekly one time a day every Wed, Sat with a start date of 06/19/2024 and end date of 06/20/2024. Surveyor noted this was marked completed in R7's June 2024 Treatment Administration Record (TAR).</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Surveyor noted an order for R7 documenting, Per Dr. [NAME] wounds should be dressed with COBANZ MATERIAL instead of ACE wraps. Wrap feet with COBANZ first the escalate up the leg to prevent LE edema every shift with a start date of 06/28/2024 and end date 08/07/2024. Surveyor noted, in R7's June and July TAR, was marked as completed every shift (except not documented on 07/18/2024 evening shift and 07/19/2024 day shift).</p> <p>Surveyor noted a progress note on 06/23/2024, at 06:33 AM documents in part, . Has ace wrap to rt. leg. Has excoriated lt. leg .</p> <p>Surveyor noted a progress note, dated 06/23/2024, at 02:40 PM, documents in part, Situation: Resident c/o pain, burning and clear discharge from bilateral legs not relieved with analgesic given. Wants to go to ER.</p> <p>Surveyor noted a progress note, dated 06/23/2024, at 10:10 PM, documents in part, Resident returns from hospital ER, . Resident has had bilateral legs wrapped with xeroform, kerlix, and ace bandages. VSS obtained, 128/74, 18 respirations, 76 heart rate, 97% room air upon arrival to our facility. He reports he is in no pain at this time. will continue to monitor.</p> <p>Surveyor noted a progress note on 06/24/2024, by NP-AA, documents resident was seen and examined today in his room at Burlington's rehabilitation center for follow-up on Leg wounds that are weeping. Resident is alert awake oriented x 4 sitting up on his comfortably with no acute distress no chest pain no shortness of breath stable vital signs, his pain level is 7-9 out of 10. On exam patient is wearing Ace wraps to bilateral legs from his knees down to his ankles.</p> <p>Surveyor noted a progress note on 06/29/2024, documents, Note Text: Per Dr. [NAME] wounds should be dressed with COBANZ MATERIAL instead of ACE wraps. Wrap feet with COBANZ first and escalate up the leg to prevent LE edema every shift no Coban available in facility, wrapped w/ kerlix f/b tubi grips.</p> <p>Surveyor noted a progress note by NP-AA, dated 07/02/2024, documents in part, . resident was seen and examined today in his room at Burlington's rehabilitation center for follow-up on Leg wounds that are weeping. Resident is alert awake oriented x 4 sitting up on his comfortably with no acute distress no chest pain no shortness of breath stable vital signs, his pain level is 7-9 out of 10. On exam patient is wearing Ace wraps to bilateral legs from his knees down to his ankles.</p> <p>Surveyor noted a progress note, dated 07/07/2024, documents, Per Dr. [NAME] wounds should be dressed with COBANZ MATERIAL instead of ACE wraps. Wrap feet with COBANZ first and escalate up the leg to prevent LE edema every shift</p> <p>COBANZ unavailable.</p> <p>Surveyor noted a progress note on 07/08/2024, by RN-K, documents Resident had ordered supplies from Amazon for his leg treatment. RN did treatment per order using these supplies. Coban wrap to be monitored for any circulation issues.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Surveyor noted a progress not on 07/11/2024, by NP-AA documents in part, . resident was seen and examined today in his room at Burlington's rehabilitation center for follow-up on Leg wounds that are weeping. Resident is alert awake oriented x 4 sitting up on his comfortably with no acute distress no chest pain no shortness of breath stable vital signs, his pain level is 7-9 out of 10. On exam patient is wearing Ace wraps to bilateral legs from his knees down to his ankles.</p> <p>Surveyor noted a progress note on 07/13/2024, documents, Per Dr. [NAME] wounds should be dressed with COBANZ MATERIAL instead of ACE wraps. Wrap feet with COBANZ first and escalate up the leg to prevent LE edema every shift. Cobanz not available. Res. has legs wrapped in kerlix.</p> <p>Surveyor noted a progress note dated 07/15/2024 by NP-AA, documents in part, . resident was seen and examined today in his room at Burlington's rehabilitation center for follow-up on Leg wounds that are weeping. Resident is alert awake oriented x 4 sitting up on his comfortably with no acute distress no chest pain no shortness of breath stable vital signs, his pain level is 7-9 out of 10. On exam patient is wearing Ace wraps to bilateral legs from his knees down to his ankles.</p> <p>Surveyor noted a progress note dated 07/22/2024 by NP-AA, documents in part, . Continue with wound care, follow-up with Dr. [NAME], per Dr. [NAME] and medical director follow-up with infectious diseases.</p> <p>Surveyor noted a progress note, dated 07/23/2024 documents, Clarification/Late entry for 7/23/2024; Wound care to BLE dressings completed, However, Resident declined to have Coban wraps applied, stating I don't need them right now, the swelling to my legs went down and I've been keeping my legs elevated MD updated, NNO sat this time.</p> <p>On 10/02/2024, at 03:07 PM, Surveyor interviewed RN-K regarding his progress note for R7's Coban. RN-K informed Surveyor that at the time the Facility did not have Coban, and the R7 ordered his own. RN-K informed Surveyor that RN-K notified Medical Records/Central Supply-J to order Coban. RN-K informed Surveyor that the supply gets to the Facility quick one ordered.</p> <p>On 10/02/2024, at 01:25 PM, Surveyor interviewed Medical Records/Central Supply-J. Medical Records/Central Supply-J informed Surveyor that usually order requests are done verbally, no logs are kept of order requests. Medical Records/Central Supply-J informed Surveyor that the order for Coban arrived to the facility on [DATE]. Medical Records/Central Supply-J informed Surveyor that the week prior to the Coban arriving, 1 pack of Coban arrived due to error when ordering.</p> <p>On 10/02.2024, at 03:12 PM, UM-F informed Surveyor that UM-F bought Coban for R7 and informed R7 not to buy his own. UM-F informed Surveyor that the Coban was sent with R7 upon discharge.</p> <p>On 10/02/2024, at 03:55 PM, Surveyor received a printout of Coban in an online Walmart cart with an estimated total of \$18.38. Surveyor was also given a copy of document titled FREE CKG W/PLATINUM CARD indicating a charge of \$18.34 on July 20,2024.</p> <p>On 10/03/2024, at 09:29 AM, Surveyor interviewed DON-B. DON-B informed Surveyor the expectation is to follow policy regarding PICC line dressing changes and flushes. DON-B informed Surveyor that PICC line dressing should be changed every 7 days or as needed, and the site should be monitored every shift. DON-B informed Surveyor that flushing a PICC would include Saline flushes before and after, as well as a Heparin flush after.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>*)R17 Glucose monitor</p> <p>On 10/01/2024, at 08:53 AM, Surveyor observed LPN-Z obtain a blood sugar from R17. Surveyor noted the glucose monitor LPN-Z was using, was not labeled. Surveyor inquired to LPN-Z if residents have their own glucose monitors. LPN-Z informed Surveyor that residents do all have their own glucose monitors. Surveyor asked LPN-Z to show Surveyor how staff know which monitor belongs to which resident. LPN-Z began looking through the medication cart for R17's bag. LPN-Z informed Surveyor she could not find the bag for R17's glucose monitor, and informed Surveyor that the glucose monitor she used is 1 of the 2 stock glucose monitors in the medication cart. Surveyor noted neither of the other glucose monitors were labeled as stock monitors and noted other bags containing glucose monitors with resident names.</p> <p>Medication left on Medication Cart</p> <p>On 10/01/2024, at 09:25 AM, Surveyor observed RN-L walk away from medication cart, leaving stock medications on top of the medication cart within reach of other residents and staff walking by.</p> <p>On 10/01/2024, at 10:00 AM, Surveyor observed RN-L leave R14's medications on top of medication cart within reach of other staff/residents and walk away from medication cart to administer medications.</p>

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49435</p> <p>Based on interview and record review, the Facility did not ensure each Resident's drug regimen was free from unnecessary drugs for 1 (R6) of 5 Residents reviewed for antibiotic use.</p> <p>*R6 began having Urinary Tract Infection (UTI) symptoms on 7/16/24. R6 had a urinalysis (UA) and culture lab test collected by the facility staff on 7/17/24 and Rocephin (an antibiotic medication) was ordered to start on 7/18/24. R6 requested to go to the emergency room (ER) on 7/17/24 due to R6's UTI symptoms. The ER doctor prescribed Bactrim (an antibiotic medication) to start on 7/18/2024. On 7/19/24, R6 received Rocephin and Bactrim for R6's UTI symptoms. On 7/20/24, R6's urinary culture results came back and Macrobid (an antibiotic medication) was ordered to start on 7/20/2024 by the on-call Medical Doctor (MD). On 7/20/24, R6 received Rocephin, Bactrim and Macrobid for R6's symptoms of UTI. On 7/21/24, R6 requested to return to the ER and was prescribed Fosfomycin (an antibiotic drug). On 7/21/24, R6's doctor, MD-U identified that R6 was on 4 different antibiotics and Rocephin and Bactrim were discontinued on 7/22/24. R6 continued Macrobid and Fosfomycin as prescribed until the UTI symptoms had resolved.</p> <p>Findings include:</p> <p>The facility policy entitled, Antibiotic Stewardship Program, dated 12/23/22, documents, in part: It is the policy of this facility to implement an Antibiotic Stewardship Program as part of the facility's overall infection prevention and control program. The purpose of the program is to optimize the treatment of infections while reducing the adverse events associated with antibiotic use .</p> <p>Antibiotic use protocols: Nursing staff shall assess residents who are suspected to have an infection . Laboratory testing shall be in accordance with current standards of practice .</p> <p>Monitoring antibiotic use: Monitor response to antibiotics, and laboratory results when available, to determine if the antibiotic is still indicated or adjustments should be made . Antibiotic orders obtained upon admission, whether new admission or readmission, to the facility shall be reviewed for appropriateness. Antibiotic orders obtained from consulting, specialty or emergency providers shall be reviewed for appropriateness.</p> <p>On 10/2/2024 at 9:10 AM, Director of Nursing informed Surveyor that the facility follows McGeer's criteria to determine the use of antibiotics for UTI symptoms. The facility McGeer's documentation included the following:</p> <p>UTIs-For Residents without an Indwelling Catheter. BOTH criteria 1 and 2 must be present</p> <p>1. At least 1 of the following sign or symptom subcriteria:</p> <p>a. Acute dysuria or acute pain, swelling or tenderness of the testes, epididymis or prostate.</p> <p>b. Fever OR leukocytosis AND at least ONE of the following localizing urinary tract subcriteria:</p> <p>- Acute costovertebral angle (mid/center back) pain or tenderness.</p> <p>(continued on next page)</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<ul style="list-style-type: none"> - Suprapubic pain. - Gross hematuria. - New or marked increase in incontinence. - New or marked increase in urgency. - New or marked increase in frequency. <p>c. In the absence of fever or leukocytosis, then TWO or more of the following localizing urinary tract subcriteria:</p> <ul style="list-style-type: none"> -Suprapubic pain -Gross hematuria -New or marked increase in incontinence. -New or marked increase in urgency. -New or marked increase in frequency. <p>2. One of the following microbiologic subcriteria:</p> <ul style="list-style-type: none"> a. At least 10 to the 5th cfu (colony forming units)/ml (milliliter), or no more than 2 species of microorganisms in a voided urine sample. b. At least 10 to the 2nd cfu/ml of any number of organisms of in a specimen collected by in-and-out catheter. <p>R6 was admitted to the facility on [DATE] with diagnosis that include Type 2 Diabetes, Chronic Heart Failure, Morbid obesity, and Chronic pain.</p> <p>R6's Admission Minimum Data Set (MDS) Assessment, dated 7/21/24, documents R6 is cognitively intact. R6 is dependent on staff for personal hygiene and for transfers. R6 is always incontinent of urine.</p> <p>R6's progress note, dated 7/16/24 at 2:46 PM, documents, in part: . Resident has burning, itching and pain when urinating. New order for UA with reflex .</p> <p>R6's progress note, dated 7/17/24 at 2:16 PM, documents, in part: . UA collected from resident 7/17/24 and was found to have an UTI after resident [complained of] burning when urinating, pain in vaginal area and itching. On 7/16/24 an attempt to collect UA was done but unsuccessful. Resident had new order for . 1 gram Rocephin [Intramuscular (IM)] for 7 days from [Nurse Practitioner (NP)]. Resident at [7 PM] requested to be sent out to [emergency room] . Resident was then taken to [name of area hospital ER] on stretcher .</p> <p>(continued on next page)</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R6's MD order with a start date of 7/18/24, documents: Ceftriaxone Sodium (Rocephin)-inject 1 gram intramuscularly one time a day for pain for 7 days.</p> <p>R6's progress note, dated 7/18/24 at 12:11 PM, documents, in part: Resident returned from ER visit new orders for Bactrim DS 1 tablet in the evening [for] 7 days .</p> <p>R6's MD order with a start date of 7/18/24, documents: Sulfamethoxazole-Trimethoprim (Bactrim) 800-160mg. Give 1 tablet by mouth two times a day for UTI until 7/25/24.</p> <p>R6's Medication Administration Record (MAR) documents that R6 did not receive Rocephin on 7/18/24. R6 received a PM dose of Bactrim on 7/18/24.</p> <p>R6's Infection Report form, dated 7/18/2024, documents R6 with the following symptoms: Suprapubic pain, New or marked increase in incontinence, New or marked increase in urgency and New or marked increase in frequency. Surveyor noted R6 met the criteria for Number one of McGeer's criteria. Surveyor noted that nothing was marked in section 2 indicating that R6 did not meet McGeer's criteria for starting antibiotics.</p> <p>R6's MAR documents R6 received an AM dose of Rocephin and an AM and PM dose of Bactrim on 7/19/24.</p> <p>R6's progress note, dated 7/20/24 at 3:19 PM, documents, in part: . Resident's UA results came back, results sent to on-call [doctor]. Resident started on Macrobid 100 mg twice a day for seven days.</p> <p>Surveyor noted that there was no documentation of a discussion about the other antibiotics R6 was receiving when the on-call doctor was notified of the UA culture results on 7/20/24.</p> <p>R6's MD order with a start date of 7/20/24, documents: Macrobid 100mg. Give 1 capsule orally two times a day for UTI for 7 days.</p> <p>R6's Infection Report form, dated 7/20/2024, documents R6 with the following symptoms: Suprapubic pain, New or marked increase in incontinence, New or marked increase in urgency and New or marked increase in frequency. Surveyor noted R6 met the criteria for Number one of McGeer's criteria. Surveyor noted that nothing was marked in section 2 indicating that R6 did not meet McGeer's criteria for starting antibiotics. On the Infection Report form, a note written and signed by Unit Manager-I, documents: provided education with antibiotic stewardship to resident with MD. Culture less than 100,000. MD aware. Continue antibiotic per residents [signs and symptoms]</p> <p>R6's MAR documents that R6 received an AM dose of Rocephin, an AM and PM dose of Bactrim and a PM dose of Macrobid on 7/20/24.</p> <p>Surveyor noted R6 received 3 different antibiotics on the same day for R6's symptoms of UTI.</p> <p>R6's progress note, dated 7/21/24 at 4:16 AM, documents: [R6] asked if [R6] could be sent to [name of hospital] for severe vaginal pain.</p> <p>R6's progress note, dated 7/21/24 at 3:50 PM, documents: Resident arrived back to facility at 12:30 PM . one new order Fosfomycin (an antibiotic medication) 3 [gram] packet two doses Tuesday morning and Thursday morning.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Burlington Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 677 E State St Burlington, WI 53105	
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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R6's MD order with a start date of 7/23/24 documents: Fosfomycin Tromethamine. Give 3 grams by mouth one time a day every [Tuesday], [Thursday] for UTI until 7/25/24.</p> <p>R6's MAR documents R6 received a PM dose of Bactrim and a PM dose of Macrobid on 7/21/24. Surveyor noted that no AM doses of antibiotics were given to R6 on 7/21/24 because R6 was out of the facility in the ER.</p> <p>R6's progress note signed by MD-U, dated 7/21/24 at midnight, documents, in part: . At this time [R6] is on 4 active antibiotics with no culture and sensitivity report. Will [discontinue] Bactrim DS and Ceftriaxone (Rocephin). Awaiting Culture and sensitivity report and will adjust accordingly . Addendum detail: Urine culture and sensitivity report showed sensitivity to [Macrobid]. Will continue as prescribed and will DC Bactrim DS and Ceftriaxone (Rocephin).</p> <p>Surveyor noted that Rocephin and Bactrim DS were discontinued on 7/22/24. R6 continued to take Macrobid and Fosfomycin as prescribed until the end of treatment.</p> <p>On 10/2/24 at 7:55 AM, Surveyor interviewed Registered Nurse (RN)-L. Surveyor asked what standard of practice the facility uses for infections. RN-L stated the facility uses McGeer's criteria. Surveyor asked what steps are taken when a resident starts having symptoms of UTI. RN-L stated that there is an infection packet that is started. The nurse will fill out the documentation and give it to Unit Manager-I. The infection packet includes the McGeer's criteria section, any lab work that is being completed and a section to include any new orders. Surveyor asked what steps are taken if a resident returns from the ER with a new antibiotic order. RN-L stated that the nurse will enter the order and fax the order to pharmacy. Surveyor asked if it is normal for a resident to be on 3 different antibiotics for symptoms of a UTI. RN-L stated that it is not normal. RN-L indicated that RN-L would call the resident's physician if RN-L noted a resident taking 3 different antibiotics for symptoms of a UTI.</p> <p>On 10/2/24 at 8:01 AM, Surveyor interviewed RN-S. Surveyor asked what steps RN-S would take if RN-S identified that a resident was taking 3 different antibiotics for symptoms of a UTI. RN-S stated she would do some follow up and possibly contact the resident's primary doctor.</p> <p>On 10/2/24 at 9:10 AM, Surveyor interviewed Director of Nursing (DON)-B. Surveyor reviewed the timeline of R6's antibiotic usage with DON-B. DON-B stated that there were multiple teams involved in prescribing R6's antibiotics. The facility provider, the ER doctors and the facility's on-call MD all contributed to R6's antibiotics order. Surveyor shared the continued concern that R6 was on 3 different antibiotics at the same time and R6 did not meet McGeer's criteria for infection. DON-B indicated DON-B understood the concern but stated that R6 also insisted on receiving the antibiotics for R6's infection. DON-B stated that Unit Manager-I had additional information to review with Surveyor.</p> <p>On 10/2/24 at 10:09 AM, Surveyor interviewed Unit Manager-I. Unit Manager-I reviewed the timeline of R6's antibiotics with Surveyor. Unit Manager-I stated that Unit Manager-I and the resident's MD spoke to R6 about the antibiotics not meeting the facilities criteria and Unit Manager-I educated R6 about the risk vs benefits of receiving antibiotics. Surveyor shared the continued concern that R6 was on 3 different antibiotics at the same time and R6 did not meet McGeer's criteria for infection.</p> <p>(continued on next page)</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 10/2/24 at 12:05 PM, Surveyor interviewed NP-T who works in the same medical group as MD-U. Surveyor asked when NP-T would put a resident on antibiotics for a UTI. NP-T stated NP-T would speak to the nurse and CNA first. Then NP-T would interview the resident for the signs and symptoms. NP-T would review the resident's medical history and then start deciding on the course of action. NP-T stated NP-T would do standard diagnostic tests first and determine what antibiotic to give based on the Culture and Sensitivity results from the urinalysis. Surveyor asked if it was standard for a resident to receive 3 different antibiotics for symptoms of a UTI infection. NP-T stated that in her multiple years of practice, NP-T has never prescribed 3 antibiotics for a UTI infection. NP-T stated that giving 3 antibiotics at one time could potentially harm the kidneys or liver based upon the age of the resident.</p> <p>On 10/2/24 at 12:18 PM, Surveyor informed Nursing Home Administrator and Director of operations-C of the concern that R6 was on 3 different antibiotics at the same time and R6 did not meet McGeer's criteria for infection. Director of Operations-C stated that they understood.</p> <p>On 10/2/24 at 3:05 PM, DON-B returned to Surveyor. DON-B indicated that 7/20/24 was a Saturday and that is part of the reason that the ON-Call MD got involved with ordering the additional antibiotics, Macrobid. Surveyor asked if DON-B would expect the nurse calling the On-call MD with the culture results to review the other antibiotics currently being taken by R6 with the MD. DON-B stated that it would be something DON-B would do but that DON-B can not speak for that nurse.</p> <p>On 10/4/24, Surveyor received an additional note from the facility signed by MD-U. The note documented, in part: . Due to non-adherence to medical advices, medications, immobility and poor hygiene, [R6] had recurrent UTIs. [R6] always claimed she knew which antibiotic she should be on and due to the presence of multiple medical teams-that included in house team, on-call team, and ER team that resulted in multiple treatments that overlapped each other at certain points.</p> <p>No further information was provided as to why the Facility did not ensure R6's drug regimen was free from unnecessary drugs.</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>20483</p> <p>Based on observation, interview, and record review the facility did not ensure its medication error rates are not 5 percent or greater. The facility medication error rate was 20%.</p> <p>*R14 received crushed Depakote (delayed release) and administered 8AM scheduled medications, including Carbidopa-levodopa, at 10:04 AM.</p> <p>*R8 received 8AM scheduled Gabapentin and Tramadol medications at 10:26 AM.</p> <p>*On 10/1/24 R3 did not receive Complex B-100 extended release with biotin & folic acid per physician orders and did not receive the correct dosage of Carvedilol.</p> <p>Findings include:</p> <p>The Facility Policy titled, Medication Administration dated 01/24, documents in part, . Medication Preparation: . 5. b. Long-acting, extended release or enteric-coated dosage forms should generally not be crushed; an alternative should be sought. Medications Administration: . 14. Medications are administered within 60 minutes of scheduled time, except before or after meal orders, which are administered based on mealtimes. Unless otherwise specified by the prescriber, routine medications are administered according to the established medication administration schedule for the nursing care center.</p> <p>On 10/01/2024, at 09:56 AM, Surveyor observed RN-L prepare R14's medications which included, Carbidopa-levodopa and Depakote (delayed release). At 10:02 AM Surveyor observed RN-L crush all R14's medications and mix them with apple sauce. At 10:04 AM Surveyor observed RN-L administer the crushed medications in apple sauce then administered to R14.</p> <p>Surveyor reviewed R14's Medication Administration Record (MAR) and noted R14 receives Depakote oral tablet delayed release 125 milligrams (mg) twice a day. According to The Federal Drug Administration (FDA) document titled, HIGHLIGHTS OF PRESCRIBING INFORMATION, last revised 05/2020, documents in part, Depakote is administered orally in divided doses. Depakote should be swallowed whole and should not be crushed or chewed (2.1, 2.2). Surveyor noted no documentation indicating R14's Depakote delayed release was reviewed and deemed safe to be crushed. R14's Depakote is also scheduled to be given at 8AM and 8PM.</p> <p>Surveyor reviewed R14's MAR and noted R14's Carbidopa-Levodopa oral tablet, 25-100mg is to be given 3 times per day at 8AM, noon and 5PM.</p> <p>On 10/01/2024, at 10:26 AM, Surveyor observed LPN-M prepare and administer R8's medications to R8.</p> <p>Surveyor reviewed R8's MAR and noted R8's Gabapentin 300mg is scheduled to be given 2 times per day, at 8AM and 8PM. Surveyor also noted, R8's Tramadol 50mg is scheduled to be given 3 times per day, at 8AM, 2PM and 8PM.</p> <p>(continued on next page)</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 10/02/2024, at 10:11 AM, Surveyor interviewed DON-B who indicated medications are to be given within a time frame of 1 hour before or 1 hour after scheduled time. DON-B indicated that if a medication is given outside of that time frame, the doctor should be notified. DON-B indicated that if there is an exception for this rule, it would be documented in a progress note in the resident's chart.</p> <p>On 10/02/2024, at 10:22 AM, Surveyor interviewed Unit Manager-I. Unit Manager-I informed Surveyor that medications are to be administered 1 hour before or 1 hour after scheduled times, unless it is a as needed (PRN) medication. Unit Manager-I informed Surveyor that the system will automatically document the time medication was given, which can not be changed, but that time will not show up in the MAR. Unit Manager-I informed Surveyor that she would need to look into how exactly someone would know the exact time a medication was given and where that would be documented. Unit Manager-I informed Surveyor the expectation of administering a medication outside of the scheduled timeframe is to notify the doctor, document in a progress note and report to the next shift nurse.</p> <p>Surveyor noted doctor notifications were not made and documented for R8 and R14 until after Surveyor brought concern to the Facility's attention.</p> <p>* On 10/1/24, at 9:00 a.m., Surveyor observed LPN (Licensed Practical Nurse)-M prepare R3's medication which consisted of acidophilus 1 capsule, Eliquis 5 mg (milligrams) one tablet, Carvedilol 12.5 mg one tablet, B complex with B12 one tablet, Hydralazine HCl 100 mg one tablet, 5% Lidocaine patch, Metronidazole 500 mg one tablet, and Pantoprazole Sodium DR (delayed release) 40 mg one tablet. LPN-M informed Surveyor she will be holding the poly powder due to R3's C diff (Clostridium difficile).</p> <p>At 9:05 a.m. Surveyor verified with LPN-M there are 7 tablets/capsule in the medication cup and one patch. LPN-M then crushed R3's oral medication with the exception of the acidophilus capsule and Pantoprazole sodium DR tablet. LPN-M placed the crushed medication, opened the acidophilus capsule and Pantoprazole sodium DR tablet in applesauce. LPN-M placed on the appropriate PPE (personal protective equipment) and entered R3's room.</p> <p>At 9:11 a.m. LPN-M administered R3's oral medication, removed the Lidocaine patch from R3's right hip and applied the Lidocaine patch on R3's right hip.</p> <p>On 10/1/24, at 3:18 p.m., Surveyor reviewed R3's physician orders and noted an order with an order date of 8/20/24 for Complex B-100 Oral Tablet Extended Release (B-Complex w/ (with) Biotin & Folic Acid).</p> <p>On 10/3/24, at 7:37 a.m., Surveyor asked RN (Registered Nurse)-K to show Surveyor the bottle of B complex with B12 that is in the medication cart. Surveyor informed RN-K R3's physician order is Complex B-100 Oral Tablet Extended Release (B-Complex w/ (with) Biotin & Folic Acid) and the B complex with B12 in the medication cart is not what the physician ordered. RN-K informed Surveyor unless it is sent by the pharmacy this is the only one I've seen in here.</p> <p>On 10/3/24, at 7:43 a.m., Surveyor informed DON (Director of Nursing)-B of R3 not receiving Complex B-100 Oral Tablet Extended Release (B-Complex w/Biotin & Folic Acid) according to physician orders. DON-B informed Surveyors she went through R3's chart and it's kind of a nightmare.</p> <p>(continued on next page)</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 10/3/24, at 8:22 a.m., Surveyor asked DON-B why the hospital discharge summary with medication changes for R3's Carvedilol was not picked up by the Facility and the incorrect dosage has been administered to R3. DON-B replied you are correct it's in there. Surveyor informed DON-B during the medication observation with R3 & LPN-M, LPN-M administered Carvedilol 12.5 mg when 25 mg should have been administered. Cross reference F760.</p> <p>This observation resulted in two medication errors for R3.</p> <p>On 10/3/24, at 12:24 p.m., NHA (Nursing Home Administrator)-A was informed of R3's two medication errors.</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20483</p> <p>Based on interview and record review the facility did not ensure 1 (R3) of 1 residents were free of significant medication errors.</p> <p>R3 was readmitted to the facility on [DATE] with discharge medications to include Carvedilol 25 mg every 12 hours. The facility did not change the dosage when R3 was readmitted and continued the previous dose of 12.5 mg. R3 received the incorrect dosage from 8/20/24 until 10/3/24 when DON (Director of Nursing)-B spoke with R3's physician on the telephone. R3 received the incorrect dose of Carvedilol 69 times during August and September 2024.</p> <p>Findings include:</p> <p>R3 was readmitted to the facility on [DATE].</p> <p>Diagnoses includes bilateral lower extremity edema, hypertension, and congestive heart failure.</p> <p>Under hospital course for date of discharge 8/20/24 under the section PCP (primary care physician) to Follow up:</p> <p>documents:</p> <ul style="list-style-type: none"> -Maintain care of tracheostomy and re-evaluate need for continued use. -re-evaluate need for Keppra. -maintain COVID-19 precautions -Medication changes: -complete 10 day course of PO (by mouth) Vancomycin 125 mg (milligrams) QID (four times daily) - increase Carvedilol to 25mg BID (twice daily). <p>The hospital expected medications list at discharge as of 8/20/24 documents Carvedilol (Coreg) 25 mg tablet. Take 1 tablet every 12 hours oral. Start date is documented as 8/20/24.</p> <p>The after visit summary for discharge date of [DATE] for discharge medications under CONTINUE taking these medications which have CHANGED documents Carvedilol 25 mg tablet. Commonly known as Coreg. What changed: medication strength, how much to take. Under details documents Take 1 tablet by mouth every 12 hours.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The nurses note dated 8/20/24 at 17:02 (5:02 p.m.) by RN (Registered Nurse)-S documents Resident, a Type 2 diabetic, returned from [Name] Medical Center. She is alert/oriented to time, place and person. She is in no respiratory distress. She has no anxiety at this time. VSS (vital signs stable). BP (blood pressure) is 142/76, Resp (respirations) is 16, pulse is 93, temp (temperature) is 97.8. She is 98% O2 (oxygen) on room air at this time. Her lungs are clear to auscultation, no wheezes or rhonci. Her tracheostomy tube, and right side central line are in place. Her primary discharge diagnosis, from [hospital name], is C diff Colitis and COVID 19. She is pleasantly communicating with RN. Standard precautions placed on her door entry. Will continue to monitor.</p> <p>The physician orders dated 8/20/24 documents Carvedilol oral tablet 12.5 mg. Give 12.5 mg by mouth every 12 hours for beta blocker. This order was discontinued on 8/29/24.</p> <p>The physician orders dated 8/29/24 documents Carvedilol oral tablet 12.5 mg. Give 12.5 mg by mouth every 12 hours for beta blocker. Hold if BP (blood pressure) is less than 110/70 or heart rate is less than 70.</p> <p>Surveyor reviewed R3's August 2024 & September 2024, MAR (medication administration record). Surveyor noted R3 received the incorrect dose of Carvedilol on 8/20 at 8:00 p.m., 8/21, 8/22, 8/23, 8/24, 8/25, 8/26, 8/27, 8/28, 8/29, 8/30, & 8/31 at 0800 (8:00 a.m.) and 2000 (8:00 p.m.)</p> <p>Surveyor noted R3 received the incorrect dosage of Carvedilol on 9/1, 9/2, & 9/3 at 8:00 a.m. & 8:00 p.m., 9/4 & 9/5 at 8:00 a.m., 9/6, 9/7, & 9/8 at 8:00 a.m. & 8:00 p.m., 9/9 at 8:00 a.m., 9/10 at 8:00 a.m. & 8:00 p.m., 9/11 at 8:00 p.m., 9/12 & 9/13 at 8:00 a.m. & 8:00 p.m., 9/14 at 8:00 p.m., 9/15 at 8:00 a.m. & 8:00 p.m., 9/16 at 8:00 a.m., 9/17 at 8:00 a.m., 9/18 at 8:00 a.m., 9/19 at 8:00 a.m. & 8:00 p.m., 9/20 at 8:00 a.m., 9/21 & 9/22 at 8:00 a.m. & 8:00 p.m., 9/23 at 8:00 a.m., 9/24 at 8:00 p.m., 9/26, 9/27, 9/28, & 9/29 at 8:00 a.m. & 8:00 p.m., & 9/30 at 8:00 a.m.</p> <p>R3 received the incorrect dose of Carvedilol 69 times during August and September 2024.</p> <p>On 10/2/24, at 7:36 a.m., Surveyor asked LPN (Licensed Practical Nurse)-M when a resident is admitted who reviews the hospital records for their medication. LPN-M informed Surveyor usually UM (Unit Manager)-F or UM-I and does the orders.</p> <p>On 10/2/24, at 1:32 p.m., Surveyor asked UM-I who reviews the hospital records when a resident is admitted . UM-I informed Surveyor the nurse on the floor will do the medication and put the orders in. UM-F does chart orders if they have a GT (gastrostomy tube), wound orders, etc. UM-I explained another nurse verifies the medication orders. Surveyor asked UM-I when R3 was readmitted on [DATE] was she involved with verifying the orders. UM-I informed Surveyor she doesn't know because R3 has been in and out so many times Surveyor showed UM-I the hospital records with the change in dosage for Carvedilol and this dose was not picked up. UM-I informed Surveyor she will have to look into this and get back to Surveyor.</p> <p>On 10/2/24, at 2:36 p.m., during the end of the day Surveyor informed NHA (Nursing Home Administrator)-A, DON (Director of Nursing)-B, and Director of Operations-C Surveyor interviewed UM-I regarding R3's Carvedilol 25 mg not being transcribed correctly when R3 was readmitted to the facility on [DATE] resulting in R3 receiving the incorrect dose. UM-I informed Surveyor she will look into this & get back to Surveyor but as of this time has not.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 10/3/24, at 8:22 a.m., Surveyor asked DON-B why the hospital discharge summary with medication changes for R3's Carvedilol was not picked up by the Facility and the incorrect dosage has been administered to R3. DON-B replied you are correct it's in there. DON-B informed Surveyor she did a medication error variance yesterday for this. DON-B informed Surveyor she text R3's physician yesterday requesting the physician contact her. DON-B informed Surveyor she spoke with the physician today and the physician said it was okay to keep the 12.5 mg dose. Surveyor asked DON-B about the facility's system for admission/readmission orders. DON-B informed Surveyor the floor nurse picks up the orders and reviews the medication orders with a second nurse for a second check. DON-B indicated then an admission audit is done by the managers. DON-B stated it was missed.</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>Provide and implement an infection prevention and control program.</p> <p>20483</p> <p>Based on observation, interview, and record review the facility did not maintain an infection prevention and control program designed to reduce the transmission of disease and infection for 1 (R3) of 2 Residents.</p> <p>* Appropriate hand hygiene was not observed during trach & incontinence cares for R3 who is on contact isolation for C diff (Clostridioides difficile).</p> <p>Findings include:</p> <p>The facility's policy titled, Management of C. (Clostridioides) Difficile Infection and not dated under policy documents This facility implements facility-wide strategies for the prevention and spread of Clostridioides difficile (C. difficile) infections. Under #5. General principles related to contact precautions for C. difficile: b. documents Hand hygiene shall be performed by hand washing with soap and water in accordance with facility policy for hand hygiene.</p> <p>The facility's policy titled Hand Hygiene and date implemented 12/23/22 under policy documents All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents and visitors. This applies to all staff working in all locations within the facility.</p> <p>Under Policy Explanation and Compliance Guidelines #2 documents Hand hygiene is indicated and will be performed under the conditions listed in, but not limited to, the attached hand hygiene table. #6 Additional considerations a. documents The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves.</p> <p>The Hand Hygiene Table for Exposure to Clostridioides difficile is suspected or likely (i.e. isolation room for C. diff) is checked for soap and water.</p> <p>R3's quarterly MDS (minimum data set) with an assessment reference date of 9/6/24 assesses R3 as dependent for toileting hygiene and frequently incontinent of urine and bowel. R3 is checked for suctioning and tracheostomy care while a resident.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525482	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/03/2024
NAME OF PROVIDER OR SUPPLIER Burlington Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 677 E State St Burlington, WI 53105	
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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 10/1/24, at 9:48 a.m., Surveyor observed LPN (Licensed Practical Nurse)-M place a gown & gloves on and entered R3's room with trach care supplies. LPN-M removed items from R3's over bed table, placed a towel on the over bed table and placed the trach care supplies on the towel. LPN-M removed her gloves, did not perform hand hygiene, opened the suction catheter kit, and placed gloves on. LPN-M poured water into the container, connected the suction to the tubing and asked R3 to take the box off. LPN-M asked R3 if she was ready, suctioned R3 and then suctioned R3 for a second time asking R3 if she was okay. LPN-M removed her gloves and placed gloves on. LPN-M did not perform any hand hygiene. LPN-M unfastened the trach ties, removed the T dressing, washed around R3's trach site, and placed a new T drainage sponge dressing on. LPN-M fastened the trach ties, removed her gloves and placed new gloves on. LPN-M did not perform any hand hygiene. LPN-M informed R3 she was going to change her cannula stating then you will be good to go. LPN-M removed the cannula, removed her gloves and placed new gloves on. LPN-M did not perform any hand hygiene. LPN-M placed the new cannula in and asked R3 to place the box on. LPN-M removed her PPE and left R3's room.</p> <p>On 10/1/24, at 10:55 a.m., Surveyor observed CNA (Certified Nursing Assistant)-G and CNA-H place a gown & gloves on and entered R3's room. CNA-G informed R3 they were going to get her washed up. CNA-H lowered the head of the bed down and removed the blanket from R3, and then covered R3 with a bath blanket. R3's gown was removed and CNA-G asked R3 if she could wash her face, handing R3 a wash cloth. CNA-G & CNA-H washed R3's upper body and then covered R3's upper body. CNA-G informed R3 they were going to wash R3's lower half. CNA-G washed R3's legs & feet and then washed R3's frontal perineal area. CNA-G removed her gloves, opened a drawer & removed out an incontinence product and placed gloves on. CNA-G did not perform any hand hygiene. R3 was assisted with positioning on the left side. CNA-G washed R3's buttocks & rectal area and then asked R3 if she was going number two. R3 replied no. CNA-G stated to R3 I think you are. Surveyor observed BM (bowel movement) on the wash cloth. CNA-G rewashed R3's rectal area. CNA-G informed R3 she needs a treatment on her bottom and placed the call light on. CNA-G informed R3 she was going to place the brief under her, stating you'll need to stay on your side until the nurse comes in. CNA-G emptied the water basins, removed her gloves, cleansed her hands with hand sanitizer and placed gloves on. CNA-G did not wash her hands with soap and water. CNA-G asked R3 what clothing she wanted to wear and removed a shirt & pants from the closet.</p> <p>At 11:21 a.m. LPN-M, wearing PPE, entered R3's room and placed cream on R3's open area. After applying the cream, LPN-M removed her PPE, cleansed her hands, and left R3's room.</p> <p>At 11:24 a.m. CNA-G and CNA-H placed pants on and fastened the incontinence product by positioning R3 from side to side. CNA-G & CNA-H placed gripper socks on, a brown bra, and a shirt on R3. CNA-G & CNA-H transferred R3 from the bed into the wheelchair using a gait belt and walker. After R3's bed was made, CNA-G and CNA-H removed their gloves and cleansed their hands.</p> <p>On 10/3/24, at 8:15 a.m., Surveyor asked DON (Director of Nursing)-B if a resident is on contact isolation for C Diff after incontinence care can staff use hand sanitizer or should they wash their hands with soap & water. DON-B informed Surveyor it's soap & water. Surveyor informed DON-B of the observations with LPN-M not performing hand hygiene after removing her gloves & placing new gloves on. Surveyor also informed DON-B of the observation R3 and CNA-G & CNA-H.</p>		