STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525482	A. Building B. Wing	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Burlington Health and Rehabilitation Center	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)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29015 Based on interviews, record reviews, and policy review, the facility failed to ensure care and services were documented for four Resident (R)1, R4, R5, and R9) of 11 residents reviewed for documentation of treatments as ordered by the physician. Failure to document medication administration and treatments to residents does not ensure the treatment or medication has been completed, and could cause a delay in treatment or medication. Findings Include: Review of the facility's policy titled, Documentation in Medical Record dated [DATE], revealed, Each resident's medical record shall contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress through complete, accurate, and timely documentation. Review of the facility's policy titled Medication Administration dated ,d+[DATE], revealed The resident's Medication Administration Record (MAR)/Treatment Administration Record (TAR), is initialed by the person administering medication, in the space provided under the date, and on the line for that specific medication dose administration and time. 1. Review of R1's undated Admission Record located in the electronic medical record (EMR) under the Profile tab, indicated readmission on [DATE] with diagnoses including chronic respiratory failure with hypoxia, diabetes mellitus, and hypertension. Review of the EMR revealed that R1 expired on [DATE]. Review of R1's [DATE] MAR/TAR located in the EMR under the Orders tab, indicated the following medications and treatments were not administered per physician orders: Coreg for beta blocker on [DATE] at 11:00PM. Hydralazine for hypertension on [DATE] at 2:00PM, [DATE] at 8:00PM, and [DATE] at 2:00PM. Tracheostomy cares on [DATE] day shift and [DATE] evening shift. Bilateral heel checks on [DATE] at 8:00PM and [DATE] at 8:00PM. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525482	A. Building B. Wing	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Burlington Health and Rehabilitation Center	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)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Foot check: Visual check of skin condition of both feet, toes, and heels on [DATE] at 8:00PM, and [DATE] at 8:00PM. Skin prep bilateral heels on [DATE] at 8:00PM and [DATE] at 8:00PM. Trach size #6 type Shiley uncuffed inner cannula, change twice daily for trach cares on [DATE] at bedtime (HS), and [DATE] on day shift. Tracheostomy cares twice daily on [DATE] on evening shift. Humidifier compressor ,d+[DATE]% three times a day on [DATE] at 10:00PM, [DATE] at 2:00PM, [DATE] at 6:00AM, and 10:00PM, on [DATE] at 2:00PM, on [DATE] at 2:00PM, on [DATE] at 10:00PM, [DATE] at 2:00PM, [DATE] at 2:00PM. Review of R1's [DATE] TAR located in the EMR under the Orders tab, indicated the following treatments were not administered to the resident per physician orders: Bilateral heel checks on [DATE] at 8:00PM, [DATE] at 8:00PM, [DATE] at 8:00PM, and [DATE] at 8:00PM. Change Heat Moisture Exchanger (HME) Trach Valve daily for Tracheostomy care on [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE] at 8:00AM daily. Change trach ties and inspect skin daily on [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE] at 8:00AM daily. Foot check: Visual check of skin condition of both feet, toes, and heels at HS on [DATE], [DATE], [DATE], and [DATE]. Trach size #6 type Shiley uncuffed inner cannula, change daily on [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE] at 8:00AM. Tracheostomy cares twice daily on [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE] on day shift; [DATE], [DATE], [DATE] on evening shift. 2. Review of R4's undated Admission Record located in the EMR under the Profile tab, indicated the resident was admitted to the facility on [DATE], with diagnoses including fracture of right tibia, diabetes mellitus, chronic kidney disease, and anxiety disorder. Review of R4's [DATE] MAR/TAR located in the EMR under the Orders tab, indicated the following medications and treatments were not administered per physician orders: Right knee: Gently remove Adaptic (Vaseline) gauze. Cover with thin layer of Vaseline and replace Adaptic gauze and Abdominal Pads (ABD); wrap with Ace bandage every evening shift on [DATE],[DATE], [DATE], [DATE], and [DATE]. Review of R4's [DATE] MAR/TAR located in the EMR under the Orders tab, indicated the following medications and treatments were not administered to the resident per physician orders: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525482	A. Building B. Wing	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Burlington Health and Rehabilitation Center	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)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Rosuvastatin daily for hypercholesterolemia at 8:00PM on [DATE], [DATE], [DATE], and [DATE]. Insulin Glargine for diabetes mellitus at bedtime (10:00PM) on [DATE], [DATE], [DATE], and [DATE]. Trazodone HS for insomnia on [DATE], [DATE], and [DATE]. Apixaban twice daily for deep vein thrombosis prophylactic at 8:00PM on [DATE], [DATE], [DATE], and [DATE]. Famotidine twice daily for gastroesophageal reflux disease on [DATE] for day shift, on [DATE], and [DATE] on evening shift. Gabapentin three times daily for nerve pain at 2:00PM on [DATE], [DATE],[DATE], [DATE], at 8:00PM on [DATE], [DATE], [DATE], and [DATE]. Review of R4's [DATE] MAR/TAR located in the EMR under the Orders tab, indicated the following medications and treatments were not administered per physician orders: Gabapentin three times a day for fractured right tibia at 8:00AM on [DATE], at 2:00PM on [DATE], [DATE], [DATE], [DATE], and [DATE]. Right Knee: Cleanse perimeter of site, gently remove gauze. Apply Xeroform (Double Layer). May substitute with oil emulsion dressing, cover with ABD pad, and ACE bandage wrap. Re-apply leg immobilizer. Change daily and as needed (PRN) on [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE]. Review of R4's [DATE] MAR/TAR located in the EMR under the Orders tab, indicated the following medications and treatments were not administered per physician orders: Glimepiride for non-insulin dependent diabetes mellitus two times a day on [DATE] at 4:00PM, and [DATE] at 8:00AM. Gabapentin three times a day for fractured right tibia on [DATE] at 8:00PM, [DATE], [DATE], [DATE], and [DATE] at 2:00PM. Right Knee: Cleanse perimeter of site, gently remove gauze. Apply Xeroform (Double Layer). May substitute with oil emulsion dressing, cover with ABD pad, and ACE bandage wrap. Re-apply leg immobilizer. Change daily and as needed (PRN), on [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE] at 8:00AM. Tx (treatment) to right inner thigh scabbed area: Dakin's ,d+[DATE] strength cleanse followed by (f/b) skin prep, f/b leave open to air change daily and as needed for wound care on [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE]. Nystatin powder, apply to groin and vagina topically three times a day for rash on [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE] at 8:00AM. On [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE] at 2:00PM. On [DATE] at 8:00PM. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525482	A. Building B. Wing	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Burlington Health and Rehabilitation Center	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)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Review of R5's undated Admission Record located in the EMR under the Profile tab, indicated the resident was readmitted on [DATE] with diagnoses left shoulder fracture, multiple rib fractures, schizophrenia, and hypertension. Review of R5's [DATE] MAR/TAR located in the EMR under the Orders tab, indicated the following medications and treatments were not administered to the resident per physician orders: Bilateral buttocks: Cleanse with ,d+[DATE] strength Dakin's solution. Pat dry. Skin prep peri wounds using non-sting skin prep f/b hydrocolloid dressing daily at 8:00AM on [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE]. Ileostomy cares every shift and as needed on day shift on [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE]. On evening shifts on [DATE], [DATE], and [DATE]. Night shift on [DATE]. 4. Review of R9's undated Admission Record located in the EMR under the Profile tab, indicated the resident was admitted to the facility on [DATE], with diagnoses including quadriplegia, ileostomy status, and pressure ulcer. Review of R9's [DATE] MAR/TAR located in the EMR under the Orders tab, indicated the following medications and treatments were not administered to the resident per physician orders: Left groin/perineum wound cleanse with ,d+[DATE] strength Dakin's, apply skin prep to peri wound, apply calcium alginate with silver along wound bed followed by dry gauze, cover with ABD pad secure with adult brief, change daily for wound care on day shift for [DATE], [DATE], [DATE], [DATE], and [DATE]. Rinse out ostomy bag daily at 8:00AM on [DATE], [DATE], [DATE], and [DATE]. Review of R1, R4, R5, and R9's Assessments located in the EMR under the Assessment tab, and Progress Notes located in the EMR under the Progress Notes tab revealed no documentation related to why the medication and treatments were not administered on the aforementioned dates and times. During an interview conducted with the Director of Nursing on [DATE] at 3:10PM, upon review of R1, R4, R5, and R9's MAR/TARs, the DON confirmed the missing documentation of medications and treatments on the MAR and TAR. The DON was asked what her expectations of the nursing staff regarding documentation in the MAR and TAR. The DON stated she expected the staff to document when the medication was administered, and treatments have been completed. The DON added that if the staff is unable to perform the tasks they are supposed to document the reason why.