

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525504	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/13/2024
NAME OF PROVIDER OR SUPPLIER Autumn Lake Healthcare at Greenfield		STREET ADDRESS, CITY, STATE, ZIP CODE 5790 S 27th St Milwaukee, WI 53221	

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 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow residents to self-administer drugs if determined clinically appropriate.</p> <p>20483</p> <p>Based on interview and record, the facility did not ensure 1 (R5) of 1 residents was assessed by the interdisciplinary team to determine it was clinically appropriate to self administer medication.</p> <p>R5 was applying medihoney on her left posterior wound without being assessed for her ability to self administer treatments.</p> <p>Findings include:</p> <p>The facility's policy titled, Resident Self-Administration of Medication and dated 4/15/24, under Policy documents: It is the policy of this facility to support each resident's right to self-administer medication. A resident may only self-administer medications after the facility's interdisciplinary team has determined which medications may be self-administered safely.</p> <p>Under Policy Explanation and Compliance Guidelines include documentation of:</p> <ol style="list-style-type: none"> 1. Each resident is offered the opportunity to self-administer medications during the routine assessment by the facility's interdisciplinary team. 2. Resident's preference will be documented on the appropriate form and placed in the medical record. 4. The results of the interdisciplinary team assessment are record on the Medication Self-Administration Assessment Form, which is placed in the resident's medical record. 8. All nurses and aides are required to report to the charge nurse on duty any medication found at the bedside not authorized for bedside storage. Unauthorized medications are given to the charge nurse for return to the family or <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 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>responsible party. Families or responsible parties are reminded of policy and procedures regarding resident self-administration when necessary.</p> <p>R5's diagnoses includes Gullian Barre syndrome, diabetes mellitus, and lymphedema.</p> <p>R5's quarterly MDS (minimum data set) with an assessment reference date of 5/8/24 has a BIMS (brief interview mental status) score of 7 which indicates severe cognitive impairment.</p> <p>Surveyor noted R5 is listed on the facility's non pressure skin concern list for left posterior calf, lymphedema dated 7/11/24.</p> <p>The physician order dated 7/26/24 documents, Wound care posterior calf. Cleanse with wound cleanser at pat dry apply medihoney to wound bed and cover with bordered gauze daily and PRN (as needed). Every day shift.</p> <p>On 8/12/24, at 9:04 a.m., Surveyor observed R5 sitting on the edge of the bed wearing only a brief with two wash basins on an over bed table in front of R5. Surveyor observed a dressing on R5's left posterior calf. Surveyor asked R5 if the nurse did her treatment on her left posterior calf this morning. R5 replied I did it myself explaining the nurses come to late. R5 stated she has the medihoney and informed Surveyor they don't give her too much. R5 showed Surveyor the tube of medihoney in a clear plastic bag along with other tubes of ointments/creams which was on her bed.</p> <p>On 8/12/24, at 9:47 a.m., Surveyor observed R5 sitting on the edge of the bed. Surveyor asked R5 if Surveyor can see the bag with the creams in it. R5 replied yes and informed Surveyor she's going to the dermatologist tomorrow. R5 handed Surveyor the clear plastic bag which was on her bed. Surveyor checked the clear plastic bag and noted the following:</p> <ul style="list-style-type: none"> -One Gold bond pain & itch relief cream Lidocaine HCl 4%. -Tube of Hydrocortisone cream 2.5%. -Tube of clobetasol Propionate 0.05% cream. -Two tubes of medihoney gel. -Tube of Mupirocin ointment 2%. <p>Surveyor observed on the small dresser next to the bed a box of sterile bordered gauze dressings.</p> <p>Surveyor reviewed R5's medical record and was unable to locate a self administration assessment for R5's medihoney along with the other creams/ointment in the plastic bag.</p> <p>(continued on next page)</p>		

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<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 8/13/24, at 8:12 a.m., Surveyor observed R5 sitting on the edge of the bed wearing a gown and tubi grips. Surveyor asked R5 how does she know how to do her treatment for the back of her left calf. R5 replied I can feel it and explained it has a wet kind of feeling and spots on the Band-Aid. Surveyor asked R5 if she still has her bag with the medihoney in it. R5 replied yes and picked up the clear plastic bag from her bed.</p> <p>On 8/13/24, at 8:21 a.m., Surveyor asked RN/UM (Registered Nurse/Unit Manager)-D if R5 can keep medihoney and other prescribed ointments/creams. RN/UM-D replied she shouldn't no. Surveyor informed RN/UM-D Surveyor wasn't able to locate a self administration assessment for the medihoney or other ointments/creams. RN/UM-D informed Surveyor R5 hasn't had any teaching because she's not suppose to do her treatments. RN/UM-D informed Surveyor R5 is activated, referring to R5's power of attorney being activated, and R5 has moments of clarity and other times she's not so clear.</p> <p>On 8/13/24, at 12:31 p.m., NHA (Nursing Home Administrator)-A, DON (Director of Nursing)-B and ADON (Assistant Director of Nursing)-N were informed of the above.</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</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 2 (R1 and R3) of 4 Residents reviewed received a prompt resolution to grievances filed, including steps taken to investigate the 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.</p> <p>*R1's representative filed a grievance with the facility and there is no evidence if the grievance was confirmed or not or if R1'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>*R3's activated Health Care Power of Attorney (HCPOA) filed grievances with the facility and there is no evidence if the grievances were confirmed or not or if R3's HCPOA was informed of the corrective actions taken by the facility and resolution. The facility did not have any documentation the grievances were investigated promptly and resolved.</p> <p>The facility's policy entitled, Resident and Family Grievances, implemented 7/10/24 documents:</p> <p>. Policy:</p> <p>It is the policy of this facility to support each Resident's and family member's right to voice grievances without discrimination, reprisal or fear of discrimination or reprisal.</p> <p>Definitions:</p> <p>Prompt efforts to resolve include the facility acknowledgment of a complaint/grievance and actively working toward resolution of that complaint/grievance.</p> <p>Policy Explanation and Compliance Guidelines:</p> <p>1. The Administrator is responsible for overseeing the grievance process; receiving and tracking grievances through to their conclusion; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances; issuing written grievance decisions to the Resident; and coordinating with state and federal agencies as necessary in light of specific allegations.</p> <p>3. A Resident or family member may voice grievances with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and other Residents, and other concerns regarding their long term care facility stay.</p> <p>4. The facility will not prohibit or in any way discourage a Resident from communicating with external entities including federal and state surveyors or other federal or state health department employees.</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 - Few</p>	<p>5. Information on how to file a grievance or complaint will be available to the Resident.</p> <p>7. Evidence demonstrating the results of all grievances will be maintained for a period of no less than 3 years from the issuance of the grievance decision.</p> <p>8. The facility will make prompt efforts to resolve grievances.</p> <p>Surveyor was also provided a Resident and Family Grievances policy implemented 5/16/24 documenting additional guidelines:</p> <p>.1. Social Worker [(SW)-C] is responsible for overseeing the grievance process; receiving and tracking grievances through to their conclusion; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances; issuing written grievance decisions to the Resident; and coordinating with state and federal agencies as necessary in light of specific allegations.</p> <p>8. Grievances may be voiced in the following forums:</p> <p>a. Verbal complaint to a staff member or Grievance Official</p> <p>b. Written complaint to a staff member or Grievance Official</p> <p>c. Written complaint to an outside party</p> <p>d. Verbal complaint during Resident or family council meetings</p> <p>e. Via the company toll free Customer Service Line .</p> <p>10. Procedure: .</p> <p>b. The staff member receiving the grievance will record the nature and specifics of the grievance on the designated grievance form, or assist the Resident or family member to complete the form.</p> <p>c. Forward the grievance form to the Grievance Official as soon as practicable.</p> <p>d. The Grievance Official will take steps to resolve the grievance, and record information about the grievance, and those actions, on the grievance form.</p> <p>i. Steps to resolve the grievance may involve forwarding the grievance to the appropriate department manager for follow up.</p> <p>ii. All staff involved in the grievance investigation or resolution should make prompt efforts to resolve the grievance and return the grievance form to the Grievance Official. Prompt efforts include acknowledgment of complaint/grievances and actively working toward a resolution of that complaint/grievance.</p> <p>e. The Grievance Official, or designee, will keep the Resident appropriately apprised of progress towards resolution of the grievances.</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 - Few</p>	<p>g. In accordance with the Resident's right to obtain a written decision regarding his/her grievance, the Grievance Official will issue a written decision on the grievance to the Resident or representative at the conclusion of the investigation.</p> <p>i. The date the grievance was received</p> <p>ii. The steps taken to investigate the grievance</p> <p>iii. A summary of the pertinent findings or conclusions regarding the Resident's concern(s)</p> <p>iv. A statement as to whether the grievance was confirmed or not confirmed</p> <p>v. Any corrective action taken or to be taken by the facility as a result of the grievance</p> <p>vi. The date the written decision was issued .</p> <p>11. Evidence demonstrating the results of all grievances will be maintained for a period of no less than 3 years from the issuance of the grievance decision.</p> <p>1) R1 was admitted to the facility on [DATE] with diagnoses of Chronic Obstructive Pulmonary Disease, Bronchitis, Moderate Persistent Asthma, Morbid Obesity, Edema, Type 2 Diabetes Mellitus, and Vascular Dementia. R1 was his own person while at the facility. R1 discharged from the facility on 4/24/24.</p> <p>R1's Quarterly Minimum Data Set (MDS) completed on 2/28/24, documents R1 has short term memory impairment, long term memory is intact and R1 demonstrates modified independence for daily decision making requiring supervision only. R1's MDS documents R1 is dependent for personal hygiene, and requires substantial to maximum assistance for dressing, mobility, and transfers.</p> <p>R1's physician orders document R1 was to have a CPAP (Continuous Positive Airway Pressure) with full face mask at bedtime with a start date of 1/17/24.</p> <p>On 8/12/24, at 8:47 AM, Surveyor reviewed the facility grievance log and notes there are no documented grievances for R1.</p> <p>On 8/12/24, at 9:55 AM, Surveyor spoke with R1's representative in regards to R1's CPAP machine. R1's representative informed Surveyor they brought R1's CPAP machine from home for R1 to use while at the facility. R1's representative stated the mask came up missing when R1 was transferred from the rehabilitation unit to the long term care unit. R1's representative stated R1's CPAP machine went missing. R1's representative realized this when representative packed up R1's belongings at time of discharge. R1's representative informed Admissions (AD)-O of the missing CPAP machine. R1's representative stated they did not receive a phone call back from the facility of a resolution.</p> <p>On 8/12/24, at 11:49 AM, Surveyor spoke with R1's community caseworker (CC)-P. CC-P stated CC-P informed the unit manager at the time that R1's CPAP machine was missing. CC-P stated the CPAP machine went missing a second time when R1 went to the hospital and again CC-P made facility staff aware. CC-P informed Surveyor as far CC-P is aware R1 has not had the missing CPAP machine replaced.</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 - Few</p>	<p>On 8/12/24, at 1:28 PM, Surveyor interviewed AD-O in regards to R1's missing CPAP machine. AD-O recalls receiving a phone call from R1's representative in regards to R1's missing CPAP machine and let Social Worker (SW-C) know of the missing CPAP machine. As far as AD-O knows, R1's CPAP machine was never found.</p> <p>On 8/12/24, at 1:35 PM, Surveyor interviewed Unit Manager (UM)-D who recalls R1 having R1's personal CPAP machine while at the facility. UM-D also recalls the facility renting a CPAP machine at one point for R1.</p> <p>On 8/13/24, at 8:49 AM, SW-C confirmed that SW-C is responsible for initiating grievances and making sure of the investigation is complete with resolution and communicating the outcome to the complainant. SW-C recalls the time when R1's mask came up missing and it was replaced. SW-C recalls speaking to R1's caseworker, but can't remember what it was about. SW-C does not recall AD-O informing SW-C of R1's missing CPAP machine. SW-C was not aware R1 had a personal CPAP machine while at the facility. SW-C confirmed SW-C did not complete a written grievance concerning R1's missing CPAP machine. SW-C stated it is not the policy of the facility to complete an inventory list on admission for the Residents.</p> <p>Surveyor notes there is an inventory completed on 7/28/23 for R1 that lists only 1 polo shirt, athletic shorts, underwear, and 1 pair of shoes. The inventory document was never updated with additional items brought in.</p> <p>On 8/13/24, at 12:13 PM, Surveyor interviewed Director of Nursing (DON)-B in regards to R1's missing CPAP machine. DON-B recalls R1 coming into the facility with R1's personal CPAP machine. DON-B stated the machine ended up not working and that is why the facility was renting a CPAP machine for R1.</p> <p>Surveyor reviewed invoices and notes the facility was renting a CPAP machine for R1 from 1/24-4/24, time of discharge. Surveyor notes there is no further documentation of an outcome/resolution or follow up with the complainant related to R1's missing CPAP machine.</p> <p>2) R3 was admitted to the facility on [DATE] with diagnoses of Chronic Obstructive Pulmonary Disease, Essential Hypertension, Chronic Hepatitis, Paroxysmal Atrial Fibrillation, Centriobular Emphysema, Hypertensive hear Disease and Anemia. R3 had an activated Health Care Power of Attorney (HCPOA) while at the facility. R3 discharged from the facility on 7/20/24.</p> <p>R3's Admission MDS (Minimum Date Set) assessment completed on 6/26/24 documents R3 had a BIMS (Brief Interview of Mental Status) score of 3 indicating R3 demonstrated severely impaired skills for daily decision making. No behaviors are documented for R3. R3's MDS documents R3 requires set-up assistance for dressing and hygiene and supervision for mobility and transfers.</p> <p>On 8/12/24, at 10:59 AM, Nursing Home Administrator (NHA)-A confirmed there are no documented grievances for the month of July 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 - Few</p>	<p>On 8/13/24, at 9:18 AM, Surveyor spoke with R3's activated HCPOA. R3's HCPOA detailed multiple concerns during the conversation. HCPOA confirmed they communicated all concerns to Social Worker (SW)-C. HCPOA stated there were several times R3 was found wet and covered in feces when HCPOA came to visit. On one occasion, HCPOA was approached in a rude way by a CNA and witnessed the CNA not being nice to R3. HCPOA stated several clothing items came up missing and HCPOA kept replacing the items. HCPOA confirmed they communicated the care issues, neglect, and missing clothing items several times to SW-C. HCPOA never received any follow-up, and consequently chose for R3 to not return to the facility.</p> <p>On 8/13/24, at 10:26 AM, Surveyor interviewed SW-C in regards to R3. SW-C informed Surveyor that SW-C can't remember any concerns involving R3. SW-C recalls being told about toileting issues by R3's HCPOA, but does not remember being told R3 was left soiled multiple times. SW-C stated SW-C would need to check their notes and get back to Surveyor.</p> <p>Surveyor notes SW-C never got back to Surveyor with additional information.</p> <p>On 8/13/24, at 12:31 PM, Surveyor shared the concern with Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B that grievances were communicated to Facility staff related to R1's CPAP was missing and R3's concerns of missing clothing items and care concerns involving R3 being found multiple times wet and covered in feces and there is no documented grievance completed, with an investigation, resolution, and follow-up with the representatives. At this time, the facility was not able to provide any additional information.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42037</p> <p>Based on record review and staff interview, the facility did not ensure all allegations involving potential abuse were thoroughly investigated and residents were protected from further abuse while alleged abuse investigations were conducted for 2 of 2 self report reviewed.</p> <p>* A Facility Misconduct Incident self-report submitted to the State Agency on 4/2/24 documents R7 and R6 had a resident to resident altercation where R7 had approached R6 and pulled their hair and possibly slapped R6 in the head. The facility did not conduct a thorough investigation into this allegation of abuse when the facility's investigation did not include documented interviews from other Residents in order to determine a possible pattern of abuse.</p> <p>*A Misconduct Incident Report was submitted to the State Agency on 7/5/24 documenting R2 was told by Certified Nursing Assistant (CNA)-F on 6/28/24, at about 8:30 AM, to Go in her incontinent product and slammed the bedpan down on the table. CNA-F stated to R2 You do this on purpose. You can do this stuff on your own. Nobody likes you because everyone knows for all the new aides you do this. R2 reported the situation to the nurse. An investigation was initiated, however, CNA-F was returned to the floor and continued to work with other residents for part of the shift.</p> <p>Findings Include:</p> <p>Surveyor reviewed the Facility Policy entitled, Abuse/Abuse, Neglect and Misappropriation Prevention Plan, revised 4/8/23 and notes the following applicable to completing a thorough investigation:</p> <p>. b. A thorough investigation of any reported incident, collect information that corroborates or disproves the incident and document the findings for each incident.</p> <p>A thorough investigation may include:</p> <p>iv. Interviewing other Residents to determine if they have been abused or mistreated.</p> <p>Surveyor notes the facility had properly completed the following related to R7 and R6's resident to resident altercation:</p> <p>-Submitted the Alleged Nursing Home Resident Mistreatment, Neglect, and Abuse Report within the required reporting time to the State Agency.</p> <p>-Submitted the Misconduct Incident Report within the required reporting time to the State Agency.</p> <p>-Interviewed all staff members that may have had knowledge of the resident to resident altercation.</p> <p>Upon review of this self-report, Surveyor was unable to identify documentation of interviews with other residents in order to establish if there was a pattern of resident to resident abuse. The facility did not establish if other residents had been witness to R7 and R6's resident to resident altercation.</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 - Few</p>	<p>On 8/13/24, at 1:30 PM, Surveyor conducted interview with NHA (Nursing Home Administrator)-A. Surveyor shared concern the facility had not completed interviews with other residents or obtained statements from additional residents who may have had knowledge of R7 and R6's altercation. The facility was unable to provide additional information to Surveyor at this time.</p> <p>38829</p> <p>2. A Misconduct Incident Report was submitted to the State Agency on 7/5/24 documenting R2 was told by Certified Nursing Assistant (CNA)-F on 6/28/24, at about 8:30 AM, to Go in her incontinent product and slammed the bedpan down on the table. CNA-F stated to R2 You do this on purpose. You can do this stuff on your own. Nobody likes you because everyone knows for all the new aides you do this. R2 reported the situation to the nurse. An investigation was initiated, however, CNA-F was returned to the floor and continued to work for part of the shift.</p> <p>*During the investigation into R2's allegation other residents were interviewed. The Facility identified around 10:00 AM, R12's family had a concern related to R12's bed being wet with urine the morning of 6/28/24 and R12 being upset. CNA-F was assigned to the care of R12 on that day as well as R2. CNA-F was re-educated by Unit Manager (UM)-E to change bed linen immediately when a bed is found to be wet and/or soiled.</p> <p>Findings Include:</p> <p>The facility's policy Abuse, Neglect and Exploitation for Residents implemented 7/10/24 documents:</p> <p>. Policy:</p> <p>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>Policy Explanation and Compliance Guidelines:</p> <p>1. The facility will develop and implement written policies and procedures that:</p> <p>a. Prohibit and prevent abuse, neglect, and exploitation of Residents and misappropriation of Resident property</p> <p>b. Establish policies and procedures to investigate any such allegation</p> <p>c. Include training for new and existing staff on activities that constitute abuse, neglect, exploitation, and misappropriate of Resident property, reporting procedures, and dementia management and Resident abuse prevention</p> <p>d. Establish coordination with the QAPI program</p> <p>V. Investigation of Alleged Abuse, Neglect and Exploitation</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Autumn Lake Healthcare at Greenfield		STREET ADDRESS, CITY, STATE, ZIP CODE 5790 S 27th St Milwaukee, WI 53221	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</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>B. Written procedures for investigations include:</p> <ol style="list-style-type: none"> 1. Identifying staff responsible for the investigation 2. Exercising caution in handling evidence that could be used in a criminal investigation 3. Investigating different types of alleged violations 4. Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations 5. Focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent, and cause 6. Providing complete and thorough documentation of the investigation <p>VI. Protection of Resident</p> <p>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. Examples include but are not limited to:</p> <ol style="list-style-type: none"> A. Responding immediately to protect the alleged victim and integrity of the investigation C. Increased supervision of the alleged victim and Residents E. Protection from retaliation <p>VII Reporting/Response</p> <ol style="list-style-type: none"> A. The facility will have written procedures that include: <ol style="list-style-type: none"> 1. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies within specified timeframes: <ol style="list-style-type: none"> 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 serious bodily injury 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 2. Assuring that reporters are free from retaliation or reprisal . <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 - Few</p>	<p>Surveyor notes the facility policy does not document the procedure (if the alleged perpetrator is an employee), for removing the employee from the resident care area immediately after the allegation of abuse and/or neglect is made and during the investigation.</p> <p>1) R2 was admitted to the facility on [DATE] with diagnoses of Major Depressive Disorder, Anxiety Disorder, Adjustment Disorder with Mixed Anxiety and Depressed Mood, Polyneuropathy, Paralytic Syndrome, Edema, and Venous Insufficiency. R2 is her own person.</p> <p>R2's Quarterly Minimum Data Set (MDS) assessment completed on 7/6/24 documents R2 has a Brief Interview for Mental Status (BIMS) score of 15, which indicates R2 is cognitively intact for daily decision making. R2's Patient Health Questionnaire (PHQ-9) score for mood is 0 indicating no depressive symptoms. R2's MDS documents R2 has verbal behaviors 1 to 3 days per week. R2's MDS also documents R2 requires supervision only for dressing, transfers, mobility, and hygiene.</p> <p>2) R12 was admitted to the facility on [DATE] with diagnoses of Generalized Anxiety Disorder, Unspecified Dementia, Essential Hypertension, Primary Arthritis, and Metabolic Encephalopathy. R12 has an activated Health Care Power of Attorney (HCPOA).</p> <p>R12's Annual MDS completed on 6/11/24 documents R12 has a BIMS score of 10, indicating R12 demonstrates moderately impaired skills for daily decision making. R12's MDS documents no mood or behavior concerns. R12 requires supervision for dressing, hygiene, transfers and mobility.</p> <p>On 8/12/24, at 11:04 AM, Surveyor reviewed the Facility's submitted Misconduct Incident report involving R2 and CNA-F. The Misconduct Incident Report was submitted to the State Survey Agency on 7/5/24 documenting R2 was told by Certified Nursing Assistant (CNA)-F at approximately 8:30 AM on 6/28/24 to go in her incontinent product and slammed the bedpan down on the table. CNA-F stated to R2 You do this on purpose. You can do this stuff on your own. Nobody likes you because everyone knows for all the new aides you do this. R2 reported her concern immediately to the nurse. An investigation was initiated. The investigation summary documents the Director of Nursing (DON)-B spoke with CNA-F about the incident between CNA-F and R2 and then had CNA-F go back to the unit to pass breakfast trays. The summary then documents DON-B had CNA-F leave the facility pending completion of the investigation at approximately 10:00-10:30 AM on 6/28/24. The summary also documents other Residents were interviewed and R12's family expressed concern R12 appeared upset when they arrive on 6/28/24 for a visit and R12's bed was wet with urine and unchanged. The Facility identified CNA-F was assigned to care for R12 as well as R2.</p> <p>On 8/13/24, at 11:37 AM, Surveyor spoke with Unit Manager (UM)-E in regards to the abuse allegation involving R2 and CNA-F. UM-E confirmed she was too part in the investigation, provided a written statement of the incident and confirmed UM-E sent CNA-F down to speak to DON-B immediately after learning of the abuse allegation. UM-E stated about 10:30 AM, on 6/28/24, UM-E sat down on R12's bed to tie R12's shoe when UM-E discovered R12's bed to be wet with urine and had not been changed. R12 was sitting in the wheelchair at the time. UM-E stated R12's HCPOA was also present. UM-E stated that UM-E had to re-educate CNA-F in regards to this. Surveyor questioned UM-E about CNA-F still being on the floor providing cares when an allegation of abuse had been made by R2. UM-E stated to Surveyor UM-E did not understand why CNA-F had returned to the floor to provide cares to Residents. UM-E stated, I was ----- livid that CNA-F was back on the floor. UM-E stated Even [R2] asked why was CNA-F was still here and [R2] was upset.</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 - Few</p>	<p>On 8/13/24, at 12:13 PM, Surveyor interviewed DON-B who stated initially, maybe I instructed CNA-F to go back up (to the unit). DON-B then stated DON-B does not remember that whole day. DON-B confirmed that when there is an investigation, the accused employee should not remain in the building during the investigation and CNA-F should not have returned to the floor to provide cares to Residents.</p> <p>On 8/13/24, at 12:31 PM, Surveyor shared the concern with Nursing Home Administrator (NHA)-A that staff statements and the documented facility summary indicate CNA-F was returned to the floor to provide cares after the allegation of abuse was reported by R2. Surveyor requested additional information of CNA-F's time punch of when CNA-F actually left the facility.</p> <p>On 8/13/24, at 1:23 PM, NHA-A informed Surveyor of the following: I'm not going to sugarcoat it. I was off that day and [CNA-F] worked the whole shift. I am so angry right now. Surveyor informed NHA-A of the concern the facility did not protect residents while an investigation of alleged abuse was in progress.</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 that based on the comprehensive assessment of a resident, residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan and the resident's choices for 2 (R5 & R3) of 12 residents.</p> <p>* R5 was completing the treatment of medihoney to her left posterior calf.</p> <p>* R3 had a wander guard without a wandering assessment being completed and did not have a smoking assessment completed.</p> <p>Findings include:</p> <p>The facility's policy titled, Wound Treatment Management and dated 5/1/24 under Policy documents To promote wound healing of various types of wounds, it is the policy of this facility to provide evidence-based treatments in accordance with current standards of practice and physician orders. Under Policy Explanation and Compliance Guidelines includes documentation of 7. The effectiveness of treatments will be monitored through on going assessment of the wound. Considerations for needed modifications include:</p> <p>a. Lack of progression towards healing.</p> <p>b. Changes in the characteristics of the wound (see above).</p> <p>c. Changes in the resident's goals and preferences, such as at end-of-life or in accordance with his/her rights.</p> <p>1.) R5's diagnoses includes Gullian Barre syndrome, diabetes mellitus, and lymphedema.</p> <p>R5's quarterly MDS (minimum data set) with an assessment reference date of 5/8/24 has a BIMS (brief interview mental status) score of 7 which indicates severe cognitive impairment.</p> <p>The vascular wound care plan initiated 8/9/23 and revised 7/16/24 includes an intervention initiated & revised 8/9/23 of Administer wound care as ordered and monitor for effectiveness.</p> <p>Surveyor noted R5 is listed on the facility's non pressure list for left posterior calf, lymphedema dated 7/11/24.</p> <p>The weekly non pressure wound tracking dated 7/11/24 documents for site 44.) left lower leg (rear) vascular. Measurements are 4.5 cm (centimeter) x 0.3 cm x 0.1. Under comments documents Res (Resident) noted with new venous ulcer to left posterior leg. Wound bed with 100% pink epithelial wound edges well defined. Wound is linear in shape and moderate amount of serosanguineous drainage noted. No s/s (signs/symptoms) of infection. Resident currently being treated by lymphedema clinic and will be treated in house with weekly wound MD (medical doctor) visits until wound is healed. Surveyor noted weekly assessments of this wound.</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>The physician order dated 7/26/24 documents Wound care posterior calf. Cleanse with wound cleanser at pat dry apply medihoney to wound bed and cover with bordered gauze daily and PRN (as needed). Every day shift.</p> <p>The weekly non pressure wound tracking dated 8/6/24 documents for site 44.) left lower leg (rear). Type is lymphedema wound. Measurements are 0.7 cm (centimeter) x 0.5 cm x 0.1. Under comments documents Wound bed with 60% slough and 40% granulation. Light serous drainage noted to previous dressing. No s/s of infection. Wound edge stable.</p> <p>On 8/12/24, at 9:04 a.m., Surveyor observed R5 sitting on the edge of the bed wearing only a brief with two wash basins on an over bed table in front of R5. Surveyor observed a dressing on R5's left posterior calf. Surveyor asked R5 if the nurse did her treatment on her left posterior calf this morning. R5 replied I did it myself explaining the nurses come to late. R5 stated she has the medihoney and informed Surveyor they don't give her too much. R5 showed Surveyor the tube of medihoney which was located in a clear plastic bag on R5's bed. On the small dresser next to the bed a box of sterile bordered gauze dressing.</p> <p>Surveyor reviewed R5's August TAR (treatment administration record) and noted R5's left posterior calf treatment is checked and initialed by RN (Registered Nurse)-J as being completed.</p> <p>On 8/12/24, at 1:48 p.m., Surveyor asked RN-J if R5 has any treatments. RN-J informed Surveyor they are done. Surveyor asked RN-J if she did the treatment or did R5 do her own treatment. RN-J informed Surveyor R5 said she did her own treatment and she signed in the TAR as she (referring to R5) can't do that. RN-J informed Surveyor R5 will do her own treatment if she has the supplies and stated I wish she would let us do it so we can see it but I think the wound MD (Medical Doctor) sees her.</p> <p>On 8/13/24, at 8:12 a.m., Surveyor observed R5 sitting on the edge of the bed wearing a gown and tubi grips. Surveyor asked R5 how does she know how to do her treatment for the back of her left calf. R5 replied I can feel it and explained it has a wet kind of feeling and spots on the Band-Aid. Surveyor asked R5 if she still has her bag with the medihoney in it. R5 replied yes and picked up the clear plastic bag from her bed.</p> <p>On 8/13/24, at 8:21 a.m., Surveyor asked RN/UM (Registered Nurse/Unit Manager)-D if R5 can do her own treatments. RN/UM-D replied no. Surveyor asked RN/UM-D if she was aware R5 was doing her own treatment to her left posterior calf. RN/UM-D replied no, she doesn't do her own treatment. RN/UM-D explained they are on first shift and the first shift nurse does her treatment. Surveyor informed RN/UM-D R5 informed her she does her own treatments and showed Surveyor her medihoney. Surveyor informed RN/UM-D Surveyor had spoken to RN-J who informed Surveyor R5 told her she did her own treatment and RN-J signed the TAR as R5 can't do that. RN/UM-D informed Surveyor R5 hasn't had any teaching because she's not suppose to do her treatments RN/UM-D informed Surveyor R5 is activated, referring to R5's power of attorney being activated, and R5 has moments of clarity and other times she's not so clear.</p> <p>On 8/13/24, at 10:23 a.m., Wound MD (Medical Doctor)-Q assessed R5's left posterior calf wound and informed R5 it's healed.</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 8/13/24, at 11:38 a.m., Surveyor asked DON (Director of Nursing)-B and ADON (Assistant Director of Nursing)-N if they were aware R5 was doing her own treatments to her left posterior calf. Both DON-B and ADON-N replied no. Surveyor informed DON-B and ADON-N R5 has been doing her treatments and RN-J signed the August TAR on the 12th because R5 can't sign the TAR.</p> <p>On 8/13/24, at 12:31 p.m., NHA (Nursing Home Administrator)-A, DON-B and ADON-N were informed of the above.</p> <p>38829</p> <p>2.) The facility's Elopements and Wandering Residents policy and procedure implemented 5/10/24 documents:</p> <p>. Policy:</p> <p>This facility ensures that Residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents, and receive care in accordance with their person centered plan of care.</p> <p>Policy Explanation and Compliance Guidelines: .</p> <p>2. The facility shall establish and utilize a systematic approach to monitoring and managing Residents at risk for elopement or unsafe wandering, including identification and assessment of risk, evaluation and analysis of hazards and risks, implementing interventions to reduce hazards and risks, and monitoring for effectiveness and modifying interventions when necessary.</p> <p>3. Monitoring and Managing Residents at Risk for Elopement or Unsafe Wandering</p> <p>b. The interdisciplinary team will evaluate the unique factors contributing to risk in order to develop a person centered care plan.</p> <p>The facility's Resident Smoking policy and procedure implemented 6/1/24 documents:</p> <p>. Policy:</p> <p>It is the policy of this facility to provide a safe and healthy environment for Residents, visitors, and employees, including safety as related to smoking.</p> <p>Policy Explanation and Compliance Guidelines: .</p> <p>5. All Residents will be asked about tobacco use during the admission process, and during each quarterly or comprehensive MDS assessment process.</p> <p>6. Residents who smoke will be further assessed using the Resident Safe Smoking Assessment, to determine whether or not supervision is required for smoking, or if Resident is safe to smoke at all.</p> <p>15. Documentation to support decision making will be included in the medical record, including but not limited to:</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>a. Resident's wishes, or those of the Resident's representative</p> <p>b. Assessment of relevant functional and cognitive factors affecting ability to smoke safely</p> <p>c. Response to smoking cessation interventions</p> <p>d. Compliance with smoking policy.</p> <p>R3 was admitted to the facility on [DATE] with diagnoses of Chronic Obstructive Pulmonary Disease, Essential Hypertension, Chronic Hepatitis, Paroxysmal Atrial Fibrillation, Centrilobular Emphysema, Hypertensive hear Disease and Anemia. R3 had an activated Health Care Power of Attorney(HCPOA) while at the facility. R3 discharged from the facility on 7/20/24.</p> <p>R3's Admission Minimum Data Set (MDS) completed on 6/26/24 documents R3 had a Brief Interview for Mental Status (BIMS) score of 3 indicating R3 demonstrated severely impaired skills for daily decision making. No behaviors concerns are documented. R3's MDS documents R3 requires set-up for dressing and hygiene and supervision for mobility and transfers.</p> <p>Surveyor reviewed R3's physician orders which document R3 had a wanderguard placed on 6/27/24 and placement needed to be checked every shift.</p> <p>Surveyor reviewed R3's comprehensive care plan and notes the following:</p> <ol style="list-style-type: none"> 1. R3 is an elopement risk/wanderer due to impaired safety awareness. R3 wanders aimlessly, Initiated 6/27/24 2. R3 is at risk for injury due to smoking with an intervention that a smoking assessment will be completed on admission, readmission, quarterly and as needed, Initiated 6/17/24 <p>Surveyor was not able to locate a smoking assessment in R3's electronic medical record.</p> <p>Surveyor reviewed R3's Wandering/Elopement Assessment completed on 6/17/24, day of admission which documents R3 is low risk for wandering and has not wandered.</p> <p>Surveyor notes an elopement/wander risk assessment was not completed to identify why R3 had a wanderguard placed on 6/27/24.</p> <p>On 6/27/2024, at 3:52 PM, Unit Manager (UM)- D documented: Writer called and spoke with POA (Power of Attorney) regarding resident moving to the 1st floor closer to the nurse station. POA is on board with moving resident to the 1st floor. Writer updated DON (Director of Nursing), Administrator and Admissions. Resident moved to room [room number], wander guard placed on Resident right ankle. Writer called and left an updated message for guardian. Message included clothes being left in bags tonight to be labeled in the morning, the floor, room number, and asking her to bring resident personal wheelchair.</p> <p>Surveyor notes there is no other documentation in R3's electronic medical record as to why the wanderguard was placed on R3 or any other documentation indicating R3 was an elopement/wander risk.</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 notes there is no documentation as to why a smoking care plan was initiated on 6/17/24 for R3.</p> <p>On 8/13/24, at 10:26 AM, Surveyor interviewed Social Worker (SW)-C in regards to R3. SW-C stated staff were worried about R3 wandering. SW-C stated she is not sure if a HCPOA needs to give permission for a wanderguard.</p> <p>On 8/13/24, at 9:18 AM, Surveyor spoke with R3's Health Care Power of Attorney (HCPOA). R3's HCPOA informed Surveyor they were not informed R3 was an elopement risk and required a wanderguard. HCPOA stated they did not give permission for the wanderguard. HCPOA stated HCPOA was informed R3 had an outburst and needed to be transferred to the 1st floor. HCPOA informed Surveyor they found R3 to have cigarettes and a lighter in R3's presence and asked the facility how R3 had gotten the cigarettes and a lighter. HCPOA stated they were informed by the facility that R3 had obtained them from an assisted living resident.</p> <p>On 8/13/24, at 11:27 AM, Surveyor interviewed Unit Manager (UM)-E. UM-E stated a HCPOA needs to give permission for a wanderguard but not sure about written. UM-E stated a wandering and smoking assessment should be completed on admission. If initially assessed as not a smoker, and the Resident is found to be smoking, a new assessment should be completed. UM-E confirmed if a Resident's wandering status changed, a new assessment should be completed.</p> <p>On 8/13/24, at 12:13 PM, Surveyor interviewed Director of Nursing (DON-B). DON-B confirmed a new wandering assessment should have been completed when the facility identified R3 to be at risk for wandering/elopement as well as if R3 started smoking, a smoking assessment should have been completed to determine if R3 was a safe smoker or not.</p> <p>On 8/13/24, at 12:31 PM, Surveyor shared the concern with Nursing Home Administrator (NHA)-A and DON-B that when R3 was identified to be smoking and at risk for elopement/wandering that assessments were not completed. Surveyor shared there is no documentation as to when and why R3 was determined to not be a safe smoker and the behaviors that put R3 at risk for wandering/elopement. No further information was provided by the facility at this time.</p>

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</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 that Residents with a pressure injury or 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 (R10) of 3 Residents reviewed for pressure injuries.</p> <p>R10 had a history of pressure injuries. R10 was admitted with a Stage 3 pressure injury on the right & left buttocks, an unstageable pressure injury on the right heel and a stage 3 pressure injury on the left heel. R10's right buttocks was identified as being healed on 5/28/24, the left buttocks pressure injury was healed on 6/11/24, the right heel was healed on 7/30/24, & the left heel was healed on 8/6/24. On 7/15/24, R10 developed three Stage 3 pressure injuries on the coccyx, left & right buttock. The Facility did not revise R10's care plan after development of these pressure injuries, R10's care plan does not include interventions of how often R10 should be repositioned and when incontinence cares should be provided for R10 who was identified as being a heavy wetter.</p> <p>Findings include:</p> <p>The facility's policy titled, Prevention of Pressure Ulcers and revised 1/16/24 under General Guidelines documents:</p> <ol style="list-style-type: none"> Pressure ulcers are usually formed when a resident remains in the same position for an extended period of time causing increased pressure or a decreased of circulation (blood flow) to that area and subsequent destruction of tissue. The most common site of a pressure ulcer is where the bone is near the surface of the body including the back of the head around the ears, elbows, shoulder blades, backbone, hips, knees, heels, ankles, and toes. Pressure can also come from splints, casts, bandages, and wrinkles in the bed linen. If pressure ulcers are not treated when discovered, they quickly get larger, become very painful for the resident, and often times become infected. Pressure ulcers are often made worse by continued pressure, heat, moisture, irritating substances on the resident's skin (i.e., perspiration, feces, urine, wound discharge, soap residue, etc.), decline in nutrition and hydration status, <p>(continued on next page)</p> 		

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NAME OF PROVIDER OR SUPPLIER Autumn Lake Healthcare at Greenfield		STREET ADDRESS, CITY, STATE, ZIP CODE 5790 S 27th St Milwaukee, WI 53221	

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>acute illness and/or decline in the resident's physical and/or mental condition.</p> <p>5. Once a pressure ulcer develops, it can be extremely difficult to heal. Pressure ulcers are a serious skin condition for the resident.</p> <p>R10 was admitted to the facility on [DATE] with diagnoses which include major depressive disorder, diabetes mellitus, morbid obesity and altered mental status.</p> <p>R10 was admitted with a Stage 3 pressure injury on the right & left buttocks, an unstageable pressure injury on the right heel and a stage 3 pressure injury on the left heel. R10's right buttocks was identified as being healed on 5/28/24, the left buttocks pressure injury was healed on 6/11/24, the right heel was healed on 7/30/24, & the left heel was healed on 8/6/24.</p> <p>The potential/actual impairment to skin integrity care plan initiated 5/20/24 & revised 8/6/24 documents the following interventions:</p> <ul style="list-style-type: none"> * Avoid scratching and keep hands and body parts from excessive moisture. Keep fingernails short. Initiated & revised on 5/20/24. * Conduct weekly body audit. Initiated 5/20/24. * Follow facility protocols for treatment of injury. Initiated and revised on 5/20/24. * Identify/document potential causative factors and eliminate/resolve where possible. Initiated & revised on 5/20/24. * Keep skin clean and dry. Use lotion on dry skin. Do not apply on ANY WOUND. Initiated and revised on 5/20/24. * Monitor/document location, size and treatment of skin injury. Report abnormalities, failure to heal, s/sx (signs/symptoms) of infection, maceration etc. to MD (medical doctor). Initiated & revised on 5/20/24. * The resident needs pressure relieving/reducing mattress, pillows, sheepskin padding etc to protect the skin while up in chair. Initiated and revised on 5/21/24. * Therapy as ordered by MD. Initiated 5/20/24. * Use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surface. Initiated & revised on 5/20/24. <p>The CNA (Certified Nursing Assistant) kardex as of 8/13/24 under the skin section documents</p> <ul style="list-style-type: none"> * Avoid scratching and keep hands and body parts from excessive moisture. Keep fingernails short. * Keep skin clean and dry. Use lotion on dry skin. Do not apply on any wound. <p>(continued on next page)</p>

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>* Use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surface.</p> <p>* Wash feet daily with mild soap and water. Dry thoroughly. May use a light dusting powder or lotion. Do not apply lotion or powder between the toes.</p> <p>Under the Resident Care section documents:</p> <p>* All staff to converse with resident while providing care.</p> <p>* Explain all procedures to the resident before starting and throughout cares.</p> <p>* Keep the resident's routine consistent and try to provide consistent care givers as much as possible in order to decrease confusion.</p> <p>* TRANSFER: Requires Hoyer A (assist) x (times) 2 for all transfers to/from bed and w/c (wheelchair).</p> <p>Surveyor noted the CNA kardex does not document how often R10 should be repositioned and when to provide incontinence cares.</p> <p>The admission MDS (minimum data set) with an assessment reference date of 5/27/24 has a BIMS (brief interview mental status score of 15 which indicates R10 is cognitively intact. R10 is assessed as not refusing cares. R10 is assessed as requiring substantial/maximal assistance for rolling left & right and is assessed as being dependent for toileting hygiene, chair/bed to chair transfer, & toilet transfer. R10 is always incontinent of bowel and bladder. R10 is assessed as being at risk for pressure injury development and has three Stage 3 pressure injuries which were present upon admission.</p> <p>The pressure injury CAA (care area assessment) dated 6/2/24 for nature of problem has not been completed & is blank. For existing pressure injury documents (Click here to add supporting documentation. Provide the basis/reason for items by clicking, including the location & date & source (if applicable), of that information).</p> <p>For extrinsic risk factors documents (Click here to add supporting documentation. Provide the basis/reason for items by clicking, including the location & date & source (if applicable), of that information).</p> <p>For intrinsic risk factors documents (Click here to add supporting documentation. Provide the basis/reason for items by clicking, including the location & date & source (if applicable), of that information).</p> <p>For medications that increase risk for pressure ulcer/injuries development documents (Click here to add supporting documentation. Provide the basis/reason for items by clicking, including the location & date & source (if applicable), of that information).</p> <p>Diagnosis & conditions that present complications or increase risk for pressure ulcer/injury is checked for diabetes, chronic or end stage renal, liver or heart disease, malnutrition, depression and pain.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Treatments and other factors that cause complications or increase risk has newly admitted or readmitted checked.</p> <p>Resident and/or family representative and care plan considerations has not been completed and is blank.</p> <p>The Braden assessment dated [DATE] has a score of 17 which indicates low risk for pressure injury development.</p> <p>The nurses note dated 7/7/24, at 21:50 (9:50 p.m.), documents Resident monitored for low SPO2, increased pulse and low BS (blood sugar), BS 144 and O2 (oxygen) 95, Resident denies any pain, resident has had loose stools throughout the day x (times) 6, given PRN (as needed) loperamide. There is excoriation bilateral to buttocks, writer covered with bordered bandage. Resident states pain of 3/10 to buttocks area. Will continue to monitor. This nurses note was written by Nursing-R. Surveyor noted there is no notification to R10's physician regarding the excoriation and bordered bandage applied.</p> <p>The nurses note dated 7/9/24, at 04:05 (4:05 a.m.), includes documentation of Changed sacrum drsg (dressing) This nurses note was written by LPN-S. Surveyor noted there is not an order for a sacrum dressing nor any assessment for the sacrum.</p> <p>The nurses note dated 7/15/24, at 05:51 (5:51 a.m.), documents Resident resting throughout the night no s/s (signs/symptoms) of pain or discomfort noted Right and Left buttock open area noted resident provided peri care barrier cream applied. This nurses note was written by RN-T. Surveyor noted there is no notification to R10's physician regarding the open areas.</p> <p>The nurses note dated 7/15/24, at 12:31, documents Writer followed up r/t (related to) open areas to BIL (bilateral) buttocks. Writer assessed buttocks and cluster wound is noted to coccyx. 3 open areas observed with purple discoloration surrounding them. Documented as cluster DTI (deep tissue injury). Res (Resident) is already seen weekly by wound MD for BIL heel wounds, new wounds added to Wound MD roster. This nurses note was written by Wound Nurse/LPN-K. Surveyor noted there is no RN assessment of R10's pressure injuries.</p> <p>The nurses note dated 7/15/24, at 12:36, documents F/U (follow up) to add wound measurements. Wound measures 6.5 cm x 4.5 cm x 0.1 cm. This nurses note was written by Wound Nurse/LPN-K.</p> <p>The nurses note dated 7/16/24, at 15:43 (3:43 p.m.), documents Res seen by Wound MD this day and BIL heel wounds noted with improvement. Yesterday after reports of new wounds writer assessed res and measured 3 wounds to coccyx area as 1 cluster wound. MD has separated these wounds to be measured and treated separately d/t location of sites. New wounds to left and right buttock as well as coccyx are stage 3's. Writer phoned res RP(Responsible Party) [Name] but she is out of the office today. Writer left message for [Name] to return call for a wound update. Sharps debridement done at bedside per MD and res tolerated well. New tx (treatment) orders received and initiated for buttocks wounds. POC (plan of care) updated to reflect the above. This nurses note was written by Wound Nurse/LPN-K.</p> <p>The weekly wound assessment dated [DATE] documents for date of onset 7/15/24. Wound site is 32.) Left Buttocks. Type is Pressure. Length in cm (centimeters) is 3.7, width 1.8, and depth 0.1. Stage is Stage III (3). Summary documents res noted with new wound to left buttock on 7/15. Wound bed with 100% granulation. Light serosanguineous drainage. Wound edges well defined.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Date of onset is 7/15/24. Wound site documents 23.) Coccyx. Type is Pressure. Length 1.6, width 1.1, and depth 0.1 Stage is Stage III (3). Under Summary documents res noted with new wound to coccyx on 7/15. wound bed with 100% granulation. Light serosanguineous drainage. Wound edges well defined.</p> <p>Date of onset is 7/15/24. Wound site documents 31.) Right Buttocks. Type is Pressure. Length 0.9, width 1.3, and depth 0.1. Stage is Stage III (3). Summary documents Res noted with new wound to right buttocks on 7/15. wound bed with 100% granulation. Light serosanguineous drainage. Wound edges well defined.</p> <p>Surveyor noted there were no revisions to R10's skin integrity care plan after R10 developed the three stage 3 pressure injuries. None of R10's care plans include interventions on how often R10 should be repositioned or when continence cares should be provided.</p> <p>The nurses note dated 7/18/24, at 23:29 (11:29 p.m.), documents Resident alert and responsive able to voice needs, treatment maintained to buttocks, resident repositioned as needed tolerated well bilat (bilateral) heels elevated in bed, This nurses note was written by Nursing-U.</p> <p>On 7/22/24 an intervention to the ADL (activities daily living) self care performance deficit care plan was added which documents Resident is resistive to cares, turning, and repositioning. This intervention was added 7 days after R10 developed 3 stage 3 pressure injuries. There is not a refusal of cares care plan.</p> <p>The weekly wound assessment dated [DATE] documents for date of onset 7/15/24. Wound site is 32) Left Buttocks. Type is Pressure. Length in cm (centimeters) is 2.9, width 1.7, and depth 0.1. Stage is Stage III (3). Summary documents Wound bed with 40% granulation and 60% slough. Light serosanguineous drainage. Wound edges well defined. No evidence of infection observed.</p> <p>Date of onset is 7/15/24. Wound site documents 23) Coccyx. Type is Pressure. Length 1.6, width 1.1, and depth 0.1 Stage is Stage III (3). Under Summary documents Wound bed with 100% granulation. Light serosanguineous drainage. Wound edges well defined.</p> <p>Date of onset is 7/15/24. Wound site documents 31) Right Buttocks. Type is Pressure. Length 0.9, width 0.8, and depth 0.1. Stage is Stage III (3). Summary documents Wound bed with 100% granulation. Light serosanguineous drainage. Wound edges well defined. No evidence of infection observed.</p> <p>The weekly wound assessment dated [DATE] documents for date of onset 7/15/24. Wound site is 32) Left Buttocks. Type is Pressure. Length in cm (centimeters) is 2.0, width 1.5, and depth 0.1. Stage is Stage III (3). Summary documents Wound bed with 100% granulation. Light serosanguineous drainage. Wound edges well defined. No evidence of infection observed.</p> <p>Date of onset is 7/15/24. Wound site documents 23) Coccyx. Type is Pressure. Length 1.6, width 1.0, and depth 0.1 Stage is Stage III (3). Under Summary documents Wound bed with 100% granulation. Light serosanguineous drainage. Wound edges well defined.</p> <p>Date of onset is 7/15/24. Wound site documents 31) Right Buttocks. Type is Pressure. Length 0.8, width 0.8, and depth 0.1. Stage is Stage III (3). Summary documents Wound bed with 100% granulation. Light serosanguineous drainage. Wound edges well defined. No evidence of infection observed.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>The weekly wound assessment dated [DATE] documents for date of onset 7/15/24. Wound site is 32) Left Buttocks. Type is Pressure. Length in cm (centimeters) is 3.5, width 0.8, and depth 0.1. Stage is Stage III (3). Summary documents Wound bed with 40% slough, 10% granulation, and 50% skin. Light serosanguineous drainage. Wound edges well defined. No evidence of infection observed.</p> <p>Date of onset is 7/15/24. Wound site documents 23) Coccyx. Type is Pressure. Length 1.1, width 0.8, and depth 0.1 Stage is Stage III (3). Under Summary documents Wound bed with 100% granulation. Light serosanguineous drainage. Wound edges well defined.</p> <p>Date of onset is 7/15/24. Wound site documents 31) Right Buttocks. Under summary documents wound is now healed.</p> <p>On 8/12/24, at 10:50 a.m., Surveyor observed R10 in bed on her back with her eyes closed, as oxygen via nasal cannula, and the head of the bed elevated. R10 is on an air mattress and is wearing blue pressure relieving boots. Surveyor noted the air mattress was provided on 5/21/24.</p> <p>On 8/12/24, at 12:21 p.m., Surveyor observed R10 continues to be in bed on her back with the head of the bed elevated.</p> <p>On 8/12/24, at 1:55 p.m., Surveyor observed R10 continues to be in bed on her back. Surveyor asked R10 what staff does for her. R10 replied they take care of what ever I need. Surveyor asked R10 if staff repositions her from side to side. R10 replied Usually I stay on my back. Surveyor asked R10 if staff asked her if she wanted to be repositioned on her side today. R10 replied no. Surveyor asked R10 if she has any pressure ulcers. R10 replied on my left heel. Surveyor asked R10 if she has anything on her bottom. R10 replied yes, two sores. Surveyor asked R10 has she developed the sores. R10 replied I don't know.</p> <p>On 8/13/24, at 8:19 a.m., Surveyor observed R10 in bed on her back with the head of the bed up high. R10 is on an air mattress and is wearing pressure relieving boots.</p> <p>On 8/13/24, at 9:41 a.m., Surveyor observed CNA-G & CNA-H enter R10's room. Surveyor asked CNA-G & CNA-H what they were going to do. CNA-G informed Surveyor they were going to change R10. Surveyor observed CNA-G & CNA-H were wear gloves. CNA-G lowered R10's head of the bed and raised the bed up. R10's blanket was removed and staff unfastened the incontinence product. Surveyor observed there is BM (bowel movement) up R10's frontal perineal area. CNA-G informed R10 she was going to clean her and washed R10's frontal perineal area to remove the BM. CNA-G informed R10 she was going to turn R10 towards the window. CNA-G pulled on the soaker pad to move R10 towards the left side of the mattress and CNA-G & CNA-H positioned R10 on the right side. CNA-G removed the dressing from R10's coccyx/left buttocks. Surveyor observed there is a Stage 3 pressure injury on R10's coccyx and left buttocks. CNA-G washed R10's rectal area & buttocks to remove the BM, applied barrier cream on R10's buttocks and an incontinence product was placed under R10 & fastened. CNA-G informed R10 the wound doctor would be here to change her patch. Surveyor asked CNA-G & CNA-H if Surveyor could look at R10's feet. CNA-G removed R10's blue pressure relieving boots. Surveyor did not observe any pressure injuries on R10's feet. CNA-G placed the pressure relieving boots back on R10 and R10 was positioned on the left side.</p> <p>On 8/13/24, at 9:54 a.m., Surveyor asked CNA-G how R10 developed the pressure injuries. CNA-G replied I'm not really sure.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 8/13/24, at 9:56 a.m., Surveyor asked CNA-H if she knew how R10 developed the pressure injuries. CNA-H informed Surveyor she usually works on the first floor or the other hallway explaining she gets moved around. Surveyor asked CNA-H if she did provided any cares to R10 prior to Surveyor's observation. CNA-H informed Surveyor she gave her ice water and changed her. CNA-H informed Surveyor R10 gets up after lunch depending on how she is. Surveyor asked CNA-H what time did she take care of R10. CNA-H informed Surveyor around 7:30 a.m. Surveyor asked CNA-H how often R10 should be repositioned CNA-H informed Surveyor probably every hour or so.</p> <p>On 8/13/24, at 9:59 a.m., Surveyor asked CNA-G how often R10 is repositioned. CNA-G replied every two hours.</p> <p>On 8/13/24, at 10:29 a.m., Surveyor asked Wound Nurse/LPN (Licensed Practical Nurse)-K how R10 developed the three Stage 3 pressure injuries on 7/15/24. Wound Nurse/LPN-K informed Surveyor it started as maceration, she's a heavy wetter, and has a history of wounds in the same area. Surveyor asked who revises skin impairment care plans. Wound Nurse/LPN-K replied typically me when we have wounds or is resolved.</p> <p>On 8/13/24, at 10:31 a.m., Surveyor observed wound rounds for R10 with Wound Nurse/LPN-K & Wound MD-Q. Wound MD-Q assessed R10's pressure injuries stating both are smaller today. Wound MD-Q assessed R10's coccyx Stage 3 pressure injury as having measurements of 0.7 cm (centimeters) x (times) 0.3 cm x 0.1. The wound bed 50% granulation and 50% slough. The left buttocks measurements are 0.5 cm x 0.3 cm x 0.1 cm. The wound bed is 100% granulation. After Wound MD-Q assessed R10's pressure injuries, Wound Nurse/LPN-K completed the treatment according to physician's orders. There were no concerns identified during this observation.</p> <p>On 8/13/24, at 10:49 a.m., Surveyor asked Wound MD-Q how R10 developed the Stage 3 pressure injuries on the left & right buttocks and coccyx on 7/15/24. Wound MD-Q informed Surveyor R10 is overweight and sometimes refuses positioning. Wound MD-Q informed Surveyor sitting in the same position you develop a pressure injury right away. Wound MD-Q stated now that R10 has the wounds she is listening more, before that not so much.</p> <p>On 8/13/24, at 10:51 a.m., Surveyor asked RN/UM (Registered Nurse/Unit Manager)-D how R10 developed the three Stage 3 pressure injuries on 7/15/24. RN/UM-D replied I don't know if I'm the right person. RN/UM-D informed Surveyor R10 was admitted with wounds. RN/UM-D informed Surveyor sometimes R10 can be non compliant with repositioning and doesn't always want to get out of bed which is their right to choose. Surveyor then read R10's nurses note dated 7/7/24 which includes there is excoriation bilateral to buttocks, writer covered with bordered bandage. Surveyor informed RN/UM-D Surveyor did not note where R10's physician was notified or any order for the excoriation. RN/UM-D informed Surveyor this may be an agency nurse. Surveyor then read R10's nurses note dated 7/9/24 which includes changed sacrum dressing. RN/UM-D informed Surveyor she didn't know anything and this was a third shift nurse. Surveyor read R10's note dated 7/15/24 which included noted right and left buttock open area noted resident provided peri care barrier cream applied. Surveyor informed RN/UM-D there is no physician notification and no assessment of the open areas. RN/UM-D informed Surveyor this nurse is no longer employed. Surveyor asked RN/UM-D who revises the care plans as Surveyor noted R10's care plan was not revised after development of the three pressure injuries. RN/UM-D replied our DON (Director of Nursing) or wound nurse does.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 8/13/24, at 11:41 a.m., Surveyor asked DON (Director of Nursing)-B and ADON (Assistant Director of Nursing)-N who revises care plans. DON-B replied we do that as a team. Surveyor asked when care plans are revised. DON-B informed Surveyor on admission, readmission, any changes that occur such as fall or new open area. Surveyor informed DON-B & ADON-N R10 developed 3 stage 3 pressure injuries on 7/15/24. There were no revisions after development of the pressure injuries to R10's care plan. Surveyor informed DON-B & ADON-N on 7/7/24 there is a nurses note regarding excoriation with a dressing being applied. Surveyor noted there was no physician notification or order for treatment. On 7/9/24 there is a nurses note which documented the sacrum dressing was changed. There is no order for a dressing or assessment of this area. On 7/15/24 there is a nurses note regarding left & right buttock open area with barrier cream being applied. The RN didn't assess this area and there is no notification to the physician. Surveyor informed DON-B and ADON-N R10's care plans do not have any interventions as to how often R10 should be repositioned and Surveyor was informed R10 is a heavy wetter but there are no interventions as to how often R10 should be checked and changed. Surveyor asked DON-B and ADON-N to provide any additional information Surveyor may have not reviewed.</p> <p>On 8/13/24, at 12:31 p.m., NHA (Nursing Home Administrator)-A, DON-B and ADON-N were informed of the above. No additional information was provided to Surveyor regarding the development of R10's three Stage 3 pressure injuries.</p>		

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<p>F 0689</p> <p>Level of Harm - 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** 47094</p> <p>Based on observation, interview, and record review the facility did not ensure each resident receives adequate supervision or assistance devices to prevent accidents for 1 (R8) of 3 residents reviewed for accidents.</p> <p>*R8 was readmitted to the facility on [DATE] and had a significant change in R8's cognition and activities of daily living (ADL's) performance and enrolled onto Hospice services. R8 care plan and certified nursing (CNA) care Kardex was not revised to indicate R8's decline. R8 had a fall on 5/18/2024 that resulted in a dislocated finger with avulsion and 3 sutures for a laceration.</p> <p>Findings include:</p> <p>The facility policy, entitled Change in a Resident's Condition or Status, revised on 5/10/2024, documents: . 2. A significant change of condition is a decline or improvement in the resident's status that: a. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions . 5. The Nurse Supervisor/Charge Nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status.</p> <p>The facility policy, entitled Care Plan Revisions, implemented on 6/14/2024, documents: The purpose of this procedure is to provide a consistent process for reviewing and revising the care plan for those residents experiencing a status change.</p> <p>Policy Explanation and Compliance Guidelines:</p> <ol style="list-style-type: none"> 1. The comprehensive care plan will be reviewed, and revised as necessary, when a resident experiences a status change, 2. Procedure for reviewing and revising the care plan when a resident experiences a status change: <ol style="list-style-type: none"> a. The Interdisciplinary Team (IDT) will discuss the resident condition and collaborate on intervention options. b. The care plan will be updated with the new or modified interventions. c. Staff involved in the care of the resident will report resident response to new or modified interventions. d. Care plans will be modified as needed by the minimum data set (MDS) Coordinator or other designated staff member. <p>(continued on next page)</p>

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NAME OF PROVIDER OR SUPPLIER Autumn Lake Healthcare at Greenfield		STREET ADDRESS, CITY, STATE, ZIP CODE 5790 S 27th St Milwaukee, WI 53221	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>R8 was initially admitted to the facility on [DATE] and R8 was readmitted to the facility on [DATE] and has diagnoses that include Chronic Obstructive Pulmonary Disease (COPD), Acute on Chronic Respiratory Failure with Hypercapnia and Hypoxia, Major Depressive Disorder, Anxiety Disorder, Metabolic Encephalopathy, history of alcohol abuse, muscle weakness, adult failure to thrive, and was dependent on supplemental oxygen.</p> <p>R8's quarterly MDS (Minimum Data Set) assessment dated [DATE] indicated R8 had intact cognition with a Brief Interview of Mental Status (BIMS) score of 15 and the facility assessed R8 to require minimal assist of 1 staff member for oral hygiene, toileting hygiene, repositioning and transferring and modified independent with set up with eating, bathing, upper and lower body dressing, and personal hygiene. R8 was able to propel self in a manual wheelchair with R8s lower legs for long distance and ambulate independently with a wheeled walker in R8's bedroom. R8 was occasionally incontinent of urine and frequently incontinent of bowel and wore adult briefs for protection. R8 was assessed on 5/17/2024 to be a moderate risk for falls with a fall risk score of 10.0. R8 was admitted on to Hospice care on 5/17/2024 for terminal COPD.</p> <p>R8's ADL (Activities of Daily Living) self-care care plan . care plan initiated on 1/21/2021 and last reviewed on 12/14/2023 had the following interventions in place: .</p> <ul style="list-style-type: none"> - Locomotion: (R8) has a w/c (wheelchair) and is able to propel self and can ambulate independently in his room. (initiated: 5/5/2021, revision: 2/4/2022) - Bed Mobility: Independent (initiated: 1/21/2021, revision: 5/24/2023) - Toilet use: Independent, he is continent of bowel and bladder (initiated: 1/21/2021, revision: 5/24/2023) - Transfer: patient able to transfer in room to/from bed, w/c and toilet at MI (modified independent with use of grab bars for support. <p>Able to ambulate in hallway with four wheeled walker and staff, requires supervision.</p> <p>When up ambulating with four wheeled walker, patient should have supervision for O2 (oxygen) tubing management and safety. (initiated:1/21/2024, revision: 5/2/2024)</p> <ul style="list-style-type: none"> - Encourage resident to use bell to call for assistance (Initiated 5/5/2021) - Monitor/document/report PRN (as needed) any changes, any potential for improvement, reasons for self-care deficit, expected course, declines in function (initiated 5/5/20210) <p>R8's risk for falls care plan . initiated on 1/27/2021 and last reviewed on 12/14/2023 had the following interventions in place: .</p> <ul style="list-style-type: none"> - Be sure (R8's) call light is within reach and encourage (R8) to use it for assistance as needed. (initiated 1/27/2021, revision: 5/5/2021) - Ensure (R8) is wearing appropriate footwear when ambulating or mobilizing in w/c. (initiated 5/5/2021, revision: 11/3/2021) <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>- Provide a reacher (initiated 2/26/2024)</p> <p>On 5/6/2024, R8 was admitted to the hospital with symptoms of shaking, tremors and elevated temperature. R8 underwent testing in the hospital, and it was documented that a lesion was found on R8's liver. R8's history indicated possible primary lung malignancy with metastasis to the liver. R8's power of attorney (POA) was activated and determined no further testing to be done due to R8's frailty and malignancy diagnosis. R8 and R8's POA decided to admit R8 into Hospice services.</p> <p>On 5/17/2024, at 18:30 (6:30 PM), in the progress notes nursing charted R8 arrival back to facility with Primary dx (diagnosis) documented as possible metastatic lung cancer versus chronic aspiration, Severe COPD</p> <p>On 5/17/2024, at 18:42 (6:42 PM), in the progress notes Assistant Director of Nursing (ADON)-N documented Nurse Practitioner (NP) aware of (R8) readmit to the facility and clarified medication orders with the NP.</p> <p>On 5/17/2023, at 21:37 (9:37 PM), in the progress notes nursing documented (R8) assessed by [Hospice company] and admitted to hospice care with diagnosis of terminal COPD. New orders noted for comfort medications.</p> <p>On 8/13/2024, Surveyor reviewed R8's hospital occupational therapy (OT) notes dated 5/17/2024 at 2:55 PM that documented:</p> <p>Cognitive Status:</p> <ul style="list-style-type: none"> - (R8) confused and flat affect, oriented to person, disoriented to time, situation, and place. <p>- overall status: impaired</p> <p>Sitting Balance:</p> <ul style="list-style-type: none"> -Minimal assist required due to posterior lean when performing UE/LE (upper extremity/ lower extremity) exercise. <p>Bed Mobility:</p> <ul style="list-style-type: none"> - Repositioning in bed: 2 person, total assist-dependent (boost towards HOB (head of bed)) - Minimal assist for BLE (bilateral lower extremity) advancement and scooting towards end of bed. (R8) tolerated sitting up two minutes before returning back to lying. <p>Assessment:</p> <ul style="list-style-type: none"> - No functional improvements. - ADL's requiring support at discharge: transfers, dressing, grooming, bathing, toileting, and ambulation. <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<ul style="list-style-type: none"> - Bathing: Total dependence, One person physical assist. <p>Not Steady during Transitions/ Walking for:</p> <ul style="list-style-type: none"> - Moving from seated to standing - Walking - Turning around - Moving on and off toilet - Surface to surface transfers <p>Surveyor noted the CNA Kardex was not revised to indicate the recommendations for R8 from the hospital regarding R8's ADL needs with the noted change in condition.</p> <p>On 5/18/2023, at 06:47 (6:47 AM), in the progress notes nursing documented (R8) alert and responsive. No s/s (signs/ symptoms) of pain or discomfort noted. Repositioning Q (every) 2 (two) hours and PRN (as needed)</p> <p>Surveyor noted the above intervention: Repositioning every 2 hours and PRN was not added to R8's care plan or CNA Kardex.</p> <p>On 5/18/2024, at 22:21 (10:21 PM), in the progress notes Registered Nurse (RN)-L documented resident found on floor by staff. Unable to explain what made (R8) fall down. On assessment (R8) was lying on right side, had injury, right 4th finger was bleeding without stopping, pressure applied. Right elbow and right shoulder also had some bleeding. (R8) was transferred to [Hospital Name] for further evaluation</p> <p>On 5/19/2024, at 01:22 (1:22 AM), in the progress notes nursing documented R8 will be returning back to facility with diagnoses of dislocated finger.</p> <p>On 5/19/2024, at 06:30 (6:30 AM), in the progress notes nursing documented (R8) returned from emergency room . splint on right hand, fourth digit</p> <p>Surveyor reviewed R8's emergency room report that documented on physical exam:</p> <ul style="list-style-type: none"> -Right wrist swelling (and ecchymosis (bruising) of ring finger), deformity (ring finger), laceration (pulp of ring finger), tenderness and bony tenderness present. <p>Procedure:</p> <ul style="list-style-type: none"> -Right ring finger, length: 2 cm, 3 sutures to area, tolerated well without complications. <p>X-ray of right hand and right fingers:</p> <p>Impression:</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>- Dislocation of the fourth phalanx (finger) with avulsion (when an injury causes a ligament or tendon to break off a small piece of bone that is attached to it).</p> <p>- Overlying soft tissue defect consistent with known laceration of the fourth digit.</p> <p>- Right fourth phalanx put into splint.</p> <p>Surveyor reviewed the fall investigation for R8's fall on 5/18/2024. RN-L documented R8 was incontinent at the time of fall and the resident stated, I was trying to go pee. The IDT (Interdisciplinary Team) reviewed the fall and documented R8 had a recent decline in health and now on Hospice services. R8 has lung cancer with metastasis. BIMS score of 9 with moderate impairment. R8 does not always call for assistance, R8 was independent prior to recent hospitalization , due to change in medical condition new intervention implemented is toileting every 2-3 hours as R8 will allow.</p> <p>On 8/13/2024, at 10:37 AM, Surveyor interviewed RN- L who stated RN-L is an agency nurse and moves around a lot and could not recall anything specific about R8 or a fall on 5/18/2024. Surveyor asked RN-L how RN-L would find information for a resident that RN-L was not familiar with to know what cares the resident needed. RN-L stated it would depend on what the facility policy is, but typically information would be gathered with shift change reporting from the previous nurse. RN-L also stated RN-L reviews the 24 hour board and will look at the care plan and what interventions are documented. Surveyor asked RN-L if RN-L recalls reviewing R8's care plan or revising the care plan after R8's fall on 5/18/2024. RN-L stated RN-L could not recall any detail regarding R8 or a fall on 5/18/2024.</p> <p>On 8/13/2024, at 11:27 AM, Surveyor interviewed Director of Nursing (DON)- B and ADON- N. Surveyor asked what staff is responsible for revising care plans. DON-B stated DON-B and ADON-N will do the initial care plan with appropriate interventions when able and any revisions to care plans are done as a team at weekly at risk meetings and as needed by other nursing staff. DON-B stated new admission, readmissions and changes of conditions are discussed with the IDT at weekly at risk meetings. DON-B stated any nursing staff is able to initiate a care plan and communicate it to management, put concerns on the 24 hour board, and make a note in progress notes. Surveyor asked what the process was when residents are readmitted to the facility and have a significant change to their previous plan of care. ADON- N stated the admitting nurse would update the care plan and manager. ADON- N stated the admitting nurse also fills out a readmit screener form and the form touches on the residents ADL function and if there are changes noted on the screener than from previous assessments of the resident then the care plan is updated and also should be noted on the 24 hour board and documented in the progress notes. Surveyor asked ADON- N if ADON- N recalled the readmission for R8 on 5/17/2024 and the changes documented from the hospital for R8. ADON- N stated ADON- N could not recall specific details about R8's readmission on 5/17/2024 or if she reviewed any of the admission paperwork. Surveyor informed ADON- N that ADON- N documented in the progress notes about contacting R8's NP regarding clarification orders for R8. ADON-N stated ADON- N did not recall the specifics or if ADON-N assisted with anything else from R8's readmission on 5/17/2024.</p> <p>Surveyor reviewed R8's re-admission screener form that was documented by RN-L on 5/17/2024, at 18:55 (6:55 PM). RN-L documented the following assessments for R8:</p> <p>BIMS-9, moderately impaired cognition</p> <p>ADLs</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<ul style="list-style-type: none"> - Eating, 5-set up or clean up assistance - Oral hygiene, 5- set up or clean up assistance - Toileting hygiene, 3- partial/moderate assistance - Sit to lying, 3- partial/moderate assistance - Lying to sitting on side of bed, 3-partial/moderate assistance - Sit to stand, 88- not attempted due to medical condition or safety concerns - Chair/bed to chair transfer, 88- not attempted due to medical condition or safety concerns - Toilet transfer, 88- not attempted due to medical condition or safety concerns - Walking, 88- not attempted due to medical condition or safety concerns <p>Bladder:</p> <ul style="list-style-type: none"> - Continent-No - How often is resident wet-once or more per shift - Resident is wet during-day and nighttime <p>Bowel:</p> <ul style="list-style-type: none"> - Continent-yes <p>Mobility:</p> <ul style="list-style-type: none"> -locomotion on unit (self-performance)-2, limited assistance <p>Surveyor noted R8's assessed decline in ADL performance, toileting needs, mobility, and cognition did not get revised on R8's care plan or CNA kardex.</p> <p>Surveyor reviewed the 24 hour boards from 5/17/2024 and 5/18/2024. The 24 hour board had the following documentation on 5/17/2024:</p> <p>PM shift:</p> <ul style="list-style-type: none"> -(R8) alert and oriented X3 (person, place, time), no respiratory distress noted, Assist of 1 with all cares and transfers, incontinent at times. <p>NOC (night) shift:</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>-(R8) no respiratory distress noted at this time, O2/ NC (nasal cannula) as ordered, scheduled breathing treatments, repositioning.</p> <p>The 24 hour board had the following documentation on 5/18/2024:</p> <p>AM shift:</p> <p>-No Issues</p> <p>PM shift:</p> <p>-(R8) fell with injury, out to hospital.</p> <p>On 8/13/2024, at 12:30 PM, Surveyor shared concerns with Nursing Home Administrator (NHA)-A, DON-B and ADON-N that R8's care plan and CNA Kardex were not revised to indicate R8's change in condition regarding R8's decline in cognition, ADL needs when R8 was readmitted from the hospital on 5/17/2024 and R8 experienced a fall on 5/18/2024 that resulted in a right hand, 4th ring finger fracture with avulsion and required 3 sutures for a laceration.</p> <p>On 8/13/2024, at 1:24 PM, Surveyor interviewed RN unit Manager (RNUM)-D who stated R8 was independent with ADLs and then declined rather quickly once R8 was readmitting to the hospital after the new cancer diagnosis and was put on hospice. Surveyor asked RNUM- D how staff are made aware of significant changes or care concerns for residents. RNUM- D stated the concerns are reviewed in the morning stand up meetings with the IDT M-F, care plans are initiated and/or revised, education is provided to nursing, concerns are put on the 24 hour board and passed on in shift to shift reporting, and documenting in progress notes. Surveyor asked what happens if concerns should arise after hours or on a weekend. RNUM-D stated managers are always on call if nursing needs guidance, but care plans should still be updated, concerns put on 24 hour board, and documented in progress notes then the IDT reviews the next business day to make sure all the concerns were addressed and updated where needed.</p> <p>On 8/13/2024, at 1:33 PM, Surveyor interviewed CNA-M who stated CNA-M noted R8 to be more confused and antsy after returning from the hospital on 5/17/2024. CNA-M stated R8 was independent with most ADLs but when he came back from the hospital and put on Hospice R8 needed more redirection and assistance. CNA-M stated CNA-M was in R8's room frequently redirecting R8 and putting R8's oxygen tubing back on because R8 kept taking it off. CNA-M stated CNA-M last checked on R8 and noted R8 to be dry and sitting in R8's wheelchair watching TV. CNA-M stated CNA-M went to collect supper trays and another CNA notified CNA-M that R8 had fallen. Surveyor asked CNA-M how CNA-M was made aware of R8's new care concerns or where CNA-M would look to see what needs R8 required. CNA-M stated in shift report CNA-M was told R8 required more assistance and redirection. CNA-M stated CNA-M also looks at the resident's care kardex for direction of any care concerns or interventions a resident might have. Surveyor asked CNA-M if CNA-M communicated to the nurse that R8 was antsy and confused. CNA-M could not recall if CNA-M communicated that or not. CNA-M stated CNA-M and RN-L checked in on R8 frequently due to needing more assistance and redirection.</p> <p>No further information was provided to Surveyor at this time.</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** 42037</p> <p>Based on interview and record review the facility did not ensure 1 (R7) of 1 residents reviewed was receiving psychoactive medications with proper indications.</p> <p>*R7 is receiving Donepezil and Olanzapine for Dementia behaviors without any documented behavior monitoring.</p> <p>Findings include:</p> <p>1.) R7 was admitted to the facility on [DATE] with diagnoses of Unspecified Dementia with Agitation, Anxiety Disorder and Disorientation. R7's Quarterly MDS (Minimum Data Set) Assessment with an ARD (Assessment Reference Date) of 5/24/24 indicates an BIMS (Brief Interview for Mental Status) score of 04, indicating R7 has severe cognitive impairment and is non-interview able.</p> <p>On 8/12/24, at 8:58 AM, Surveyor observed R7 in their room. R7 was resting quietly in bed without signs or symptoms of distress. Surveyor did not observe R7 experiencing any adverse behaviors at this time.</p> <p>On 8/12/24, at 11:20 AM, Surveyor observed R7 in their room. R7 was resting quietly in bed without signs or symptoms of distress. Surveyor did not observe R7 experiencing any adverse behaviors at this time.</p> <p>Surveyor reviewed R7's medical record including diagnosis list, physician orders, MAR (Medication Administration Record), CNA (Certified Nursing Assistant) Care Kardex and comprehensive care plan.</p> <p>R7's comprehensive behavior care plan with an initiation date of 3/26/24 and a revision date of 5/30/24 documents: R7 has a behavior problem r/t (related to) Anxiety, MDD (Major Depressive Disorder), Alzheimer's e/b (evidenced by) following staff down hallways at times calling out insults, history of pushing/grabbing at items at the nurses station, 3/25/24 resident to resident altercations, 4/5/24 physically aggressive with staff during cares. R7's comprehensive care plan interventions include: Administer medications as ordered .Monitor for side effects and effectiveness .monitor behavior episodes and attempt to determine underlying cause. Consider location, time of day, persons involved and situations, document behavior and potential causes .</p> <p>Surveyor reviewed R7's physician orders. R7's prescribed medication dosing is documented as follows: Donepezil 10 mg orally at bedtime for Unspecified Dementia with Agitation .Olanzapine 2.5 mg orally at bedtime for Unspecified Dementia with Agitation.</p> <p>On 8/12/24, at 3:05 PM, at the daily exit meeting, Surveyor asked DON (Director of Nursing)-B where behavior monitoring would be documented for residents who receive psychoactive medications. DON-B responded that behavior monitoring should be documented every shift on a resident's MAR.</p> <p>On 8/13/24, at 8:15 AM, Surveyor reviewed R7's MAR. Surveyor did not note any documented behavior monitoring on R7's MAR.</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 8/13/24, at 11:20 AM, Surveyor conducted interview with DON-B. Surveyor reported to DON-B that R7's behavior documentation was not listed on R7's MAR. Surveyor asked DON-B if it was possible that there may be documentation of R7's behavioral monitoring in another location in R7's electronic medical record. DON-B told Surveyor that R7's behavior monitoring had been missed and has not been documented on since R7's admission to the facility.</p> <p>On 8/13/24, at 1:30 PM, Surveyor conducted interview with NHA (Nursing Home Administrator)-A. Surveyor shared concern that R7's is receiving psychoactive medications for their Diagnosis of Dementia without any routine documented behavior monitoring. The facility was unable to provide additional information to Surveyor at this time.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525504	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/13/2024
NAME OF PROVIDER OR SUPPLIER Autumn Lake Healthcare at Greenfield		STREET ADDRESS, CITY, STATE, ZIP CODE 5790 S 27th St Milwaukee, WI 53221	

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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 (R10) of 1 Residents.</p> <p>* Appropriate hand hygiene was not observed during incontinence cares for R10 and staff were not wearing gowns during this care observation for R10 who is on EBP (enhanced barrier precautions). There was not a sign posted for enhanced barrier precautions on R10's door nor was there a PPE (personal protective equipment) cart outside the room.</p> <p>Findings include:</p> <p>The facility's policy titled, Enhanced Barrier Precautions and revised 12/1/23 under Policy Explanation and Compliance Guidelines for 1. prompt recognition of need includes documentation of c. Clear signage will be posted on the door or wall outside of the resident room indicating the type of precautions, required personal protective equipment (PPE), and the high-contact resident care activities that require the use of gown and gloves.</p> <p>2. Initiation of Enhanced Barrier Precautions documents:</p> <p>a. Nursing staff may place residents with certain conditions or devices on enhanced barrier precautions empirically while awaiting physician orders.</p> <p>b. An order for enhanced barrier precautions will be obtained for residents with any of the following:</p> <p>i. Wounds (e.g. chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers) and/or indwelling medical devices (e.g., central lines, hemodialysis catheters, urinary catheters, feedings tubes, tracheostomy/ventilator tubes) even if the resident is not known to be infected or colonized with a MDRO (Multi-drug resistant organisms).</p> <p>ii. Infection or colonization with any resistant organisms targeted by the CDC (Centers for Disease Control and Prevention) and epidemiologically important MDRO when contact precautions do not apply.</p> <p>3. Implementation of Enhanced Barrier Precautions</p> <p>a. Make gowns and gloves available immediately outside of the resident's room. Note: face protection may also be needed if performing activity with risk of splash or spray</p> <p>4. High-contact resident care activities include:</p> <p>a. Dressing</p> <p>b. Bathing</p> <p>(continued on next page)</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>c. Transferring</p> <p>d. Providing hygiene</p> <p>e. Changing linens</p> <p>f. Changing briefs or assisting with toileting</p> <p>g. Device care or use: central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes</p> <p>h. Wound care: any skin openings requiring a dressing.</p> <p>The facility's policy titled, Hand Hygiene and dated 1/31/24 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>R10 has diagnoses which include major depressive disorder, diabetes mellitus, morbid obesity and altered mental status. R10 currently has Stage 3 pressure injuries on the coccyx and left buttocks.</p> <p>[R10's first name] requires enhanced barrier precautions for WOUNDS care plan initiate and revised 7/16/24 includes the following interventions:</p> <ul style="list-style-type: none"> * All staff providing direct cares follow EBP protocols on donning and doffing isolation garb. Initiated 7/16/24. * EBP signage on door. Initiated 7/16/24. * Encourage frequent and thorough hand hygiene. Initiated 7/16/24. * Ensure the proper use of personal protective equipment (PPE) and the availability of PPE and hand hygiene supplies at the point of care. Initiated 7/16/24. * Gown and Gloves for all high contact interactions in room (bathing, showering, high contact transfers/ambulation, wound care, toileting, etc). Initiated 7/16/24. <p>The admission MDS (minimum data set) with an assessment reference date of 5/27/24 has a BIMS (brief interview mental status) score of 15 which indicates cognitively intact. R10 is assessed as being dependent for toileting hygiene, chair/bed to chair transfer, & toilet transfer. R10 is always incontinent of bowel and bladder.</p> <p>On 8/12/24, at 10:50 a.m., Surveyor observed R10 in bed on her back with her eyes closed. Surveyor did not observe an enhanced barrier precaution sign on R10's door or next to R10's door. Surveyor also did not observe a PPE (personal protective equipment) cart outside R10's room.</p> <p>On 8/12/24, at 12:21 p.m., Surveyor observed R10 continues to be in bed on her back. Surveyor noted there is still not an enhanced barrier precaution sign on the door and there is not a PPE cart outside R10's room.</p> <p>(continued on next page)</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>On 8/12/24, at 1:55 p.m., Surveyor observed R10 continues to be in bed on her back. Surveyor noted there is still not an enhanced barrier precaution sign on the door and there is not a PPE cart outside R10's room.</p> <p>On 8/13/24, at 8:19 a.m., Surveyor observed R10 in bed on her back. Surveyor noted there is still not an enhanced barrier precaution sign on the door and there is not a PPE cart outside R10's room.</p> <p>On 8/13/24, at 9:41 a.m., Surveyor observed CNA-G & CNA-H enter R10's room. Surveyor asked CNA-G & CNA-H what they were going to do. CNA-G informed Surveyor they were going to change R10. Surveyor observed CNA-G & CNA-H were wearing gloves but did not have a gown on. Surveyor also noted there is not an enhanced barrier precaution sign on the door and there is not a PPE cart outside R10's room. CNA-G lowered R10's head of the bed and raised the bed up. R10's blanket was removed and staff unfastened the incontinence product. Surveyor observed there is BM (bowel movement) up R10's frontal perineal area. CNA-G informed R10 she was going to clean her and washed R10's frontal perineal area to remove the BM. CNA-G informed R10 she was going to turn R10 towards the window. CNA-G pulled on the soaker pad to move R10 towards the left side of the mattress and CNA-G & CNA-H positioned R10 on the right side. CNA-G removed the dressing from R10's coccyx/left buttocks which contained BM, and removed R10's incontinence product. CNA-G went into the bathroom and wet a towel & soap and washed R10's rectal area and buttocks to remove the BM. CNA-G informed R10 she was doing really good and R10 was really red. After washing R10's buttocks, CNA-G removed her gloves and placed gloves on. CNA-G did not perform any hand hygiene. CNA-G applied barrier cream on R10's buttocks and an incontinence product was placed under R10. CNA-G removed her gloves, informed R10 the wound doctor would be here to change her patch and R10 was positioned on the left side. CNA-H handed CNA-G a pair of gloves which CNA-G placed on. CNA-H & CNA-G fastened R10's incontinence product. CNA-G informed R10 they were going to turn her towards the window, and CNA-H & CNA-G positioned R10 on her right side with a pillow under R10's right side. CNA-G raised the head of the bed asking if it's too high. R10 replied no, should be higher and CNA-G raised the head of the bed higher. R10 was covered with a blanket. CNA-H removed her gloves and washed her hands. CNA-G asked R10 if she wanted ice water, removed her gloves and washed her hands. Surveyor noted this is the first time hand hygiene was observed.</p> <p>On 8/13/24, at 9:54 a.m., Surveyor asked CNA-G how she knows if a resident is on enhanced barrier precautions. CNA-G had a confused look on her face and wasn't able to tell Surveyor. CNA-G then left Surveyor, walked down the hall and returned telling Surveyor there's a sign on the door.</p> <p>On 8/13/24, at 9:56 a.m., Surveyor asked CNA-H how she knows if a resident is on enhanced barrier precautions. CNA-H informed Surveyor the nurse will tell them and it's also in POC. Surveyor asked what POC was. CNA-H informed Surveyor point click care.</p> <p>On 8/13/24, at 11:00 a.m., Surveyor asked RN/UM (Registered Nurse)/(Unit Manager)-D if R10 is on enhanced barrier precautions. RN/UM-E informed Surveyor there is a list of residents on enhanced barrier precautions at the nurses station. RN/UM-E informed Surveyor she will check the list, left her office and came back informing</p> <p>(continued on next page)</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>Surveyor according to the list at the nurses station, no. Surveyor asked RN/UM-D which residents are placed on enhanced barrier precautions. RN/UM-D informed Surveyor anyone with wounds, Foley, ostomy, tube feeding and their IC (infection control) will place them on the precautions. Surveyor informed RN/UM-D R10 has stage 3 pressure injuries and asked if she knew why R10 was not on enhanced barrier precautions. RN/UM-D replied not 100% sure why. Surveyor asked RN/UM-D what is the expectation for hand hygiene when staff are performing incontinence cares. RN/UM-D informed Surveyor staff should be using hand sanitizer when entering the room, and when they change or remove their gloves they should wash their hands with soap and water. Surveyor asked after staff washes a resident with BM should they remove their gloves and wash their hands before going to the next task. RN/UM-D replied yes. Surveyor informed RN/UM-D there is not an enhanced barrier precaution sign on the door, a PPE cart outside the room and CNA-G & CNA-H not wearing a gown during incontinence cares & repositioning R10. Surveyor informed RN/UM-D of hand hygiene concerns with CNA-G.</p> <p>On 8/13/24, at 11:41 a.m., Surveyor met with DON (Director of Nursing)-B and ADON (Assistant Director of Nursing)-N. Surveyor asked DON-B and ADON-N if a resident has a pressure injury should the resident be on enhanced barrier precautions. Both DON-B and ADON-N replied yes. Surveyor informed DON-B and ADON-N of the observation of no sign on R10's door for enhanced barrier precaution, no PPE cart outside the room and CNA-G & CNA-H not wearing a gown during incontinence cares & repositioning for R10. Surveyor also informed DON-B and ADON-N of the hand hygiene concerns with CNA-G.</p> <p>On 8/13/24, at 12:31 p.m., NHA (Nursing Home Administrator)-A, DON-B and ADON-N were informed of the above.</p>		