

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525507	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/25/2024
NAME OF PROVIDER OR SUPPLIER Golden Age Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 220 Scholl CT Amery, WI 54001	

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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>48793</p> <p>Based on interview, the facility did not ensure residents (R) received adequate supervision in transferring with a mechanical lift to prevent the risk of falling. This occurred for 3 of 3 residents. (R5, R6 and R7).</p> <p>Findings include:</p> <p>On 09/25/24 at 1:31 PM, Surveyor interviewed Certified Nurse Assistant (CNA) C and asked CNA C about any staffing concerns. CNA C indicated that last week on 09/14/24 during day shift around 1:15 PM, CNA C had to be on CNA C's own to transfer three residents (R5, R6 and R7) to bed via Hoyer lift. CNA C indicated that CNA C knew that CNA C shouldn't be transferring R5, R6 and R7 on CNA C's own but had no choice. Surveyor asked CNA C to explain the events of the day. CNA C indicated that the other CNA working with CNA C had to leave for a family emergency and that left CNA C short on west wing.</p> <p>On 09/25/24 at 5:15 PM, Surveyor interviewed Nursing Home Administrator (NHA) A and Director of Nursing (DON) B and asked if NHA A and DON B if aware there was a shortage of staff on 09/14/24. DON B indicated that no one called DON B, so DON B did not know that. NHA A indicated that NHA A was made aware that following Monday on 09/16/24 that CNA C was short on west wing. Surveyor asked NHA and DON B if NHA A and DON B were aware that CNA C had to transfer R5, R6, and R7 with a Hoyer lift to bed alone. NHA A and DON B indicated NHA A and DON B did not know this information. NHA A indicated that if NHA A and DON B knew there was a staffing emergency then NHA A and DON B could have tried to fix the issue. NHA A and DON B indicated that transferring residents via Hoyer by oneself is not ok. NHA A and DON B indicated NHA A and DON B's expectation is Hoyer lifts are always two people.</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
---	-------	-----------