STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525508	A. Building B. Wing	12/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alden Meadow Park Hcc	709 Meadow Park Dr Clinton, WI 53525

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 36105 Based on interview, record review, and facility policy review, the facility failed to ensure an allegation of abuse was submitted to the State Survey Agency within two hours after the allegation was made and failed to submit the results of the investigation to the State Survey Agency within five working days of the incident for 2 (Resident #1 and Resident #2) of 4 residents reviewed for resident-to-resident abuse. Findings included: A facility policy titled, Abuse Policy, dated 09/2020, revealed, This facility affirms the right of our residents to be free from abuse, neglect, misappropriation of resident property, corporal punishment and involuntary seclusion. The facility will report reasonable suspicion of a crime. This facility therefore prohibits mistreatment, neglect or abuse of its residents and has attempted to establish a resident sensitive and resident secure environment. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of mistreatment, neglect or abuse of our residents. The policy revealed, Initial Reporting of Allegations are reported immediately. CMS [Centers for Medicare and Medicaid Services] defines 'immediately' as not later than 2 hours after forming the suspicion of abuse which results in serious body injury or not later than 24 hours if no bodily injury. The policy revealed, c. Five Day Final Investigation Report. Within five working days after the report of the occurrence, a complete written report of the conclusion of the investigation, including steps the facility has taken in response to the allegation will be sent to the Wisconsin Division of Quality Assurance. An Admission Record indicated the facility admitted Resident #1 on 07/16/2021 and most recently admitted the resident on 10/22/2024. According to the Admission Record, the resident had a medical history that included diagnoses of depression and adjustment disorder with mixed anxiety and depressed mood. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/29/2024, revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS indicated the resident did not exhibit physical, verbal, or other behavioral symptoms directed toward others during that assessment period. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #1's care plan included a focus area initiated 12/03/2024, that indicated Resident #1 was at risk for abuse related to a history of repetitive verbalizations/yelling out and a history of socially inappropriate behavior. Interventions directed staff to redirect the resident calmly and firmly to more socially acceptable behaviors; respond with reassurance; not to argue with the resident; and to remind others to ignore or move away from repetitive noises or comments. An Admission Record indicated the facility admitted Resident #2 on 06/22/2022. According to the Admission Record, the resident had a medical history that included diagnoses of senile degeneration of the brain, dementia, mild cognitive impairment, hemiplegia, anxiety disorder, and major depressive disorder. A quarterly MDS, with an ARD of 09/20/2024, revealed Resident #2 had a BIMS (Brief Interview of Mental Status) score of 14, which indicated the resident had intact cognition. The MDS indicated the resident had verbal behaviors directed toward others for one to three days during the assessment period. Resident #2's care plan included a focus area initiated 08/26/2024, that indicated Resident #2 was at risk for abuse related to a diagnosis of dementia. Interventions directed staff to redirect the resident calmly and firmly to more socially acceptable behaviors; respond with reassurance and not argue; and to monitor and report signs and symptoms of abuse. A Concern Form, dated 11/14/2024, revealed that Resident #1 stated that they were walking down the hall when Resident #2 stuck their foot out as they were passing Resident #2 and caught the back of their leg. The section of the form labeled Time, date and person notified of outcome of concern: revealed 11/14/2024 4:45 PM. An Alleged Nursing Home Resident Mistreatment, Neglect, and Abuse Report, dated 11/14/2024, revealed that Resident #1 stated that Resident #2 attempted to trip them when they walked by. The report revealed Resident #1 used explicit language when confronting Resident #2. The report revealed the Maintenance Director redirected Resident #1 and the residents were separated. Further review revealed that the report was submitted to the State Survey Agency on 11/14/2024 at 8:00 PM, which was not compliant with the required timeframe. A Misconduct Incident Report, dated 11/21/2024, revealed the incident between Resident #1 and Resident #2 occurred on 11/14/2024 at 2:00 PM. According to the Summary of Incident, section of the Misconduct Report, Resident #2 was sitting in their wheelchair in the hallway when Resident #1 was walking down the hallway. The summary revealed Resident #2 moved toward Resident #1 and Resident #1 yelled out that Resident #2 was trying to trip them. The summary revealed, Resident #1 then started being verbally aggressive towards Resident #2. The summary revealed the Maintenance Director witnessed the incident, intervened, and did not observe contact between the residents. Further review revealed that the report was submitted to the State Survey Agency on 11/22/2024 at 9:19 PM, which was not compliant with the required timeframe. During an interview on 12/07/2024 at 7:48 AM, the Administrator stated she did not know why the report was not submitted on time. She stated she signed the report on 11/21/2024, but it was not submitted until 11/22/2024.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 36105 Based on observation, interview, record review, and facility clinical guideline review, the facility failed to ensure staff used proper hand hygiene during wound care, which affected 1 (Resident #6) of 2 residents observed for wound care. Findings included: The facility's Clinical Practice Guidelines included a guideline titled, Non-Sterile Dressing Change, dated 03/2021, that revealed, 6. Perform hand hygiene and apply gloves. 7. Prepare/open dressing items on the work area. If dressings need to be cut to size, use clean or sterile scissors. Open packages and cut the tape. 8. Reposition resident to expose area to be dressed. 9. May place the linen saver or towel under the resident. 10. Remove soiled dressing and place in a trash bag after observing soiled dressing and peri-wound for any drainage, checking for amount, color, consistency and odor. Document all observations on Skin Progress Notes (S.P.N.) in E.H.R. (Electronic Health Record) or Treatment Administration Records (T.A.R.) when using paper documentation. 11. Remove gloves, perform hand hygiene, and apply new gloves. The guideline revealed, 15. Upon completion remove gloves, perform hand hygiene and apply new gloves. 16. Apply liquid barrier film or moisture barrier to periwound (if applicable). 17. Apply prescribed topical agent to the wound bed. 18. Apply wound dressing. The guideline revealed, 21. Discard gloves and all supplies in trash bag and remove equipment. 22. Perform hand hygiene. An Admission Record indicated the facility admitted Resident #6 on 11/22/2024. According to the Admission Record, the resident had a medical history that included diagnoses of type 2 diabetes, congestive heart failure, chronic kidney disease, and anemia. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/29/2024, revealed Resident #6 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS indicated the resident had diabetic foot ulcers and surgical wounds. Per the MDS, the resident received treatment that included application of nonsurgical dressings and dressings to their feet. Resident #6's care plan included a focus area initiated 11/22/2024, that indicated the resident had amputated toes to their right foot, surgical/arterial wound to their right foot, abrasion to the right knee, and scattered areas to the right lower leg with drainage secondary to edema. Interventions directed staff to use enhanced barrier precautions during high contact resident care activities for chronic wounds (initiated 11/22/2024), and to provide Treatment as ordered (initiated 11/22/2024). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #6's Order Summary Report, dated 12/06/2024, revealed an order dated 12/06/2024 for povidone-iodine swab 10% to be applied to the right great toe each day shift, with directions to cleanse the area with normal saline, Paint the wound, and then wrap the lower leg and foot with Kerlix (gauze) and cover with Tubigrip (support bandage). The Order Summary Report also revealed an order dated 12/05/2024 for Optifoam Gentle Ex 4x4 External (foam dressing), to be applied to the right knee topically each day shift, with directions to cleanse the knee with normal saline, pat dry, then apply the dressing. The Order Summary Report revealed an order dated 12/06/2024 for Xeroform (medicated dressing) to the right leg, with directions to cleanse the area with normal saline, apply and cover with abdominal Kerlix and Tubigrip or ACE wrap (compression wrap). During an observation of Resident #6's wound care on 12/06/2024 at 10:44 AM, Registered Nurse J (RN) performed hand hygiene and applied new gloves, a gown, and a mask. She cleaned and used a barrier on the bedside table for wound dressing supplies. She placed a barrier under Resident #6's feet and removed the resident's right stocking. RN J removed the Kerlix wrap from Resident #6's leg and foot and the soiled dressings from the resident's right leg and right knee, performed hand hygiene, and applied clean gloves. RN J held gauze under Resident #6's open knee wound and dripped normal saline on the wound, and patted the knee dry with the gauze. At 10:49 AM, RN J dripped normal saline on the scattered open areas on Resident #6's right leg and patted the areas dry. RN J proceeded to clean the resident's right third toe with normal saline and patted it dry. RN J cleaned the resident's wound areas without performing hand hygiene or applying new gloves between the wounds. RN J applied clean gloves without performing hand hygiene and placed a clean barrier under Resident #6's leg. She opened and applied the povidone-iodine swab, did not clean her hands or change gloves, and applied an Optifoam dressing to Resident #6's right knee. RN J applied new gloves but did not perform hand hygiene and dressed Resident #6's right mid-leg wound with Xeroform dressings, applied abdominal pads, and wrapped the resident's leg and foot with Kerlix wrap. During an interview on 12/06/2024 at 11:12 AM, RN J stated she had been trained on infection control related to wound care. She stated she was supposed to perform hand hygiene after every change of gloves. She stated for wound care with more than one wound, she should have changed gloves between cleaning the wounds and dressing the wounds. She stated she was trained to clean and dress one wound at a time to prevent cross contamination between wounds. She stated that she did not realize she had not done that. During an interview on 12/06/2024 at 11:26 AM, the Director of Nursing (DON) stated that after removing the soiled dressings, the nurse should have removed her gloves, changed the barrier, performed hand hygiene, and put on clean gloves. The DON stated the nurse should have performed hand hygiene and changed gloves between wounds and should have cleaned and dressed each wound separately to prevent cross contamination of the wounds. She stated that there was a risk that an infection could be transferred from one wound to the next. The DON stated the nurse should start and finish one wound at a time. She stated that hand hygiene should be performed between each time the nurse's gloves were taken off. During an interview on 12/07/2024 at 9:37 AM, the Administrator stated she expected staff to follow the policy for hand hygiene and to complete a clean procedure.