STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525504	A. Building B. Wing	09/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Greenfield	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)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38253 Based on observation, interview, and record review, the facility did not ensure residents with pressure injuries received care consistent with professional standards of practice to promote healing for 2 (R14 and R13) of 3 residents reviewed with pressure injuries. *R14 was admitted to the facility on [DATE] with a Stage 3 pressure injury to the right buttock. The pressure injury was comprehensively assessed and documented on 9/24/2024 when R14 was seen by Wound Physician-I, four days after admission. *R13 was observed sitting in a Broda chair without heel boots on and the feet pressed up against the footboard of the Broda chair. R13 was to have bilateral heel boots on per the Skin Integrity Care Plan. Findings include: The facility policy and procedure entitled Skin assessment dated [DATE] documents: Policy Explanation and Compliance Guidelines: 1. A full body, or head to toe, skin assessment will be conducted by a licensed or registered nurse upon admission/re-admission, daily. The assessment may also be performed after a change of condition or after any newly identified pressure injury. 7. Documentation of skin assessment: a. Include date and time of the assessment, your name, and position title. b. Document observations (e.g. skin conditions, how the resident tolerated the procedure, etc.). c. Document type of wound. d. Describe wound (measurements, color, type of tissue in wound bed, drainage, odor, pain). e. Document if resident refused assessment and why. f. Document other information as indicated or appropriate. 1.) R14 was admitted to the facility on [DATE] with diagnoses of acute respiratory failure, diabetes, morbid obesity, encephalopathy, coronary artery disease, atrial fibrillation, congestive heart failure, cerebral infarction, and duodenal ulcer. No Minimum Data Set (MDS) assessment had been completed at the time of survey due to R14 being newly admitted . (continued on next page)

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

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

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/20/2024 on the Admit/Readmit Screener form, R14 had a Brief Interview for Mental Status (BIMS) score of 13 indicating R14 was cognitively intact for daily decision making. The Skin Integrity section was completed and documented R14 had a Stage 3 pressure injury to the right buttock that measured 9.0 cm (centimeters) x 6.0 cm x 0.1 cm with the notation the right buttock wound measured as cluster wound due to open areas in very close proximity. The number of open areas was not documented. The tissue type of the wound bases were not documented. The Skin Integrity section of the form was signed by Director of Nursing (DON)-B on 9/22/2024, two days after admission. R14's Skin Integrity Care Plan was initiated on 9/20/2024. A treatment order for the right buttock wound was initiated on 9/20/2024. On 9/21/2024 on the Skilled Nursing Charting form, nursing documented R14's skin was intact. On 9/22/2024 on the Skilled Nursing Charting form, nursing documented R14 had a pressure injury to the right buttock. No other documentation was found regarding the right buttock wound. On 9/23/2024 on the Skilled Nursing Charting form, nursing documented R14's skin was not intact. No other documentation was found regarding R14's skin. On 9/24/2024 on the Skilled Nursing Charting form, nursing documented R14's skin was intact. On 9/24/2024, at 8:05 AM, in the progress notes, Licensed Practical Nurse (LPN)-D documented R14 was given an air mattress upon admission due to a pressure injury to the right buttock and R14 was unhappy with how the mattress felt. R14 stated the bed was so uncomfortable. A pressure relieving mattress was placed on the bed per R14's request. Risks vs benefits were discussed. On 9/24/2024, R14 was seen by Wound Physician-I. Wound Physician-I assessed R14's right buttock Stage 3 pressure injury and documented the wound measured 0.8 cm x 0.6 cm x 0.1 cm with 20% slough and 80% granulation. This was the first comprehensive assessment documented of the pressure injury, four days after admission. On 9/24/2024 at 3:28 PM, Surveyor observed R14 sitting in R14's room in a wheelchair with a sling underneath R14. An air mattress was observed in place on R14's bed. R14 stated there was an air mattress on the bed when R14 first got to the facility but it was very uncomfortable, so they put a regular mattress on the bed. R14 stated today they put a new air mattress on the bed, but it keeps beeping and R14 would really like to lay down. While R14 was talking, the air mattress alarm went off and the light on the panel indicated low pressure. R14 pushed the call light for assistance with the bed alarm. Surveyor was not able to observe the treatment to R14's pressure injury due to the treatment being scheduled for the evening. In an interview on 9/25/2024, at 8:56 AM, Surveyor asked LPN-E what the process was for assessing the skin of a newly admitted resident. LPN-E stated the nurse on the floor does the complete admission assessment. LPN-E stated for any wound the nurse would measure the wound and document what the would looks like. LPN-E stated the wound nurse comes around and does some daily and some weekly assessments but was not sure who the wound nurse would see. LPN-E stated LPN-E was an agency nurse so did not know all the roles in the facility. Surveyor asked LPN-E if there was a unit manager. LPN-E was not sure. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 9/25/2024, at 9:01 AM, Surveyor asked Med Tech (MT)-F if there was a unit manager. MT-F was not sure. MT-F stated MT-F does not normally work on that unit. In an interview on 9/25/2024, at 9:05 AM, Surveyor asked Assistant Director of Nursing (ADON)-C what the process was for assessing the skin of a newly admitted resident. ADON-C stated the floor nurse does the head to toe assessment. ADON-C stated if ADON-C was looking at the referral from the hospital and saw the resident was coming in with a wound, they would get an air mattress and things like that in place before the resident arrived. LPN-D entered the office during the interview and stated the floor nurse would do a complete assessment of the new resident. LPN-D was the facility wound nurse that assisted Wound Physician-I with weekly wound rounds. LPN-D stated the nurse would get the measurements, but a Registered Nurse (RN) has to stage the wound and would have to do the assessment because an LPN cannot assess. Surveyor shared with ADON-C and LPN-D the concern R14's Stage 3 pressure injury to the right buttock was not comprehensively assessed on admission. Surveyor shared with ADON-C and LPN-D the wound was measured but there was no documentation of tissue type or how many open areas were present, and the Skin Section of the Admit/Readmit Screener form was signed by DON-B on 9/22/2024, not 9/20/2024 when R14 was admitted . LPN-D stated there was an RN on duty that night and she would have expected the RN to sign the form at that time. LPN-D stated maybe it was completed by the RN on duty and signed at that time and then signed a second time by DON-B later and that made the first signature unable to be seen. ADON-C agreed that they do not have the capability of seeing if anyone signed the section prior to 9/22/2024 when DON-B signed it. ADON-C reviewed the documentation on the Admit/Readmit Screener form and stated it was a vague description of the wound on the admission assessment. LPN-D stated it was a cluster wound at that time and now there is only one wound so there is improvement. LPN-D stated R14 was seen by Wound Physician-I yesterday, 9/24/2024. In an interview on 9/25/2024, at 10:04 AM, Surveyor asked DON-B when was R14's admission skin assessment completed. DON-B stated R14 was assessed on admission. Surveyor shared with DON-B the concern the skin assessment on the Admit/Readmit Screener form was signed by DON-B on 9/22/2024, two days after R14 was admitted . DON-B stated DON-B was at home on 9/22/2024 looking through assessments and signed R14's admission skin assessment at that time. DON-B stated LPN-D did R14's admission skin assessment on Friday, 9/20/2024 and touched base with DON-B and then DON-B signed the assessment on 9/22/2024. Surveyor shared with DON-B the concern R14's admission skin assessment did not include tissue type of the wound bed so was not comprehensively assessed until 9/24/2024 when R14 was seen by Wound Physician-I. Surveyor shared with DON-B the concern R14 was not assessed by an RN. On 9/25/2024, at 10:46 AM, Nursing Home Administrator (NHA)-A and LPN-D provided Surveyor with a New Admit Skin/Wound Checklist worksheet that LPN-D had completed on 9/20/2024 for R14's admission. The worksheet was handwritten with measurements and descriptions of the wounds. NHA-A stated LPN-D completes their own worksheet for skin assessments for each new admission. LPN-D stated the charting box in the Admit/Readmit Screener form in the computer charting system does not have enough characters for her to be more specific about the wound. Surveyor asked NHA-A and LPN-D if the assessment worksheet is documented in R14's medical record. NHA-A stated these forms are kept in a binder in LPN-D's office. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/25/2024 at 10:59 AM, DON-B stated to Surveyor DON-B remembered DON-B was with LPN-D on 9/20/2024 and looked at all the new residents that were admitted on that day, so DON-B did put eyes on R14's wounds. DON-B stated on 9/22/2024, DON-B pulled up the charting and saw the assessment was not signed so DON-B signed it on 9/22/2024 even though DON-B saw R14 on 9/20/2024. Surveyor shared the concern that what was documented on R14's admission skin assessment was not comprehensive and did not document the tissue type and the worksheet LPN-D completed was not part of R14's medical record. No further information was provided at that time. 2.) R13 was admitted to the facility on [DATE] with diagnoses of osteoarthritis, malnutrition, anxiety, chronic kidney disease, and Alzheimer's disease. R13's Quarterly Minimum Data Set (MDS) assessment dated [DATE] documented R13 was severely cognitively impaired per staff assessment. R13 has been receiving hospice services since admission on 1/27/2022 with a diagnosis of senile degeneration of the brain. R13 has an activated Power of Attorney. R13's Activities of Daily Living Care Plan initiated 2/15/2022 documents R13 requires one assist with feeding and bed mobility. R13's Skin Integrity Care Plan was initiated on 1/4/2023 with current interventions of air loss mattress, reposition every two hours, and bilateral heel boots to both feet as R13 tolerates. R13 had a history of pressure injuries to the left second toe and left heel. R13 currently has a Stage 4 pressure injury to the sacrum that developed 7/18/2022. The wound has been comprehensively assessed weekly by Wound Physician-I. On 9/20/2024, Wound Physician-I documented the Stage 4 pressure injury to the sacrum measured 0.8 cm x 0.3 cm x 0.2 cm with 30% slough and 70% granulation. On 9/24/2024 at 10:57 AM, Surveyor observed R13 sitting in a Broda chair in the common area of the unit by the nurses' station. R13 appeared well groomed. A pillow was observed to be under R13's calves. R13 had socks on and the feet were pressed against the foot board of the Broda chair. Surveyor observed heel boots in R13's room on a chair. On 9/24/2024 at 12:24 PM, Surveyor observed R13 lying in bed on the left side. R13 had bilateral heel boots on. On 9/24/2024 at 1:14 PM, Surveyor observed Wound Physician-I assess and treat R13's sacral wound with the assistance of Licensed Practical Nurse (LPN)-D. Wound Physician-I stated R13's wound has much improvement. LPN-D stated R13 has had this pressure injury for a long time. Wound Physician-I used ultrasound mist to treat the sacral wound which had almost healed. On 9/25/2024 at 8:02 AM, Surveyor observed R13 sitting in a Broda chair in the common area of the unit by the nurses' station waiting for breakfast. R13 did not have heel boots on, and the feet were pressed against the foot board of the Broda chair. Surveyor observed heel boots in R13's room on a chair. Surveyor asked Certified Nursing Assistant (CNA)-H if R13 wore heel boots. CNA-H was not sure if R13 wore heel boots and would find out. CNA-H approached LPN-G and asked LPN-G if R13 wore heel boots. LPN-G looked in the computer charting system to find out. LPN-G and CNA-H discussed R13's care plan. LPN-G told CNA-H R13 should have heel boots on at all times. LPN-G instructed CNA-H to put R13's heel boots on. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/25/2024, at 10:04 AM, Surveyor shared with Director of Nursing (DON)-B the observation of R13 not having heel boots on per care plan on 9/24/2024 and 9/25/2024 when R13 was sitting in the Broda chair. DON-B stated R13 will sometimes kick off the heel boots or refuse them. Surveyor shared with DON-B CNA-H had not attempted to put R13's heel boots on that morning and was not aware R13 should have boots on. No further information was provided at that time.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38253 Based on observation, interview, and record review, the facility did not ensure residents received adequate assistance devices to prevent accidents for 1 (R13) of 3 residents reviewed for accidents. *R13's At Risk for Falls Care Plan had the intervention of bilateral fall mats on the floor. Observations were made of R13 having one fall mat on the floor and not two fall mats. Findings include: 1.) R13 was admitted to the facility on [DATE] with diagnoses of osteoarthritis, malnutrition, anxiety, chronic kidney disease, and Alzheimer's disease. R13's Quarterly Minimum Data Set (MDS) assessment dated [DATE] documented R13 was severely cognitively impaired per staff assessment. R13 has been receiving hospice services since admission on 1/27/2022 with a diagnosis of senile degeneration of the brain. R13 has an activated Power of Attorney. R13's Risk for Falls Care Plan was initiated on 1/28/2022 with the following interventions: -Anticipate and meet R13's needs. -Bed to be in lowest position and bilateral floor mats. -Educate R13/family/caregivers about safety reminders and what to do if a fall occurs. -Neuro checks per policy. -Vital signs per policy. No revisions were made to the Risk for Falls Care Plan since its initiation on 1/28/2022. R13 did not have any falls documented. On 7/13/2024 on the Fall Risk Evaluation form, nursing documented R13 was a moderate risk for falls with a score of 10. On 9/24/2024, at 10:57 AM, Surveyor observed R13 sitting in a Broda chair in the common area of the unit by the nurses' station. R13 appeared well groomed. Surveyor observed one fall mat in R13's room between the bed and the window. No second fall mat was observed on the floor or folded out of the way. On 9/24/2024, at 12:24 PM, Surveyor observed R13 lying in bed on the left side. The bed was in a low position. A fall mat was observed on the floor between the bed and the window. No fall mat was observed on the side of the bed between the bed and the door. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 9/25/2024, at 8:02 AM, Surveyor asked Licensed Practical Nurse (LPN)-G if R13 was supposed to have one or two floor mats. LPN-G looked in the computer charting system to find out. LPN-G stated LPN-G was not very familiar with the electronic charting system, so it took a little time to find information. LPN-G stated the Care Plan says R13 should have bilateral fall mats. Surveyor shared with LPN-G the observation of R13 having only one floor mat in the room. LPN-G stated LPN-G would get another fall mat placed in R13's room. On 9/25/2024, at 10:04 AM, Surveyor shared with Director of Nursing (DON)-B the observation of R13 having one fall mat on the floor when the At Risk for Falls Care Plan indicated there should be two fall mats. DON-B stated LPN-G had shared that information with DON-B earlier. No further information was provided at that time.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50775 Based on record review and interviews, the facility did not ensure 1 (R10) of 1 residents reviewed for catheters received appropriate care and treatment of the catheter. R10 did not have physician orders for the care and treatment of their Foley catheter. Findings include: *The facility policy entitled, Catheter Care, Urinary dated 10/10, states: . Input/Output, 1: observe the residents urine level for noticeable increases or decreases. If the level stays the same, or increase rapidly, report it to the physician or supervisor. Maintaining the unobstructed urine flow: 1: Check the resident frequently to be sure he or she is not lying on the catheter to keep the catheter and tubing free of kinks. 2: Unless specifically ordered, do not apply a clamp to the catheter. 3: The urinary drainage bag must be always held or positioned lower than the bladder to prevent the urine in the tubing and drainage bag from flowing back into the urinary bladder. Empty the bag as needed to prevent backflow into the bladder. R10 was originally admitted to the facility on [DATE] with a diagnosis of rhabdomyolysis, stage 3 kidney disease, type 2 diabetes. R10 was readmitted to the facility on [DATE] after being transferred to the hospital on 9/5/24. R10 had diagnoses of acute hypoxic respiratory failure and urinary retention. R10's Change of Condition Minimum Data Set (MDS) assessment was incomplete at the time of the survey On 9/24/24, at 3:03 PM, Surveyor requested from Nursing Home Administrator (NHA)-A R10's care plan with revisions, physician orders from the 9/11/24 re-admission, Certified Nursing Assistant (CNA) Kardex and nursing readmission assessment. On 9/25/24, Surveyor reviewed R10's hospital discharge summary dated 9/11/24. Surveyor noted the hospital discharge summary only listed medication orders and it did not include orders for the care and treatment of R10's newly placed Foley catheter. Surveyor reviewed R10's care plan which documented, toileting use, total assist and provide Foley care q (every) shift. Surveyor notes R10's care plan did not include care plan interventions for the care and treatment of the Foley catheter. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/25/24, at 10:43 AM, Surveyor interviewed Certified Nursing Assistant (CNA) J. Surveyor asked CNA-J how CNA-J would know what kind of cares to provide to residents. CNA-J stated by asking the resident what they needed or by checking the CNA-Kardex that is kept at the nurse's station. Surveyor asked CNA-J how would staff know if a resident had a change of condition? CNA-J stated, I would think the nurse would tell you. CNA-J stated, she had worked for the facility for a while and was familiar with the residents' needs. Surveyor asked how new staff or agency staff would know the type of care each resident needs. CNA-J stated they could check the CNA-Kardex located at the nurses station. CNA-J stated the staff also do a shift-to-shift report to share updates on resident status. On 9/25/24 Surveyor located the CNA-Kardex at the nurse's station for the 1 East Unit. R10's CNA Kardex, date 9/24/23, was reviewed by Surveyor, documented was, Toileting: total assist and provide Foley care q shift. On 9/25/24, at 11:00 AM, Surveyor interviewed Unit Manager (UM)-L in regard to readmissions and how readmission orders are processed. UM-L stated she enters the orders (into the Electronic Medical Record) by reviewing the hospital discharge summary orders. The orders are then reviewed in the morning management meeting and are read back to make sure the orders are correct. UM-L stated they are new to the position and haven't fully completed a readmission at this time and the (ADON) Assistant Director of Nursing) or DON (Director of Nursing) have been completing the admission/readmission process. UM-L stated any paperwork from the hospital is scanned into the computer (Electronic Medical Record) and the facility also keeps a hard (paper) copy with the admissions department. Surveyor asked UM-L if the discharge paperwork did not include needed physician orders what would UM-L do? UM-L stated she would ask the physician for the order. On 9/25/24, at 12:15 PM, Surveyor interviewed UM-L and asked how the admission/readmission orders are processed. UM-L stated UM-L receives the physician orders on the hospital discharge summary and the orders are entered into the MAR/TAR (Medication Administration Record/Treatment Administration Record) and the care plan is updated. UM-L then advised Surveyor UM-L had just updated R10's physician orders to include R10's Foley catheter care. Surveyor asked UM-L when she received the orders for R10's Foley catheter care and UM-L stated, just now. On 9/25/24, at 1:05 PM, Surveyor requested a copy of R10's physician orders. At 1:13 PM, NHA-A provided Surveyor with a copy of R10's updated physician orders which now includes orders for the care and treatment of R10's Foley catheter. On 9/25/24, at 1:47 PM, Surveyor interviewed Director of Nursing (DON)-B in regard to the Facility's process for obtaining readmission orders. DON-B stated sometimes the paperwork comes with the patient and sometimes it comes early and the paperwork is sent to the admission department. DON-B stated the information is then entered into the EMR. Surveyor informed DON-B of the concern R10 was readmitted to the Facility with a Foley catheter and there were no orders for the care and treatment of the catheter. On 9/25/24, at the exit conference Nursing Home Administrator (NHA)-A and DON-B were informed of the above. No further information was provided.