STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525495	A. Building B. Wing	09/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ascension Living - Lakeshore at Siena	5643 Erie Street Racine, WI 53402

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 0563 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to receive visitors of his or her choosing, at the time of his or her choosing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22692 Based on interviews and record review, the facility did not ensure the right of a Resident to receive visitors and at the time of their choosing for 1 (R36) of 1 Resident reviewed for visitation rights. The facility restricted a family member immediate access to R36 without developing any strategies to continue safe and enjoyable visits for R36. Findings include: R36 was admitted to the facility on [DATE] with diagnoses of Heart Failure, Anxiety Disorder, and Alzheimer's Disease. R36's medical record indicates R36 has an Activated Power of Attorney for Health Care (HCPOC). R36's Quarterly Minimum Data Set (MDS) with an assessment reference date of 7/5/24 documents R36's Brief Interview for Mental Status (BIMS) not able to be completed due to severe cognitive deficits. On 9/17/24, a Facility Reported Incident dated 8/16/24 was reviewed and indicated on 8/15/24 it was reported that R36's family member was observed to say shut up to R36 in a loud voice. During the investigation a statement from 8/17/24 indicated R36's family member also pushed R36's head into the bed. The Facility Administration determined at that time to institute supervised visitation between R36 and their family member. On 9/17/24, at 10:30 AM, Nursing Home Administrator (NHA)-A was interviewed and indicated R36's family member must make an appointment for visitation to be supervised and currently they don't have anyone to supervise the visitation on weekends. Administrator-A indicated he was working on getting supervision for weekend visits but the Facility investigation substantiated the abuse did occur. So, the facility did not have any plan to change R36's visits with her family member and they would remain by appointment and supervised. Nursing Home Administrator-A could not provide any documentation to indicate he meet with R36's family to discuss the Facility imposed visitation arrangements after 8/16/24 when it was put in place. (continued on next page)

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0563 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/17/24, at 10:45 AM, Social Worker (SW)-C was interviewed and indicated she had previously talked to R36 about R36's family member being restricted to supervised visitation. SW-C indicted R36 did not respond and looked out the window during the conversation. SW-C indicated she did not document this interaction or complete an assessment as to the potential impact the restricted visitation would have on R36. SW-C indicated R36's family member would visit her several hours a day and provide some of the care R36 received. SW-C indicated she did not meet with R36's family regarding the restricted visitation. On 9/19/24, an email sent by R36's family member was reviewed and indicated, the Facility never told her what was required for the supervised visitation to occur with R36. R36's family member stated when she showed up to visit with R36 on 9/5/24 she was turned away with the Facility saying she needed to make an appointment for supervised visitation even though she was allowed to visit on 7/3/24 and 7/4/24 with just staff monitoring the visit and not sitting with her the whole time. R36's family member denied the allegations made against her. On 9/18/24, the Facility's policy titled Visitation dated 11/22 was reviewed and documented: The community provided 24 hour access to individuals visiting. The above findings were shared with Nursing Home Administrator-A and Director of Nurses (DON)-B on 9/19/24 at the daily exit meeting. Additional information was requested if available, none was provided as to why R36's family member was not allowed visitation without an appointment or on weekends as the facility put a restriction in place that it could not provide for.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47094 Based on interview and record review the facility did not ensure advanced directives were in the resident's medical record for 2 (R6, R19) of 13 residents reviewed. R6 did not have a Do Not Resuscitate consent form placed in R6's medical record. The facility was unable to locate the signed form. R19 did not have a Do Not Resuscitate consent form place in R19's medical record. The facility was able to locate the signed form. Findings include: The facility policy entitled Do Not Resuscitate Order last approved on 6/2022 documents: . Policy Interpretation and Implementation- A. Do not resuscitate orders must be signed by the resident's Attending Physician on the physician's order sheet maintained in the resident's medical record. B. A Do Not Resuscitate (DNR) order form must be obtained from the Attending Physician and resident (or resident's legal surrogate, as permitted by State Law) and placed in the resident's medical record. 1. Use State-required DNR forms as applicable. 1) R6 was admitted to the facility on [DATE] and has diagnoses that include systolic/diastolic heart failure, atrial fibrillation, vascular dementia, major depressive disorder, osteoarthritis, and muscle weakness. R6's annual minimum data set (MDS) dated [DATE] indicated R6 has moderately impaired cognition with a brief interview for mental status (BIMS) score of 11. R6 has an activated power of attorney (POA) that makes medical decisions for R6. On 9/16/2024, R6's medical record was reviewed, and Surveyor was unable to locate R6's DNR form. Surveyor requested a copy of R6's DNR form. On 9/18/2024, at 10:12 AM, Nursing Home Administrator (NHA)-A stated R6's DNR form was not able to be located and they are in the process of getting a form signed. Surveyor asked what the process was for obtaining a DNR form. Director of Nursing (DON)-B stated on admission if the resident comes electing a DNR status the admitting nurse will get the form signed or the form is obtained on admission. NHA-A and DON-B were unsure why R6 did not have a signed DNR form in their medical record. Surveyor shared concern with NHA-A and DON-B that R6 did not have a signed DNR form in their medical record per Facility policy. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2) R19 was admitted to the facility on [DATE] and has diagnoses that include cerebral infarction resulting in left side hemiplegia, dysphagia, and dysarthria, type 2 diabetes mellitus, neurologic neglect syndrome, anxiety disorder, and depression. R19's quarterly Minimum Data Set (MDS) dated [DATE] indicates R19 is cognitively intact with a Brief Interview of Mental Status (BIMS) score of 15. R19 has an activated Power of Attorney (POA) that makes medical decisions for R19. On 9/16/2024, R19's medical was reviewed, and Surveyor was unable to locate R19's DNR form. Surveyor requested a copy of R19's DNR form. On 9/18/2024, at 10:12 AM, Nursing Home Administrator (NHA)-A stated R19's DNR form was not able to be located and they are in the process of getting a form signed. Surveyor asked what the process was for obtaining a DNR form. Director of Nursing (DON)-B stated on admission if the resident comes in electing a DNR status the admitting nurse will get the form signed or the form is obtained on admission. NHA-A and DON-B were unsure why R6 did not have a signed DNR form in their medical record . Surveyor shared concern with NHA-A and DON-B that R19 did not have a signed DNR form in their medical record per Facility policy.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47094 Based on interview and record review the facility did not ensure residents were free from abuse/neglect for 1 (R19) of 4 residents reviewed for abuse/neglect. R19 was transferred using a Hoyer lift and assist of 1 staff member instead of 2 staff members per R19's care plan resulting in a bruise to R19's right forearm. Findings include: The facility policy entitled Abuse Prevention last approved on 6/2022 documents: Our residents have the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. PREVENTION- A. The community will develop and implement policies and procedures to aid our community in preventing and prohibiting all types of abuse, neglect, or mistreatment of our residents. C. Implement preventative measures to address factors that may lead to abusive situations. 9. Identification, ongoing assessment, care planning, and appropriate interventions and monitoring of residents with needs and behaviors that may lead to conflict and neglect. The facility policy entitled Mechanical Lifts last revised 1/2024 documents: It is the policy of [Facility name] to use mechanical lift(s) according to current standards of practice and keeping with manufacturers guidelines. G. Education shall be provided on the proper use of the assistive mechanical lifting equipment prior to use. R19 was admitted to the facility on [DATE] and has diagnoses that include cerebral infarction resulting in left side hemiplegia, dysphagia, and dysarthria, type 2 diabetes mellitus, neurologic neglect syndrome, anxiety disorder, unsteadiness on feet, and depression. R19's quarterly minimum data set (MDS) dated [DATE] indicates R19 is cognitively intact with a brief interview for mental status (BIMS) score of 15 and the facility asses R19 needing total assistance of 1 staff member with 1 staff member for toileting hygiene, personal hygiene, dressing, repositing, and requires a Hoyer lift transfer with 2 staff. R19's care plan documents assistance with daily activities of daily living (ADL) related to (R/T) immobility, left side weakness, and neglect, initiated 9/15/2023 has the following intervention: -TRANSFER: I need total assistance with 2 person staff support. I use total assist device. On 7/9/2024, at 10:53 AM, in the progress notes nursing documented observed 6.7 X 8.3 centimeter (cm) bruise to resident's right outer forearm. There is a 1 cm in diameter knot located in the center of the bruise. Bruise is black and blue in color. R19 denies pain, R19 stated hit arm on the windowsill. nurse practitioner made aware and new orders to apply ice every shift until resolved. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/29/2024, at 22:28 (10:28 PM), in the progress notes nursing documented monitoring bruise/mass to right forearm, PRN (as needed) ice pack used for pain and was effective. Director of Quality Management (DQM)-[K] notified about increase in size and mass. Nurse practitioner (NP) will assess resident tomorrow. Surveyor reviewed R19's medication list and noted R19 was ordered the following medications that would increase risk of bleeding: - Aspirin 81 mg (milligrams)- 1 tab daily - Clopidogrel 75mg- 1 tab every day The facility submitted a self-report to the State Agency regarding R19's injury of unknown origin/current bruise increasing in size. Surveyor reviewed the facility self-report and noted the facility concluded R19's right forearm bruise increased in size as a result of a certified nursing assistant (CNA)-S transferring R19 into bed using a Hoyer lift by themselves. On 9/18/2024, at 7:39 AM, Surveyor noted R19 was wearing tubigrips on R19's right and left arms. Surveyor asked R19 why R19 was wearing tubigrips. R19 stated R19 bruises easily and the tubigrips were supposed to protect her arms due to R19 bumping them a lot. Surveyor asked R19 if R19 has any current bruising. R19 stated had a bruise when she hit her arm on her windowsill, but the bruise was now gone. Surveyor asked R19 if R19 ever got a bruise when transferring into R19's bed with a Hoyer lift. R19 could not recall if R19 got a bruise when being transferred. Surveyor asked R19 if R19 was ever transferred using the Hoyer lift and only 1 staff member being present. R19 could not recall if only 1 staff member transferred R19 using the Hoyer lift. On 9/18/2024, at 9:58 AM, Surveyor interviewed Nursing Home Administrator (NHA)-A and Director of Nursing (DON-B). NHA-A stated during the investigation into why R19's right forearm bruise increased in size Registered Nurse (RN)-T stated R19 was transferred into bed with the assist of 1 staff. At the time there was RN-T and CNA-S on the unit and when RN-T last checked on R19, R19 was in the broda wheelchair and did not have the bruise to R19's right forearm. When RN-T went in later, R19 was in bed and that is when the bruise to R19's right forearm was noted. DON-B stated through interviews CNA-S never stated that CNA-S transferred R19 by themselves using the Hoyer lift, but R19 stated R19 was transferred with only CNA-S. DON-B stated R19 could not recall bumping R19's arm during the transfer but stated could have bumped it. DON-B stated that R19 bruises very easily, and the physician ordered for tubigrips for protection. CNA-S is no longer employed with the facility and was unavailable for interview. RN-T was not available for interview. On 9/18/2024, at 10:30 AM, Surveyor shared concern with NHA-A and DON-B that R19 was transferred using a Hoyer lift and only one staff member when R19's care plan is documented as needing 2 staff members. CNA-S neglecting to follow R19's care plan resulting in R19's right forearm bruising. No additional information provided at this time.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 49845 Based on interview and record review the facility did not report 3 allegations of abuse/neglect for 1 Resident (R36) of 4 residents reviewed for allegations of abuse, neglect, misappropriation, or injury of unknown origin allegations, immediately to the Nursing Home Administrator or to the State Agency within the required timeframe. *An allegation of verbal abuse was observed between R36's family and R36 which was alleged to have occurred on 08/11/2024. This incident was not reported to Nursing Home Administrator (NHA)-A until 08/15/2024. NHA-A reported the allegation of verbal abuse on 08/16/2024 at 03:06 PM to the State Agency. *An allegation of physical abuse was alleged to have occurred between R36's family and R36 on 08/10/2024 and 08/11/2024. It was not reported to NHA-A until 08/17/2024. The allegation of physical abuse was not reported to the State agency, law enforcement, or APS until 09/18/2024 during survey. *On 6/2/24, an allegation of neglect was reported to Registered Nurse (RN)-G related to R36. The allegation was not reported to NHA-A or the State Agency within specified time frame and was not investigated. Findings include: Surveyor reviewed the Facility policy, titled, Abuse Prevention, with a last reviewed date of 08/2024, and documents in part: (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The objective of this abuse policy is to comply with the seven-step approach to abuse and neglect detection and prevention. DEFINITIONS Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish including abuse facilitated or enabled through the use of technology. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Immediately means as soon as possible, but are not to exceed 24 hours after discovery of the incident, in the absence of a shorter state time frame requirement. * immediately for the purposes of reporting a crime resulting in serious bodily injury means covered individual shall report immediately but not more than two hours after forming the suspicion. Mental abuse is the use of verbal or nonverbal conduct which causes or has the potential to cause the resident to experience humiliation, intimidation, fear, shame, agitation, or degradation. Neglect means the failure of the community, it's employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress. IDENTIFICATION . B. Associates or person affiliated with this community who has witnessed or who believes that a resident has been a victim of mistreatment, abuse, neglect, or any other criminal offense shall immediately report suspected abuse or incidents of abuse to the administrator or designee 1. If such incidents occur or are discovered after hours, the administrator or designee shall be notified and informed of such incident. a. Failure to report such an incident may result in legal/criminal action being filed against the individual(s) withholding such information. INVESTIGATION A. The community will investigate and report any allegations of abuse within timeframe as required by federal, state, and local requirements; B See Abuse Investigation Reporting policy for reporting guidelines and roles and responsibilities. REPORTING/RESPONSE A. The community will immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse of result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, report alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of property, to the Administrator and/or designee, State agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specified time frames. Surveyor reviewed the Facility Reported Incident (FRI) submitted to the State Agency, titled, Alleged Nursing Home Resident Mistreatment, Neglect, and Abuse Report. Surveyor noted the following information, Date discovered 08/15/2024. Surveyor noted, the summary of incident documents, Allegation of verbal abuse by resident's daughter [initials of R36's daughter] of yelling shut up to resident (R36). Investigation has been initiated. Report submitted to the State Agency on 08/16/2024, at 03:06 PM, by NHA-A. The Facility provided document, entitled Investigation Summary, documents in part, Type of Incident: Abuse Date: August 11, 2024 Time: 6:00 PM. Investigation Steps Included: Thursday, 8/15/24- Approximately 2:45 PM, the Executive Director was notified. Surveyor notes NHA-A was not informed of the allegation of abuse immediately when the staff was aware of the allegation on 8/11/24 and NHA-A was informed on 8/15/24. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor reviewed the Facility provided document, with no date, signed by Registered Nurse (RN)-U; and documents in part on 08/11/2024, RN-U heard R36's family member telling R36 to shut up repeatedly and was in an aggressive sounding voice. RN-U asked two other CNA's that were working if they ever heard R36's family member telling R36 to shut up. RN-U was then made aware of alleged physical contact observed between R36's family member and R36 by the CNA's. The Facility provided document, entitled, Witness Statement, signed on 08/17/2024, documents in part, Certified Nursing Assistant (CNA)-J witnessed, on 08/11/2024, R36's family member whisper shut up into R36's ear and then the family member placed a hand on R36's forehead, shook R36's head and told R36 to stay lying down. CNA-J documented, I witnessed this while charting in plain view. CNA-J documented witnessing R36's family member pushing R36's head down, telling R36 to lay down and be quiet on 08/10/2024. Surveyor notes CNA-J did not inform Facility administration of her observations on 8/10/24 and 8/11/24 of alleged abuse until 8/17/24 when the Facility was conducting and investigation of alleged verbal abuse. The Facility provided document, entitled, Witness Statement, signed on 08/17/2024, documents CNA-V witnessed R36's family member tell R36 to shut up, family member put a finger on R36's nose and R36's head went back a little bit. On 09/16/2024, at 02:12 PM Surveyor interviewed CNA-J. CNA-J informed Surveyor she could not remember the exact date but recalls during night shift, R36's family member kept telling R36 to shut up and lay down and put a hand on R36's head. CNA-J informed Surveyor the nurse asked her the same night if CNA-J heard R36's family member tell R36 to shut up, which is when she told the nurse what she witnessed. CNA-J informed Surveyor that any signs of abuse are to be reported to NHA-A right away. On 09/17/2024, at 02:38 PM, Surveyor interviewed NHA-A who indicated only the Ombudsman was notified of the verbal abuse allegation on 08/16/2024. On 09/17/2024, 03:28 PM, Surveyor interviewed NHA-A and Director of Nursing (DON)-B. NHA-A informed Surveyor RN-S called NHA-A on 08/15/2024 and reported the 08/11/2024 abuse allegation regarding R36. NHA-A informed Surveyor NHA-A will submit a facility self-report (to the State Agency) today (09/17/2024), regarding the physical abuse allegation involving R36 that occurred on 08/10/2024, 08/11/2024 and reported on 08/17/2024. An allegation of verbal and physical abuse was not reported to NHA-A immediately and not reported to the State Agency until days and weeks after the incidents. The Facility did not report the physical abuse allegation to the State Agency until the Survey Team informed the Facility of their concerns. No further information was provided during time of Survey. 22692 On 9/18/24, R36's progress notes dated 6/2/24, at 9:30 PM, written by Registered Nurse (RN)-G were reviewed and documented: Daughter believes that R36 was up in her wheelchair for 40 hours continuous according to a staff member Writer states that I didn't think that occurred. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/18/24, at 1:30 PM, Nursing Home Administrator-A was interviewed and indicated he was not aware of the allegation that R36 was up 40 hours continuous and should have been made aware. On 9/18/24, at 1:45 PM, Director of Nurses (DON)-B was interviewed and indicated she was not aware of the allegation R36 was up 40 hours continuous and should have been made aware. No other notes were made regarding R36's behavior or staying up in a wheelchair with the last progress note before 6/2/24 being 5/29/24. On 9/18/24, at 10:00 AM, RN-G was interviewed and indicated she did not report the allegation R36 was up 40 hours continuous because she thought it was ridiculous and could not have happened. RN- indicated R36's daughter is always making up stories and did not feel a need to notify Nursing Home Administrator-A or DON-B. On 9/19/24, the Facility's policy entitled Abuse prevention dated 8/24 was reviewed and documented: Neglect means the failure of the community, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress. The community will immediately, but not longer than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse, and do not involve serious bodily injury, report alleged violations involving neglect to the Administrator or designee, State agency, adult protective services and all other required agencies. The above findings were shared with Nursing Home Administrator-A and DON-B on 9/19/24 at 3:00 PM at the daily exit meeting. Additional information was requested if available, none was provided as to why RN-G did not report neglect allegations to Nursing Home Administrator-A and/or DON-B.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49845 Based on record review and interviews, the facility did not ensure a thorough investigation was completed for 3 allegations of abuse/neglect for 1 (R36) of 4 residents reviewed for alleged abuse investigations. *The Facility did not ensure a thorough investigation was completed related to the allegation of verbal abuse of R36 by R36's daughter which was to have occurred on August 11, 2024. *The Facility did not ensure a thorough investigation was completed related to the allegation of physical abuse of R36 by R36's daughter which were identified during the investigation of the August 11, 2024, alleged verbal abuse. *On 6/2/24, Registered Nurse-G documented R36's daughter expressed a concern R36 was left up for 40 hours continuously and the Facility did not investigate the allegation of neglect. Findings include: The Facility policy, titled, Abuse Investigation and Reporting, with a last revised date of 11/2023, documents in part, . Role of the Administrator or designee: A If an incident or suspected incident of resident abuse, mistreatment, neglect, or injury of unknown sources reported, the Administrator or designee will assign the investigation to an appropriate individual. C. The administrator or designee will keep the resident and his/her representative informed of the progress of the investigation. Reporting A. All alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of an unknown source and misappropriation of property will be reported to the Administrator or designee and to the following other officials or agencies: 1. The state licensing/certification agency responsible for surveying/licensing the community; 2. Other officials in accordance with State Law, including adult Protective Services where state law provides for jurisdiction in long term care facilities; 3. The Resident's Representative (Sponsor) of Record; . B. Alleged violations involving abuse, neglect, exploitation, or mistreatment (including injuries of unknown source and misappropriation of resident property) will be reported: 1. Abuse or Serious Bodily Harm-Immediately but not later than two hours. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R36 was admitted to the facility on [DATE] with diagnoses that include Alzheimer's Disease, metabolic encephalopathy, and insomnia. R36's Quarterly Minimum Data Set (MDS), dated [DATE], documents R36 has adequate hearing, does not use hearing aids, has severely impaired cognitive skills, short- and long-term memory problems. The Facility provided document, entitled Investigation Summary, prepared by Nursing Home Administrator (NHA)-A, documents in part, Type of Incident: Abuse Date: August 11,2024 Time: 6:00 pm. Description of Incident: Staff reported they overheard the (R36's) daughter in the room yelling at Resident [R36's name] to shut up. Investigation Steps Included: -Thursday, 8-15-24, Approximately 2:45 pm, the Executive Director was notified. -Thursday, 8-15-24- Executive Director spoke with [R36's family members name] about the allegation. She said she would type up a statement and bring in the following day, she stated she talks loud because her mom is hard of hearing. -Friday, 8-16-24, Executive Director and interim Director of Nursing (DON) again spoke with [daughter's name] about a witness statement. Daughter declined to fill out a witness statement as earlier agreed, but stated she was on the phone with either her husband or her sister when saying shut up but did not confirm who she was talking with. -Friday, 8-16-24- Executive Director and interim DON called [name of Ombudsman], to inform her of the situation. The Ombudsman stated to allow visitation of the daughter in public areas but not in the room. Executive Director and interim DON attempted to contact daughter to inform her of the allowed visitation. There has been no response to the calls. -Reasonable conclusion as follows: upon investigation, other staff had concerns that they had brought to the nurse around the same time. CNA-J Reported seeing [daughter's name] in what seemed like placing a hand on her forehead and shake her head and tell her to stay laying back down. Certified Nursing Assistant (CNA)-V heard [daughter's name] state shut up ma and noted what seemed like placing a finger on her (R36's) nose hard enough for resident's head to move back a little. Upon conclusion of the investigation, the center will substantiate the act of abuse related to the investigation findings, but we reserve the right to amend if [name of R36's daughter] provides her statement. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/17/2024, at 01:43 PM, NHA-A informed Surveyor NHA-A was informed on 08/15/2024 of the verbal abuse allegations against R36's daughter. NHA-A informed Surveyor he spoke to R36's accused family member regarding the allegation and asked for a statement about what transpired. NHA-A stated R36's family member wanted to type it and was going to send via email. NHA-A informed Surveyor R36's family member came in to the Facility the next day with their husband and no longer wanted to write a statement, and stated to NHA-A, she talks loudly to her sister and husband on phone. NHA-A informed Surveyor he reached out to the Ombudsman, who informed him to implement supervised visitation between R36's family member and R36. NHA-A informed Surveyor he attempted to reach back out to R36's family member regarding the need for supervised visits, but no phone calls were returned. NHA-A informed Surveyor the police were notified of the verbal abuse allegation. NHA-A stated he spoke to R36's family member on the phone and informed the family member they would be able to have supervised visitation. NHA-A stated R36's family member would need to arrange visits ahead of time to ensure proper staff for supervised visits. (Cross Reference F563) Surveyor notes the Facility did not complete a thorough investigation of the alleged verbal abuse between R36's daughter and R36 that occurred on 8/11/24 as the Facility did not meet with R36's family to discuss why staff alleged R36's daughter verbally abused R36, discuss with R36's daughter and Activated Health Care Power of Attorney the reason the Facility was implementing supervised visits and how long they would occur, or meet with the family of R36 to identify the history of family dynamics or the families understanding of long and short term memory loss in the elderly and appropriate interventions to be implemented during interactions. Surveyor also notes the Facility did not investigate the allegations of physical abuse between R36's daughter and R36 when Facility administration was made aware of the allegations on 8/17/24, during the investigation of the 8/11/24 allegation of verbal abuse. On 09/17/2024, at 03:28 PM, NHA-A informed Surveyor he will submit a Facility self-report to the State Agency today (09/17/2024), regarding the physical abuse allegation reported on 08/17/2024 and start an investigation at this time. On 09/17/2024, at 04:08 PM, Surveyor spoke with Caledonia Police Department Officer-P regarding reported allegation. Caledonia PD Officer-P informed Surveyor an officer responded to a call for an assault at the Facility, on 08/16/2024, case # [12970]. Caledonia PD Officer-P informed Surveyor, there was no report of physical abuse, no bruising, or marks, and it was reported that the nurse reported daughter yelling shut up to R36. Surveyor informed NHA-A of the above concerns. No further information was provided. 22692 3) On 9/18/24 Surveyor reviewed R36's progress notes which documented, on 6/2/24, at 9:30 PM, written by Registered Nurse (RN)-G, Daughter believes that R36 was up in her wheelchair for 40 hours continuous according to a staff member. Writer documents, I didn't think that occurred. No other notes were made regarding R36's behavior or staying up in her wheelchair with the last progress note before this 6/2/24 progress note being 5/29/24. On 9/18/24, at 1:30 PM, Surveyor interviewed Nursing Home Administrator-A who indicated he was not aware of the allegation that R36 was up 40 hours continuous and should have been made aware so he could investigate. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/18/24, at 1:45 PM, Director of Nurses (DON)-B was interviewed and indicated she was not aware of the allegation that R36 was up 40 hours continuous and should have been made aware. On 9/18/24, at 10:00 AM, RN-G was interviewed and indicated she did not report the allegation that R36 was up 40 hours continuous because she thought it was ridiculous and could not have happened. RN- indicated R36's daughter is always making up stories and did not feel a need to notify Nursing Home Administrator-A or DON-B to do an investigation. RN-G indicated she talked to a couple staff on the shift but does not know who they were and did not document the conversations. The above findings were shared with Nursing Home Administrator-A and DON-B on 9/19/24, at 3:00 PM, at the daily exit meeting. Additional information was requested if available, none was provided as to why RN-G did not report neglect allegations to Administrator-A and/or DON-B so an investigation could be completed.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47094 Based on interview and record review, the facility did not ensure residents at risk for pressure injuries received necessary treatment and services consistent with professional standards of practice, to prevent the development of pressure injuries and to promote healing for 1 (R307) of 4 residents reviewed for pressure injuries. On 9/26/2023, R307 is documented to have developed a deep tissue injury to the left heel. R307's care plan was not revised until 9/29/2023. On 9/30/2023, R307 developed a suspected deep tissue injury to the right heel, there was not a comprehensive assessment completed for the right heel pressure injury until the wound doctor assessed on 10/3/2023 and R307's care plan was not revised. On 10/3/2023, R307's left heel is assessed to have declined to an unstageable pressure injury. Findings include: The facility policy titled PROCEDURE: Pressure Injury Assessment/Treatment last revised on 7/2024 documents: The purpose of this procedure is to provide guidelines for consistent method of identification of and for the initial care of identified pressure injuries, alterations in skin integrity, and the prevention of acquiring additional pressure injuries . Pressure injury interventions/Care Strategies- A. Pressure 1. Determine cause of pressure and relieve. 2. Redistribute pressure and interventions to off-load, if indicated; consider turn schedule as indicated. 3. Implement pressure-relieving device(s) in accordance with resident's assessed needs; to reduce friction and shearing, reduce cause by using transfer techniques, devices or products, as needed . 8. Document evaluation in the medical record. 9. Update the care plan . Documentation- The following information should be recorded in the resident's medical record, treatment sheet or designated wound form: . B. Wound appearance, including wound bed, edges, presence of drainage. E. All assessment data (i.e. wound bed color, size, drainage, etc.) obtained when inspecting the wound. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	H. If the resident refused the treatment and the reason(s) why. Reporting- A. Notify the supervisor if the resident refuses the procedure or interventions. B. If the resident refused treatment, the reason for refusal and the resident's response to the explanation of the risks of refusing the procedure, the benefits of accepting and available alternatives. R307 was admitted to the facility on [DATE] and has diagnoses that include chronic peripheral venous insufficiency/peripheral vascular disease, lymphedema, chronic vascular wound left lower extremity, chronic heart failure, and chronic kidney disease stage 3. R307's admission minimum data set (MDS) dated [DATE] indicated R307 had intact cognition with a Brief Interview for Mental Status (BIMS) score of 14 and the facility assessed R307 to require maximal assistance with 1 staff for repositioning, lower body dressing, and toileting/personal hygiene and total assist with 2 people and sit to stand lift for transferring. R307 was assessed on 9/19/2023 to be a mild risk for pressure injuries with a BRADEN score of 15. R307 was admitted to the facility for physical/occupational therapy, bilateral lower extremity venous insufficiency with edema and recurring blisters, and treatments for a left leg venous ulcer. R307 discharged home on 10/5/2023. R307 had a pressure ulcer/skin prevention care plan initiated on 9/19/2023 with the following interventions: . - Keep bed linens wrinkle free and do not use excess pads. - Observe skin for redness and breakdown during routine care. - Use pressure relieving devices. Cushion on wheelchair and off of (sic) heels as indicated. - Follow community skin care protocol. - Treatments as indicated, see physician order sheet. - Pressure reducing mattress on bed. On 9/26/2023, at 19:30 (7:30 AM), in the progress notes nursing documented a correction addendum: Wound MD-Q updated on pressure wound to left heel, orders received. Wound bed moist, granulation tissue with deep purple discoloration. Blister roof partially removed and remains attached at lateral edge. DTI (deep tissue injury) in evolution. 5.5 X 5.5 X 0.1 (length X width X depth), serosanguineous drainage. Surveyor noted R307's pressure ulcer/skin prevention care plan was not revised until 9/29/2023 with the following interventions: (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	(R307) has impaired skin integrity related to pressure wound to left heel. - Provide treatment as ordered - Maintain head of bed at lowest degree appropriate for resident's clinical condition (ideally 30 Degrees) - Educate resident and/or family to the importance of frequent turning/shifting and repositioning - Minimize force and friction applied to skin. - Registered dietician consult - Assess and evaluate wound size, depth, color, and drainage present every week - Assist/teach to reposition self to reduce pressure (shifting own weight and turning) - Provide supplements to promote healing as ordered by physician - Float heels when in bed - Specialize mattress - Wound to be treated by in house MD On 9/30/2027, at 0531 (5:31 AM), in progress notes nursing documented (R307) brought concern of pain to right heel. Intact fluid filled blister to right heel. Skin prep applied and covered with Allevyn dressing. Feet floated on pillows, education to keep feet off mattress. Surveyor noted there was not a comprehensive assessment done to R307's right heel blister and R307's care plan was not revised. On 10/3/2023, R307's right and left heel pressure injuries were assessed by Wound MD-Q with the following assessments: Right heel- - 3.0 X 2.9 X 0.1, wound bed: purple, attached edges, periwound: edematous. - Pressure Ulcer- Suspected DTI Left heel- - 3.6 X 5.1 X 0.2, wound bed: 25% granulation tissue, 75% eschar, moderate serous drainage. - Pressure ulcer- Unstageable - New treatment ordered (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Surveyor noted R307's left heel pressure injury was assessed as unstageable with 75% eschar and new depth of 0.2 cm. (centimeters). On 9/17/2024, at 12:25 PM, Surveyor interviewed wound MD-Q who recalled R307 was weak when admitted , unable to move very much and R307 had a preference to lay a particular way with knees bent a little and heels would dig into the mattress. Wound MD-Q encouraged to offload heel and to use heel boots. Wound-MD stated R307 had very poor circulation issues to lower extremities and was already compromised due to the vascular ulcer so would not take long for blisters to develop so offloading would be very important. On 9/19/2024, at 9:05 AM, Surveyor interviewed Registered Nurse Unit Manager (RNUM)-I who remembered R307's face but could not recall specifics about R307's admission in the facility. Surveyor asked what the facility policy is when a new skin area of concern is observed on a resident. RNUM-I stated an assessment should be completed describing the area of concern, an RN stages the area if it is a pressure wound because Licensed Practical Nurses (LPNs) are unable to stage wounds, get a treatment through the physician, notify and inform family, physician, Director of Nursing, and update the care plan. Surveyor asked what the expectation is time wise for care plan revision or initiation. RNUM-I stated the care plan should be initiated/revised right away. Surveyor informed RNUM-I that Surveyor could not locate a comprehensive assessment to R307's right heel when a blister was observed on 9/30/2023 and R307's care plan was not revised until 3 days later when R307's left heel pressure injury was observed, and the care plan was not revised after R307 developed a right heel pressure injury. RNUM-I stated they would look to see if they could find any information because that all should have been completed. On 9/10/2024 at 11:48 AM, Surveyor interviewed Certified Occupational Therapy Assistant (COTA)-L who recalled R307 was noncompliant with therapy in the beginning of R307's admission but then complied with education and encouragement. COTA-L did not recall if R307 could reposition self in bed or independently move the lower extremities. Surveyor reviewed R307's medical record and did not locate any documentation regarding if R307 refused cares or interventions. Surveyor reviewed R307's Medication Administration and Treatment Administration Records (MAR/TAR) for September 2023 and October 2023 and noted 10/2/2023 for evening shift nursing documented (R) on the TAR for R307's right and left heel treatments. Surveyor noted that there was no documentation regarding why R307 refused treatment, R307's care plan was not revised to indicated R307 refusing treatment, and no documentation noting risk versus benefits was reviewed with R307 for refusal of treatments. On 9/19/2024, at 12:52 PM, RNUM-I informed Surveyor no documentation could be located regarding R307's right heel assessment when first observed on 9/30/2023. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 9/19/2024, at 3:24 PM, Surveyor shared concerns with Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B regarding R307's development of pressure injuries to both right and left heels, care plan not being revised until 3 days later on 9/29/2023 when R307 developed a DTI on 9/26/2023. Surveyor also informed NHA-A and DON-B no comprehensive assessment was completed when R307 developed a pressure injury to the right heel on 9/30/2023 and the care plan was not revised, and R307's left heel declined to an unstageable pressure injury. No further information was provided at this time.

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22692 Based on interview and record review the facility did not ensure that 1 (R36) of 13 Residents reviewed were provided medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being. * R36's family member was denied regular visitation and the facility implemented appointment only supervised visitation with R36's family member. An assessment and monitoring of how the decision was affecting R36 was not completed. No meetings with R36's Family member and Power of Attorney for Healthcare (HCPOA) were conducted to establish how visits with R36's family would continue in the future. Findings include: R36 was admitted to the facility on [DATE] with diagnoses of Heart Failure, Anxiety Disorder, and Alzheimer's Disease. R36's medical record indicates R36 has an Activated Power of Attorney for Health care (HCPOC). R36's Quarterly Minimum Data Set (MDS) with an assessment reference date of 7/5/24 documents R36's Brief Interview for Mental Status (BIMS) not able to be completed due to severe cognitive deficits. On 9/17/24, a Facility Reported Incident from 8/16/24 was reviewed and indicated on 8/15/24 it was reported R36's family member was observed to say shut up to R36 in a loud voice. During the investigation a statement from 8/17/24 indicated R36's family member also pushed R36's head into the bed. It was determined by the Facility to institute supervised visitation with R36's family member at this time. On 9/17/24, at 10:30 AM, Nursing Home Administrator-A was interviewed and indicated R36's family member must make an appointment for visitation to be supervised and currently they don't have anyone to supervise the visitation on weekends. Nursing Home Administrator-A indicated he was working on getting supervision for weekend visits but the investigation substantiated the abuse did occur and the Facility did not have any plan to change R36's visits with her family member and they would remain with an appointment and supervised. Nursing Home Administrator-A could not provide any documentation that he meet with R36's family to discuss the visitation arrangements after 8/16/24 when it was put in place. On 9/17/24, at 10:45 AM, Social Worker (SW)-C was interviewed and indicated she had previously talked to R36 about R36's family member being restricted to supervised visitation. SW-C indicted R36 did not respond and looked out the window during the conversation. SW-C indicated she did not document this interaction or complete an assessment as to the potential impact on R36 having restricted visitation. SW-C indicated R36's family member would visit her several hours a day and provide some of the care R36 received. SW-C indicated she did not meet with R36's family regarding the restricted visitation. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/17/24, R36's care plan was reviewed and did not contain any revisions based on the visitation restrictions put in place on 8/16/24. On 9/19/24, an email sent by R36's family member was reviewed and indicated. The facility never told her what was required for the supervised visitation with R36. R36's family member documented when she showed up to visit with R36 on 9/5/24 she was turned away with the facility saying she needed to make an appointment for supervised visitation even though she was allowed to visit on 7/3/24 and 7/4/24 with just staff monitoring the visit and not sitting with her the whole time. R36's family member denied the allegations of abuse made against her. On 9/23/24, the Facility policy titled Social Services dated 12/17 was reviewed and documented: the social service department is responsible for: maintaining contact with residents family members, involving them in residents total plan of care. Identifying individual social and emotional needs. Factors that have a potential negative effect on psychosocial functioning include: the lack of family/social support system. The above findings were shared with Nursing Home Administrator-A and Director of Nurses (DON)-B on 9/19/24 at the daily exit meeting. Additional information was requested if available, none was provided as to why R36's was not assessed and ongoing monitoring conducted into R36's mental well being after visitation was restricted with a family member who visited multiple hours daily.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. 49845 Based upon observation and interview, the Facility did not ensure Facility equipment was maintained in proper working order for 2 of 3 dishwashing machines located in the on unit kitchens. The machines were leaking water onto the floor. 1 of 3 dishwashers did not display temperatures. This deficient practice has the potential to affect 24 of 24 residents total on the 2 units. *Surveyor observed 2 of 3 dishwashing machines in the on the unit kitchens, to be leaking water onto the floor, causing a potential hazard. *Surveyor observed 1 of 3 dishwashing machines in the on unit kitchen, did not have a temperature display to properly identify the dishwasher is reaching required water temperature. Findings include: On 09/16/2024, at 11:39 PM, Surveyor observed the dishwasher on the Fairview Unit, on the floor next to the dishwasher were soaked towels and water. Dietary Manager-N informed Surveyor this started happening this morning, a maintenance request has already been submitted and maintenance will be looking at it this afternoon. On 09/16/2024, at 11:47 PM, Surveyor observed the dishwasher on the church view unit spraying out water onto the floor and observed the display for water temperature was not working. Dietary Manager-N informed Surveyor that the dishwasher is supposed to spit water out like that when building up pressure. Dietary Manager-N informed Surveyor that the dishwasher display screen went out last week. Surveyor asked Dietary Manager-N how they know the dishwasher is getting up to the proper temperature without the display functioning properly. Dietary Manager-N informed Surveyor that they use a disk simulator that goes inside the washing machine. Surveyor asked Dietary Manager-N to show Surveyor how the disk simulator works inside the washing machine, Dietary Manager-N informed Surveyor she would need to go get the device. Dietary Manager-N then left the unit kitchen area and shortly returned with a disk simulator. Dietary Manager-N then placed the disk simulator into the washer. On 09/17/2024, at 07:47 AM, Surveyor observed water on the floor around the dishwasher on the unit Church View. On 09/17/2024, at 07:56 AM, Surveyor observed the dishwasher on the Fairview unit had water on the floor around the dishwasher. On 09/17/2024, at 08:17 AM, Surveyor interviewed Director of Facilities-E. Director of Facilities-E informed Surveyor that he was given a verbal request last night or this morning regarding the dishwasher leaking on the unit Fairview. Director of Facilities-E informed Surveyor that the dishwashing machines are worked on through a contract company. Director of Facilities-E informed Surveyor he still needs to put in a request for the company to come out for the dishwasher on unit Fairview. On 09/17/2024, at 08:24 AM, Director of Facilities-E informed Surveyor that they are waiting on a part to come in before the company can come fix the dishwasher. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525495	A. Building B. Wing	09/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ascension Living - Lakeshore at Siena	5643 Erie Street Racine, WI 53402

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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Director of Facilities-E provided Surveyor with an e-mail, dated 09/17/2024, providing confirmation of service request for the company to come out for the dishwashers on 09/19/2024. Surveyor informed Nursing Home Administrator (NHA)-A of above findings. No further information was provided.