Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/01/2024
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525522	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/27/2024
NAME OF PROVIDER OR SUPPLIER Manor of Fond Du Lac		STREET ADDRESS, CITY, STATE, ZIP CODE 517 E Division St Fond Du Lac, WI 54935	

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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F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give the resident's representative the ability to exercise the resident's rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43361 Based on staff interview and record review, the facility did not ensure the wishes of 2 Residents (R) (R23 and R25) of 14 residents were followed when they admitted R23 and R25 whose Power of Attorney for Healthcare (POAHC) paperwork indicated R23 and R25 did not want to be admitted to a nursing home. R23 had an activated POAHC prior to admission to the facility on [DATE]. R23's POAHC paperwork indicated R23 did not want R23's POAHC to admit R23 to a nursing home. R25 had an activated POAHC prior to admission to the facility on [DATE]. R25's POAHC paperwork indicated R25 did not want R25's POAHC to admit R25 to a nursing home. Findings include: Wisconsin Chapter 155.20(2)(c)2 indicates: A health care agent may consent to the admission of a principal to the following facilities, under the following conditions: a. To a nursing home, for recuperative care for a period not to exceed 3 months, if the principal is admitted directly from a hospital inpatient unit, unless the hospital admission was for psychiatric care. b. If the principal lives with his or her health care agent, to a nursing home or a community-based residential facility, as a temporary placement not to exceed 30 days, in order to provide the health care agent with a vacation or to release temporarily the health care agent for a family emergency. 1. R23 was admitted to the facility on [DATE] with diagnoses including cerebral infarction. R23's Minimum Data Set (MDS) assessment, dated 3/19/24, contained a Brief Interview for Mental Status (BIMS) score of 0 out of 15 which indicated R23 had severe cognitive impairment. R23 had an activated POAHC. Between 3/25/24 and 3/27/24, Surveyor reviewed R23's medical record and noted the following. ~On 6/11/18, R23 signed POAHC paperwork that indicated under Section 5 Admission to Nursing Home or Community-Based Residential Facilities: My health care agent may admit me to a nursing home or residential-based facility for short-term stays for recuperative or respite care. If I have checked Yes to the following, my health care agent may admit me for a purpose other than recuperative care or respite care, but if I have checked No to the following, my health care agent may not admit me. A. A Nursing home - R23 checked No. (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 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	~R23's Statement of Incapacity form was signed by a second physician on 3/6/23 which was 7 days prior to R23's admission to the facility. ~R23 was initially admitted to the facility for rehabilitation, but resided at the facility since 3/13/23. -Section Q0400 of R23's Annual MDS, dated [DATE], indicated R23 did not have an active discharge plan. 2. R25 was admitted to the facility on [DATE] with diagnoses including Alzheimer's disease. R25's MDS assessment, dated 3/6/24, contained a BIMS score of 6 out of 15 which indicated R25 had severe cognitive impairment. R25 had an activated POAHC. Between 3/25/24 and 3/27/24, Surveyor reviewed R25's medical record and noted the following: ~On 3/7/05, R25 signed POAHC paperwork which indicated: My health care agent may admit me to a nursing home or community-based residential facility for short-term stays for recuperative care or respite care. Agent Authority to admit me to a nursing home or community-based residential facility for long-term care. If I check no I cannot be admitted to a Wisconsin long-term care facility without a court order. R25 checked the box that indicated: No, my health care agent does not have the authority to admit me to a nursing home or a community-based residential facility for a long term stay. ~On 11/27/23, R25's Statement of Incapacity form was signed by a second physician which activated R25's POAHC 2 days prior to R25's admission to the facility. ~Section Q0400 of R25's Significant Change of Condition MDS, dated [DATE], indicated R25 did not have an active discharge plan. On 3/26/24 at 12:31 PM, Surveyor interviewed Social Worker (SW)-L who indicated R23 was initially admitted to the facility for rehab but remained at the facility for long-term care. SW-L indicated R25's family planned on having R25 stay at the facility. SW-L indicated SW-L discussed discharge with R25's POAHC, however, R25's POAHC indicated R25 knew the staff at the facility and did not want R25 to discharge at that time. SW-L indicated SW-L was aware if the admission to nursing home box was checked 'No' on a POAHC document, a resident should not be admitted for long-term care. SW-L confirmed R23 and R25 needed to go through the court system to remain in the facility based on their wishes when they created their POAHC documents.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43361 Based on staff interview and record review, the facility did not ensure a physician and Power of Attorney for Healthcare (POAHC) were notified of a change in condition for 1 Resident (R) (R25) of 14 sampled residents. R25's physician and POAHC were not notified when staff observed a bump and bruise on R25's head on 2/26/24. Findings include: On 3/25/24, Surveyor reviewed R25's medical record. R25 was admitted to the facility on [DATE] and had diagnoses including Alzheimer's disease. R25's Minimum Data Set (MDS) assessment, dated 3/6/24, contained a Brief Interview for Mental Status (BIMS) score of 6 out of 15 which indicated R25 had severe cognitive impairment. R25 had an activated POAHC (POAHC-M and POAHC-P) and received Hospice services. A hospice communication form, dated 2/26/24, contained handwritten and highlighted information on the bottom of the form that indicated: Noticed bruise/bump right eye/cheek/eyebrow. Spoke to (Certified Nursing Assistant) (CNA-N) who noticed the injuries at lunch. R25's medical record did not indicate R25's physician or POAHC were notified and did not contain progress notes, skin assessments, pain assessments, or follow up documentation after the bump/bruise was discovered. On 3/26/24 at 3:24 PM, Surveyor reviewed a Risk Management Report, dated 2/26/24 at 1:29 PM, that was completed by [NAME] President of Clinical Services (VPCS)-C. The report indicated: Nursing Description: (R25) was noted to have a bruise to right forehead above the eye. Resident Description: Unable to answer questions. Immediate Action Taken: Investigation determined (R25) bumped forehead and was seen by writer leaning forward reaching for dropped utensil. Writer notified (POAHC-P) and Medical Doctor (MD-O). No new orders were obtained. Injury report post incident: No injuries observed post incident. Witnesses: (Name was left blank); Relation: Staff; Date 2/26/24. Agencies/People Notified: MD-O and POAHC-P. Notes: 2/26/24 (R25) was witnessed by writer leaning forward reaching for item causing a bruise to forehead above right eye (signed VPCS-C). The bottom of the report indicated the report was privileged and confidential and not part of R25's medical record. On 3/26/24 at 1:19 PM, Surveyor interviewed CNA-N who indicated CNA-N noticed R25's face during lunch. CNA-N indicated R25's face had just started to bruise and pointed to CNA-N's right forehead to indicate the location of the bruise. CNA-N indicated a Hospice aide also noticed the bruise and asked what happened. CNA-N stated R25 couldn't tell staff what happened. CNA-N indicated the Hospice aide was going to notify the Hospice nurse of the bruise/bump. CNA-N stated CNA-N reported the injury to a facility nurse but was unsure if there was any follow-up. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/26/24, Surveyor reviewed the facility's staffing schedules. Surveyor interviewed Licensed Practical Nurse (LPN)-Q who indicated LPN-Q usually worked a different wing and was not informed of a bruise on R25's face on 2/26/24. Surveyor left a message for the Registered Nurse (RN) who worked on 2/26/24 but did not receive a return call. On 3/27/24 at 1:11 PM, Surveyor interviewed POAHC-M and POAHC-P who were visiting in R25's room. POAHC-M and POAHC-P stated they noticed the bruise on R25's right eye during their regular visit but were not notified of the bruise or told how it occurred. POAHC-M thought R25 rolled in bed and hit R25's head. POAHC-M indicated the facility usually called POAHC-M because POAHC-P was hard of hearing on the phone. POAHC-M indicated R25 had a bruise that puffed up a little bit. During a follow-up interview on 3/27/24 at 11:59 AM, CNA-N indicated CNA-N was in the dining room prior to lunch when R25 walked in and CNA-N noticed R25's bruise. CNA-N stated Hospice staff took R25 from the dining room between 12:30-12:45 and noticed the bruise at that time. On 3/27/24 at 2:43 PM, Surveyor interviewed [NAME] President of Clinical Services (VPCS)-C via phone who indicated Risk Management Reports are not part of residents' medical records. VPCS-C could not recall where and when VPCS-C observed R25 hit R25's head. VPCS-C indicated VPCS-C was in the facility doing a mock survey and saw R25 lean over and hit R25's head. When Surveyor indicated the Risk Management Report provided by the facility did not contain details of where or when the injury occurred, VPCS-C stated don't quote me and indicated the injury occurred in the dining room in the afternoon. VPCS-C indicated VPCS-C notified MD-O of R25's bruise via phone. VPCS-C indicated staff informed VPCS-C that POAHC-P was R25's POAHC. VPCS-C could not recall how VPCS-C contacted POACH-P. VPCS-C then indicated VPCS-C thought POAHC-P was in the building and VPCS-C told POAHC-P. VPCS-C stated sometimes POAHC-P is forgetful. VPCS-C indicated when notes are entered in the Risk Management program, they should pull into the residents' electronic medical records; however, the facility had issues with pulling information between medical records and the Risk Management program. On 3/27/24 at 3:04 PM, Surveyor interviewed MD-O via phone. MD-O indicated Nursing Home Administrator (NHA)-A reminded MD-O that Hospice noted the bruising. MD-O stated when Hospice enters a note in their system, the resident's electronic medical record at the hospital tags MD-O. MD-O indicated the note from Hospice indicated an investigation was being completed. MD-O verified facility staff did not contact MD-O regarding R25's bruising, but MD-O was electronically notified from Hospice. On 3/27/24 at 3:10 PM, Surveyor interviewed NHA-A who verified the facility should have notified MD-O of R25's injury and documented MD-O's response in R25's medical record. NHA-A also confirmed POAHC notification should have been documented in R25's medical record.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43361 Based on staff interview and record review, the facility did not accurately code Minimum Data Set (MDS) 3.0 assessments correctly for 2 Residents (R) (R23 and R24) of 14 sampled residents. R23's MDS assessment, dated 3/19/24, did not indicate R23 smoked. R24 had a physician order for continuous positive airway pressure (CPAP) therapy. R24's MDS assessment, dated 2/11/24, did not indicate R24 used a CPAP machine. Findings include: 1. R23 was admitted to the facility on [DATE] with diagnoses including cerebral infarction (stroke). Between 3/25/24 and 3/27/24, Surveyor reviewed R23's medical record. R23's medical record contained a smoking care plan and R23 was observed smoking outside. R23's Annual MDS assessment, dated 3/19/24, indicated R23 did not use tobacco. On 3/27/24 at 12:10 PM, Surveyor interviewed Minimum Data Set Coordinator (MDSC)-J who indicated MDSC-J codes residents' MDS assessments, works in the facility approximately 2 days per week, and also works at a sister facility. MDSC-J indicated MDSC-J looks for a smoking assessment when completing section J1300. MDSC-J indicated MDSC-J must have missed the assessment and verified R23's MDS should have been coded to indicate R23 uses tobacco. 48794 2. R24 was admitted to the facility on [DATE] with diagnoses including obstructive sleep apnea. On 3/26/24, Surveyor reviewed R24's medical record. R24's Admission MDS assessment, dated 2/11/24, indicated R24 did not use a CPAP machine. On 3/27/24 at 12:26 PM, Surveyor observed a CPAP machine in R24's room. On 3/27/24 at 12:10 PM, Surveyor interviewed MDSC-J who stated MDSC-J looks at residents' medical charting, vital signs, and physician orders when completing section O0110G3A. MDSC-J verified R24's MDS assessment did not indicate R24 used a CPAP machine but R24 had a physician order for CPAP therapy.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48794 Based on staff interview and record review, the facility did not ensure Pre-Admission Screen and Resident Review (PASRR) requirements were met for 4 Residents (R) (R24, R26, R5, and R133) of 5 sampled residents. R24 was admitted to the facility with a diagnosis of spastic diplegic cerebral palsy. R24's PASRR Level I Screen did not indicate R24 had a suspected intellectual disability/developmental disability (ID/DD). The facility did not obtain county exemption for R24's admission and the facility was unable to provide documentation that R24 was referred for a PASRR Level II Screen. R26's PASRR Level I Screen was not completed timely and a county exemption was not obtained. R5's PASRR Level I Screen indicated R5 had a mental illness (MI) and received medications to treat the symptoms/behaviors of the MI. The facility did not obtain county exemption for R5's admission and R5's PASRR Level II Screen was not completed timely. R133's PASRR Level I Screen indicated R133 had an MI and received medications to treat the symptoms/behaviors of the MI. The facility did not obtain county exemption for R133's admission and R133's PASRR Level II Screen was not completed timely. Findings include: According to the State of Wisconsin Department of Health Services, PASRR is a federal requirement that all applicants to Medicaid-certified nursing facilities be assessed to determine whether they might have an ID/DD and/or MI. This is called a Level I Screen. The purpose of a Level I Screen is to identify individuals whose total needs require they receive additional services for their ID/DD and/or MI. Individuals who test positive at Level I are then evaluated in depth to confirm the determination of an ID/DD and/or MI for PASRR purposes. This is a Level II Screen. This assessment produces a set of recommendations for necessary services that are meant to inform the individual's plan of care. Nursing facilities may seek county exemption for applicants with ID/DD and/or MI whose stay in the facility is expected to be recuperative care or short-term. 1. From 3/25/24 to 3/27/24, Surveyor reviewed R24's medical record. R24 was admitted to the facility on [DATE] with diagnoses including spastic diplegic cerebral palsy (a condition related to abnormal development of the brain). R24 had a physician's order for Zoloft (an antidepressant medication) with a corresponding diagnosis of depression related to spastic diplegic cerebral palsy. A PASRR Level I Screen was completed for R24 upon admission; however, the Level I Screen indicated R24 did not have an MI or ID/DD and was not prescribed psychotropic medication. A county exception was not completed for R24's admission and a Level II Screen was not completed when R24 remained in the facility. On 3/26/24 at 12:31 PM, Surveyor interviewed Social Worker (SW)-L who stated SW-L originally marked Yes on the form that R24 had an ID/DD; however, Contracted Agency (CA)-R (who was responsible for completion of Level II Screens) informed SW-L that R24 did not qualify for a Level II Screen and indicated SW-L should change the response to No. SW-L indicated SW-L did not document the conversation with CA-R. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/26/24 at 12:45 PM, Surveyor spoke with CA-R who did not have record of R24 in their system or documentation of a response related to completion of a Level II Screen. CA-R stated in this instance, their process was to issue a Canceled Level II or a Partial Level II. 2. From 3/25/24 to 3/27/24, Surveyor reviewed R26's medical record. R26 was admitted to the facility on [DATE] with diagnoses including major depressive disorder, recurrent, and anxiety disorder, unspecified. PASRR Level I and Level II Screens were completed on 5/24/23 and indicated R26 had an MI diagnosis. A county exception was not completed for R26 prior to admission. 3. From 3/25/24 to 3/27/24, Surveyor reviewed R5's medical record. R5 was admitted to the facility on [DATE] with diagnoses including major depressive disorder, single episode, severe with psychotic features, agoraphobia, and generalized anxiety disorder. R5 had physician orders for Zyprexa (an antipsychotic medication) and Valium (a medication used to treat anxiety). A PASRR Level I Screen was completed upon admission and indicated R5 had a diagnosed MI and was prescribed psychotropic medication. A county exception was not completed for R5 prior to admission and a Level II Screen was completed on 12/21/23 which was 6 days after R5's admission. 4. From 3/25/24 to 3/27/24, Surveyor reviewed R133's medical record. R133 was admitted to the facility on [DATE] with diagnoses including dysthymic disorder (a milder, but long-lasting form of depression). R133 had a physician's order for Wellbutrin (an antidepressant medication) with a corresponding diagnosis of depression related to other specified anxiety disorders. A PASRR Level I Screen was completed upon admission which indicated Yes to MI and Yes to psychotropic medication. A county exception was not completed for R133 prior to admission and a Level II Screen was completed on 3/22/24 which was 6 days after R133's admission. On 3/26/24 at 3:31 PM, Surveyor completed a follow-up interview with SW-L who indicated SW-L did not do county exemptions for residents with MI or ID/DD prior to admission to the facility. On 3/27/24 at 2:14 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A who was not aware SW-L did not complete county exemptions. NHA-A stated since the recent change in the PASRR system, NHA-A was unsure of the process for county exemptions. NHA-A stated NHA-A expected county exemptions to be completed as specified on the Level I Screen.

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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** 43361 Based on observation, staff interview, and record review, the facility did not ensure smoking materials were safely stored for 1 Resident (R) (R23) of 2 residents. R23's care plan indicated staff should store R23's smoking materials when not in use. On multiple occasions from 3/25/24 through 3/26/24, Surveyor observed cigarettes and a lighter on R23's bedside table. Findings include: The facility's undated Smoking/Vaping Safety policy indicates: The facility has the right to enforce a policy prohibiting residents from keeping any smoking materials in his/her possession for health, safety, and security reasons. A smoking assessment will be completed to determine the level of assistance and supervision needed during smoking, the ability to carry and store smoking materials, and if a smoking apron is indicated. The plan of care shall reflect the results of this assessment. This assessment will be completed upon admission, quarterly, and with significant change. The facility's undated Smoking/Vaping guidelines indicate: Smoking materials may be kept by a resident in his or her room if assessed to be independent, but must be locked up while not in use due to safety precautions. All smoking products will be kept in a secure area if resident is assessed to need supervision while smoking. R23 was admitted to the facility on [DATE] with diagnoses including cerebral infarction (stroke). R23's Minimum Data Set (MDS) assessment, dated 3/19/24, contained a Brief Interview for Mental Status Score (BIMS) score of 0 out of 15 which indicated R23 had severely impaired cognition. Between 3/25/24 and 3/27/24, Surveyor reviewed R23's medical record and noted the following: ~A communication care plan indicated R23 could answer yes/no questions and could write simple responses if needed. ~A smoking care plan was initiated on 6/12/23 when R23 began smoking again. The care plan contained an intervention indicated: Facility storage of tobacco, fire material, e-cigarette, disposable vape(s). On 3/25/24 at 10:00 AM, Surveyor interviewed R23 who appeared to understand Surveyor but had difficulty with expressive language. On 3/25/24 at 2:17 PM, Surveyor observed a pack of cigarettes and a lighter on a bedside table in R23's room. On 3/26/24 at 9:37 AM, Surveyor observed R23 in R23's room and observed a pack of cigarettes and a lighter on R23's bedside table. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/26/24 at 1:14 PM, Surveyor observed R23 in R23's room and observed a pack of cigarettes and a lighter on R23's bedside table. On 3/26/24 at 1:20 PM, Surveyor interviewed Certified Nursing Assistance (CNA)-K who confirmed R23 smoked. CNA-K stated residents' cigarettes are stored at the nursing station in a box; however, R23 liked to keep R23's cigarettes in Social Worker (SW)-L's office. When Surveyor informed CNA-K that Surveyor observed cigarettes and a lighter in R23's room, CNA-K indicated R23 should not have smoking materials in R23's room. On 3/26/24 at 1:25 PM, Surveyor interviewed SW-L who indicated SW-L kept R23's cigarettes and lighter in SW-L's desk drawer. SW-L opened the drawer and showed Surveyor a carton of cigarettes. When Surveyor informed SW-L that Surveyor observed smoking materials on R23's bedside table, SW-L confirmed R23 should not have smoking materials in R23's room. SW-L indicated R23 should pick up R23's smoking materials on the way to smoke and drop them off when R23 is finished.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45942 Based on observation, staff and resident interview, and record review, the facility did not ensure 1 Resident (R) (R11) of 2 residents received the necessary care and services for respiratory therapy. The facility provided R11 with respiratory therapy via continuous positive airway pressure (CPAP) without a physician's order. In addition, R11's need for and use of CPAP therapy was not care planned, assessed, or monitored. Findings include: The facility's CPAP Therapy policy, dated 5/3/22, indicates: .CPAP is used to treat obstructive sleep apnea (OSA). The goals of this therapy include improve ventilation, improve quality of sleep, decrease hospitalization s, improve cognitive function, improve oxygen saturation during sleep, decrease work of breathing, and improve lung compliance. Procedure: 10) Verify physician orders .18) If ordered, adjust ramp to prescribed time. Cleaning and Maintenance: 4) Follow these steps for cleaning your CPAP patient circuit . I. Remove the headgear from the mask or nasal pillows shell. Disconnect the mask or shell, swivel, and tubing. J. With a soft cloth, gently wash the mask or pillows with a solution of warm water, and a mild clear liquid detergent. K. Rinse thoroughly .L. Allow the mask or pillows to air dry .M. Wash tubing as necessary with a solution of warm water, and a mild clear liquid detergent. Rinse thoroughly and allow to air dry. N. Clean and inspect all components regularly .5) Clean the CPAP unit as necessary. E. Unplug the unit before cleaning. Never immerse the unit in water. F. Using a damp cloth, wipe the outside of the unit. G. Use a dry cloth to wipe the unit dry. H. Make sure the unit is thoroughly dry before plugging it in again. 6) Filter maintenance .Disposable filters should be replaced per manufacturers' recommendations. Reusable filters should be rinsed of dust and allowed to air dry. Never put a damp filter in your CPAP unit. The facility's Respiratory Therapy-Prevention of Infection policy, revised 4/2012, indicates: The purpose of this procedure is to guide prevention of infection associated with respiratory therapy tasks and equipment . Preparation: 1) Review the resident's care plan to assess for any special circumstances or precautions related to the resident .General Guidelines: 1) Distilled water used in respiratory therapy must be dated and initiated when opened and discarded after 24 hours. 2) Condensate in the breathing circuits must be drained back into waste bottles, which must be marked with resident's name, and emptied into the toilet or hopper at the end of every shift. Condensate should be considered infectious. Condensate should never be drained back into the breathing circuit or cascade. From the website: https://www.sleepfoundation.org/cpap/how-to-clean-a-cpap-machine: Continuous positive airway pressure (CPAP) machines are a standard treatment for sleep apnea, a serious breathing disorder. While they are an effective way to treat sleep apnea, CPAP machines do require frequent care and cleaning. Given that the mask, tubing, and other components are breathed into and deliver air throughout the night, their cleanliness can be a serious health concern. Daily cleaning removes dangerous microbes, mold, dust, and debris to ensure your CPAP treatment makes you feel better and not worse. While daily cleaning may seem overwhelming, it is a relatively quick process that is easy to integrate into your daily schedule. Manufacturers and experts tend to recommend daily cleaning of your CPAP machine's components, and users should commit to weekly cleaning at a minimum. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/25/24, Surveyor reviewed R11's medical record. R11 was admitted to the facility on [DATE] with diagnoses including OSA, congestive heart failure (CHF), and type 2 diabetes mellitus. R11's Minimum Data Set (MDS) assessment, dated 2/22/24, contained a Brief Interview for Mental Status (BIMS) score of 13 out of 15 which indicated R11 had intact cognition. R11's medical record indicated R11 had an activated Power of Attorney (POA). During multiple observations from 3/25/24 through 3/27/24, Surveyor observed a CPAP machine on R11's nightstand. The machine's tubing was not labeled with a date to indicate when it was connected for use or last changed. On 3/26/24, Surveyor reviewed R11's medical record and noted R11 did not have an order for CPAP therapy and R11's plan of care did not contain a CPAP cleaning schedule. On 3/26/24 at 11:59 AM, Surveyor interviewed Registered Nurse (RN)-I who confirmed R11 did not have an order for CPAP therapy or a CPAP cleaning schedule. On 3/26/24 at 1:53 PM, Surveyor interviewed R11 who indicated R11's CPAP machine was not cleaned since R11 was admitted on [DATE]. On 3/26/24 at 1:56 PM, Surveyor completed a follow-up interview with RN-I who indicated R11 should have an order for CPAP therapy and a cleaning schedule and stated R11's provider should be contacted for an order. On 3/26/24 at 2:06 PM, Surveyor interviewed Assistant Director of Nursing (ADON)-H who confirmed R11 did not but should have an order for CPAP therapy, a cleaning schedule for the equipment, and a care plan with interventions for CPAP use.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 48794 Based on staff interview and record review, the facility did not ensure the posted daily nurse staffing data was retained for a minimum of 18 months. This practice had the potential to affect all residents residing in the facility. The facility did not retain daily nurse staffing data for the required minimum 18 months. Findings include: On 3/25/24, Surveyor reviewed the facility's nurse staffing posting and requested to review the previous three months of nurse staffing postings. On 3/26/24 at 10:30 AM, Surveyor interviewed Nursing Home Administrator (NHA)-A who indicated the facility did not have the requested 3 months of nurse staffing postings. NHA-A stated the night nurse did not save the nurse staffing postings as required. On 3/27/24 at 2:15 PM, Surveyor completed a follow-up interview with NHA-A who stated staff education will be completed to ensure the nurse staffing postings are maintained going forward.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 43361 Based on staff interview and record review, the facility did not designate a person to serve as the food and nutrition services director who was a certified dietary manager, had a national certification for food service management and safety from a national accrediting body, or had an associates or higher level degree in food service management or hospitality. This had the potential to affect all 31 residents residing in the facility. Dietary Manager (DM)-D did not complete an approved dietary manager or food service manager certification course or other related education. Findings include: On 3/26/24 at 11:27 AM, Surveyor interviewed DM-D who indicated DM-D completed a ServSafe course in October of 2023. DM-D indicated DM-D started as the Dietary Manager approximately 2 years prior and had no prior experience or training in food service management. DM-D indicated DM-D was learning what needs to be done to meet the regulations and acknowledged there were things DM-D was not aware DM-D should be doing, including cleaning and disinfecting the filter on the ice machine, maintaining a testing log for the sanitizing buckets, and dating bread. DM-D acknowledged DM-D was not aware of the regulation that Dietary Managers must complete an approved dietary manager or food service manager course or have an associates or higher level degree in food service management or hospitality. DM-D indicated the facility did not have a full time dietitian onsite, but indicated a dietitian came to the facility on ce weekly and was available via email if needed.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45942 Based on observation, resident and staff interview, and record review, the facility did not ensure food preferences were honored for 1 Resident (R) (R4) of 14 sampled residents. R4's meal card stated NO GRAVY and no mashed potatoes. On 3/26/24, R4 was served mashed potatoes with gravy for lunch. Findings include: On 3/25/24, Surveyor reviewed R4's medical record. R4 was admitted to the facility on [DATE]. R4's Minimum Data Set (MDS) assessment, dated 12/10/23, contained a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R4 had intact cognition. R4's care plan indicated R4 was at risk for nutritional problems due to a diagnosis of adult failure to thrive and tolerated a general diet with soft or pureed foods per R4's preference. R4's activities of daily living self-care performance deficit related to osteoarthritis care plan, initiated on 3/6/23 and revised on 7/18/23, indicated R4 was able to eat items per choice with set up assistance and was allowed to choose pureed or soft foods. On 3/25/24 at 9:43 AM, Surveyor interviewed R4 who indicated R4's food preferences were not consistently honored. R4 indicated R4 wanted pureed food; however, R4 preferred regular scrambled eggs and not pureed eggs. R4 indicated R4 was served pureed eggs for breakfast and showed Surveyor a plastic container of what appeared to be pureed eggs. On 3/26/24 at 8:38 AM, Surveyor interviewed R4 who indicated R4 received pureed eggs again for breakfast. R4 indicated R4 informed staff many times that R4 did not want pureed eggs but R4 continued to receive them. On 3/26/24 at 12:24 PM, Surveyor observed staff deliver R4's room tray. The meal card on R4's bedside table stated NO GRAVY and no mashed potatoes. R4's lunch meal included applesauce, chocolate cake, pureed peas, scalloped potatoes, and mashed potatoes with gravy. Surveyor noted the gravy was poured over the scalloped and mashed potatoes and was partially on the pureed peas. R4 stated R4 did not like gravy and refused to eat the meal. R4 indicated R4 liked scalloped potatoes and wanted to eat them, but there was gravy on them. R4 also indicated R4 was served food that R4 disliked and was served pureed eggs daily. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/26/24 at 12:30 PM, Surveyor interviewed Dietary Manager (DM)-D who indicated R4's food preferences were only vegetables, no gravy, and chicken at times and stated R4 had a choice of consistency of pureed or soft. DM-D indicated R4 ate regular scrambled eggs instead of pureed eggs. DM-D indicated food preferences are printed on residents' meal cards. DM-D stated menus are printed every Thursday and given to residents. If there are no changes to the menu, residents are provided what is on the menu. If a resident wants something different than what is on on the menu, the unwanted item is crossed out. DM-D stated residents fill out the menu per their preference and the dietary department accommodates them as able or offers an alternative. DM-D indicated DM-D meets with R4 to determine R4's vegetable preference. Per DM-D, R4 goes back and forth with pureed and soft depending on the day. Surveyor informed DM-D that R4's lunch contained scalloped and mashed potatoes with gravy and R4 wanted a new serving of scalloped potatoes. Surveyor also informed DM-D that R4's eggs were pureed. DM-D indicated DM-D was not aware of the errors and stated DM-D would bring R4 a new lunch tray and ensure R4's eggs were scrambled. On 3/26/24 at 1:47 PM, Surveyor completed a follow-up interview with DM-D who confirmed R4's lunch meal contained mashed potatoes and gravy. DM-D indicated meals should honor R4's preferences and stated mashed potatoes and gravy should not have been served.

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F 0812

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Many

Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.

43361

Based on observation, staff interview, and record review, the facility did not ensure food was stored and prepared in a safe and sanitary manner. This practice had the potential to affect all 31 residents residing in the facility.

The ice machine contained black slime on the back inside filter.

Two microwaves contained dried food debris.

The freezer in the solarium did not contain a thermometer and a temperature log was not maintained.

Multiple food items did not contain open or use-by dates.

Logs that contained parts per million (PPM) testing of the sanitizer buckets were not maintained.

Findings include:

On 3/25/24 at 8:27 AM, Surveyor began an initial kitchen tour with Dietary Aide (DA)-E.

On 3/26/24 at 11:27 AM, Dietary Manager (DM)-D indicated the facility follows the Wisconsin Food Code.

Ice Machine:

The Wisconsin Food Code documents at 4-602.11 Equipment Food Contact Surfaces and Utensils: (E) . Surfaces of utensils and equipment contacting food that is not time/temperature control for safety food shall be cleaned: (4) In equipment such as ice bins and beverage dispensing nozzles and enclosed components of equipment such as ice makers, cooking oil storage tanks and distribution lines, beverage and syrup dispensing lines or tubes, coffee bean grinders, and water vending equipment: (a) At a frequency specified by the manufacturer, or more frequently as necessary to preclude accumulation of soil or mold, or (b) Absent manufacturer specifications, at a frequency necessary to preclude accumulation of soil or mold.

During the initial kitchen tour on 3/25/24, Surveyor observed an ice machine in a room across the hall from the kitchen. Surveyor noted a gray plastic filter on the back of the ice machine contained dark and slimy areas throughout the filter. Surveyor placed a finger on the black substance and noted it felt slimy. Surveyor observed water flowing over areas that contained the slimey substance.

On 3/26/24 at 11:27 AM, Surveyor and DM-D observed the ice machine. DM-D indicated DM-D cleaned the machine monthly and wiped down the inside walls with a sanitizer rag but did not clean the filter. DM-D confirmed there was a black slimy substance throughout the filter.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 3/27/24 at 2:30 PM, Surveyor interviewed DM-D who indicated DM-D was researching how to clean mold out of an ice machine. Surveyor referred DM-D to the user's manual or manufacturer specifications for cleaning and disinfecting the ice machine. Microwave Cleanliness: The Wisconsin Food Code documents at 4-601.11 Equipment, Food Contact Surfaces, Nonfood-Contact Surfaces, and Utensils: (A) Equipment food-contact surfaces and utensils shall be clean to sight and touch. (B) The food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris. The Wisconsin Food Code documents at 4-602.12 Cooking and Baking Equipment: (B) The cavities and door seals of microwave ovens shall be cleaned at least every 24 hours by using the manufacturer's recommended cleaning procedure. During the initial kitchen tour on 3/25/24, Surveyor observed the inside of the microwave in the kitchen. Surveyor noted the top of the microwave contained multiple areas of dried splattered food. DA-E confirmed the top of the microwave was dirty and indicated staff must clean the sides but not the top. On 3/26/24 at 10:33 AM, Surveyor observed the a microwave in the solarium. Surveyor observed the inside of the microwave and noted the top of the microwave contained multiple areas of dried food. On 3/26/24 at 11:33 AM, Surveyor interviewed DM-D who confirmed microwaves should not contain dried food and should be cleaned when they are dirty. Freezer Thermometer and Temperature Log: The Wisconsin Food Code documents at 3-501.16 Time/Temperature Control for Safety Food, Hot and Cold Holding: .Time/temperature control for safety food shall be maintained: (1) 135 degrees Fahrenheit (F) or above, except that roasts cooked to a temperature and for a time specified in paragraph 3-401.11 (B) Or reheated as specified in paragraph 3-403.11 (E) May be held at a temperature of 130 degrees F or above; or (2) At 41 degrees F or less. On 3/26/24 at 10:33 AM, Surveyor observed a refrigerator and freezer in the solarium which were used to store resident food from outside sources. Surveyor observed a refrigerator temperature log on top of the refrigerator. Surveyor could not locate a temperature log for the freezer and noted the freezer did not contain a thermometer. On 3/26/24 at 11:33 AM, Surveyor interviewed DM-D who indicated activity staff maintain the refrigerator and freezer and provide DM-D with temperature logs at the end of each month. DM-D indicated DM-D received logs for the refrigerator but not the freezer. DM-D confirmed the freezer should contain a thermometer and staff should maintain a log with freezer temperatures. Dating: (continued on next page)

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F 0812

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Many

The Wisconsin Food Code documents at 3-501.17 Ready-to-Eat, Time/Temperature Control for Safety Food:(A) .Refrigerated, ready to eat, time/temperature control for safety food prepared and held in a food establishment for more than 24 hours shall be clearly marked to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded when held at a temperature and time combination of 5 degrees Celsius (C) (41 degrees F) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1.

Commercially processed food open and held cold .refrigerated, ready to eat, time/temperature control for safety food prepared and packaged by a food processing plant shall be clearly marked at the time the original container is opened in a food establishment and, if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded, based on the temperature and time combinations specified in paragraph (A) of this section and; (1) The day the original container is opened in the food establishment shall be counted as Day 1; and (2) The day or date marked by the food establishment may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on food safety.

During the initial kitchen tour on 3/25/24, Surveyor observed the following:

~Thirty two loaves of bread on the top shelf of the walk-in cooler did not contain delivery or best by dates.

~Six loaves of bread on a shelf in the freezer did not contain delivery or best by dates.

~One open and undated gallon of 2% milk in the walk-in cooler.

~One open and undated 5 pound package of devil's food cake mix.

~The snack cart used for resident snack delivery contained 7 undated paper bowls of fruit with plastic drink covers and 4 undated paper bowls of mandarin oranges with plastic drink covers.

During the initial kitchen tour on 3/25/24, DA-E indicated when food items are delivered, staff should date the items with a delivery date. DA-E also indicated when items are opened, staff should date the items with an open date. DA-E confirmed the gallon of milk was undated and indicated gallons of milk in the walk-in cooler are mostly used for recipes. DA-E was unsure when the gallon was opened. DA-E also indicated the fruit bowls on the snack cart should be dated.

On 3/26/24 at 11:33 AM, Surveyor interviewed DM-D who was not aware the bread should have been dated because it did not contain a manufacturer's best by date. DM-D also confirmed open items and items on the snack cart should be dated.

Sanitizer Bucket Logs:

The Wisconsin Food Code documents at 1-106.14 (B) Maintain and provide to the regulatory authority or the department upon request records specified under section 1-106.12 that demonstrate that the following is routinely employed: (2) Monitoring of the critical control points.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The Wisconsin Food Code documents at 3-304.14 Wiping Cloths, Use Limitation: (B) Cloths in use for wiping counters and other equipment surfaces shall be: (1) Held between uses in a chemical sanitizer solution at a concentration specified. The Wisconsin Food Code documents at 4-501.116 Warewashing Equipment, Determining Chemical Sanitizer Concentration: Concentration of the sanitizing solution shall be accurately determined by using a test kit or other device. On 3/26/24 at 11:33 AM, Surveyor interviewed DM-D and asked to review the logs for the sanitizer buckets. DM-D indicated the facility did not test the buckets to ensure the sanitizing solution reached the required PPM. DM-D indicated the facility recently received test strips from their provider; however, DM-D was not aware that staff should maintain a testing log.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43361 Based on staff interview and record review, the facility did not ensure a medical record contained accurate and complete information for 1 Resident (R) (R25) of 14 sampled residents. On 2/26/24, staff discovered a bump and bruise on R25's head. R25's medical record did not contain information regarding the injury. Findings include: On 3/25/24, Surveyor reviewed R25's medical record. R25 was admitted to the facility on [DATE] with diagnoses including Alzheimer's disease. R25's Minimum Data Set (MDS) assessment, dated 3/6/24, contained a Brief Interview for Mental Status (BIMS) score of 6 out of 15 which indicated R25 had severely impaired cognition. R25 had Activated [NAME] of Attorney for Healthcare (POAHC-M and POAHC-P) and received Hospice services. Surveyor reviewed a Hospice note, dated 2/26/24. The note was handwritten, scanned into R25's medical record, and contained highlighted information at the bottom that indicated: Noticed bruise/bump right eye/cheek/eyebrow. Spoke to Certified Nursing Assistant (CNA-N) who noticed it at lunch. R25's medical record did not contain any other information regarding the injury, including notifications, follow-up, assessments, care plan updates, or an investigation to determine how the injury occurred. On 3/26/24 at 3:24 PM, Surveyor reviewed a Risk Management Report, dated 2/26/24. The report was completed by [NAME] President of Clinical Services (VPCS)-C on 2/26/24 at 1:29 PM and contained the following information: Incident Description: Nursing Description: (R25) was noted to have bruise to right forehead above the eye. Resident Description: Unable to answer questions. Immediate Action Taken: Investigation determined (R25) bumped forehead. Was seen by writer leaning forward reaching for dropped utensil. Writer notified (POAHC-P) and (Medical Doctor (MD)-O). No new orders were obtained. Injury report post incident: No injuries observed post incident. Witnesses: (Name was blank); Relation: Staff; Date 2/26/24. Agencies/People Notified: Physician (MD-O) and (POAHC-P). Notes: 2/26/24 (R25) was witnessed by writer leaning forward reaching for item causing a bruise to forehead above right eye (signed VPCS-C). The bottom of the report indicated the report was privileged and confidential and not part of R25's medical record. On 3/27/24 at 2:39 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A who indicated Risk Management Reports are not part of residents' medical records. On 3/27/24 at 2:43 PM, Surveyor interviewed VPCS-C via phone who indicated Risk Management Reports are not part of residents' medical records. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/27/24 at 3:10 PM, Surveyor interviewed NHA-A who verified a description of R25's bump/bruise, assessment, MD and POAHC notification, and follow-up were not contained in R25's medical record. NHA-A confirmed R25's medical record should contain documentation regarding notification, MD recommendations, and follow up.

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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. 32768 Based on observation, staff interview, and record review, the facility did not establish and maintain and infection control program designed to provide a safe and sanitary environment to help prevent the development and transmission of disease and infection for 1 Resident (R) (R8) of 2 residents observed during the provision of care. During an observation of peri and Foley care for R8, CNA (Certified Nursing Assistant)-G did not appropriately remove gloves and cleanse hands. Findings include: The facility's Hand Hygiene/Handwashing policy indicates: Hand hygiene means cleaning your hands by using either handwashing (washing hands with soap and water), antiseptic hand wash, or antiseptic hand rub (i.e. alcohol-based hand sanitizer including foam or gel). Examples of when to perform hand hygiene (either alcohol-based hand sanitizer or handwashing): ~Before and after having direct contact with a patient's intact skin (taking a pulse or blood pressure, performing physical examinations, lifting the patient in bed). ~After contact with blood, body fluids or excretions, mucous membranes, non intact skin, or wound dressings. ~After contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient. ~If hands will be moving from a contaminated body site to a clean body site during patient care. ~After glove removal. On 3/26/24, Surveyor reviewed R8's medical record. R8 was admitted to facility on 9/6/23 with diagnoses including spina bifida, paraplegia, neuromuscular dysfunction of bladder, MRSA (methicillin-resistant Staphylococcus aureus) and CRE (carbapenem-resistant Enterobacterales). R8's Minimum Data Set (MDS) assessment, dated 2/29/24, contained a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R8 had intact cognition. The MDS also indicated R8 was dependent on staff for transfers, bed mobility, dressing, and personal hygiene. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525522	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/27/2024
NAME OF PROVIDER OR SUPPLIER: Manor of Fond Du Lac		STREET ADDRESS, CITY, STATE, ZIP CODE: 517 E Division St Fond Du Lac, WI 54935	

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/26/24 at 9:31 AM, Surveyor observed CNA-F and CNA-G complete peri and Foley care for R8. When Surveyor entered R8's room, CNA-F and CNA-G were in the room wearing gowns and gloves. CNA-G gave R8 a clean wash cloth. R8 washed R8's face and under arms. CNA-G then removed gloves, sanitized hands, and donned clean gloves. CNA-G washed, rinsed, and dried R8's belly folds and scrotum. CNA-G then washed, rinsed, and dried R8's Foley tubing from the meatus downward. CNA-G removed gloves, and without performing hand hygiene, donned clean gloves. CNA-G touched R8 and R8's blanket as CNA-F and CNA-G assisted R8 onto R8's right side. CNA-G washed R8's buttocks from front to back with a clean cloth. Surveyor noted a dressing and an open wound on R8's sacral area. CNA-G continued washing R8's buttocks near the open wound and then rinsed and dried the area. CNA-G pushed a soiled Chux pad and sheet under R8 and touched R8 in the process. CNA-G then removed gloves, sanitized hands, and donned clean gloves. CNA-F and CNA-G removed R8's soiled sheets and replaced them with a clean Chux pad and clean sheets. CNA-F and CNA-G then removed gloves, sanitized hands, and donned clean gloves. CNA-F and CNA-G assisted R8 with getting dressed and removed the soiled linens from the room. On 3/26/24 at 10:06 AM, Surveyor interviewed CNA-G who verified CNA-G did not wash or sanitize hands after providing frontal pericare and completing care on R8's buttocks near an open wound.