STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525531	A. Building B. Wing	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Christian Home Care and Rehab Center LLC	452 Fox Lake Road Waupun, WI 53963

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 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** 50228 Based on interview and record review, the facility did not immediately notify and consult with a resident's physician when there was a significant change in condition. This occurred for 1 of 3 residents (R17) reviewed for change in condition. R17 had a significant weight loss that was not reported to R17's provider timely. R17 had a change in condition on 11/24/24 that was not reported to R17's provider timely. This is evidenced by: The facility's Notification of Change policy, dated 1/2025, states, in part: The community will consult the resident's physician, nurse practitioner, or physician assistant and notify the resident representative or an interested family member when there is: .acute illness or a significant change in the resident's physical, mental, or psychosocial status (i.e., deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications). The facility's Weights of Residents policy, dated 1/2019, states, in part: .3. Resident should be reweighed if there is a weight variance of over 3 pounds or more. (important to note: the policy does not indicate when the physician should be notified of weight variance.) The facility's Nurse/CNA (certified nursing assistant) / RA (resident assistant) Meeting Agenda, dated [DATE] and 31, 2024, states, in part: .11. Weights .d. Once you look at the weight on the clipboard, if you notice a change in weight of 3 pound either way, please reweigh resident to verify weight. e. If there is a change, notify nurse immediately. Nurse will update provider of weight change and enter a nurse progress note in the chart. R17 was admitted to the facility on [DATE], and has diagnoses that include vascular dementia (a type of cognitive decline caused by damage to the blood vessels in the brain; depression; and dysphagia (difficulty swallowing). R17's Minimum Data Set (MDS) dated [DATE] shows R17 has a Brief Interview of Mental Status (BIMS) score of 8, indicating moderate cognitive impairment. Example 1 (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R17's physician's orders state, in part: Weight Management: Weights-daily x3 (3 times), and then weekly. Start date 11/20/24. R17's care plan states, in part: Focus: Nutrition/Hydration: Potential for Complications with Nutritions/Hydration d/t (due to) appetite, meal intake, medication side effects, past medical history. Date initiated: 11/25/24. R17's Weights and Vitals Summary indicates the following weights: *11/19/24 222 Lbs (pounds) *11/20/24 222.2 Lbs *11/21/24 221.6 Lbs *11/25/24 224.2 Lbs *11/27/24 222.4 Lbs *12/18/24 196.8 Lbs *12/25/24 198.8 Lbs *12/25/24 198.8 Lbs *1/1/25 196.9 Lbs *1/1/25 196.4 Lbs *1/8/25 194.4 Lbs *1/15/25 189 Lbs *1/22/25 187 Lbs On 1/29/25 at 9:36 AM, Surveyor interviewed RN C (Registered Nurse) and asked how often residents are weighted. RN C stated that residents are weighed at least weekly, some as often as daily. Surveyor asked if weights are monitored. RN C stated that the standard is for physician to be notified of a 3 pound change in 1 day or a 5 pound change in 1 week. Surveyor asked where physician notification is documented. RN C stated in the resident's chart under progress notes. Surveyor asked if R17 has had any change in her weight. RN C reviewed the chart and stated R17 has had weight loss. RN C stated she could see a 10 pound weight loss in an alert screen. RN C stated that weight loss would be significant and would need physician notification. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/29/25 at 1:45 PM, Surveyor interviewed DON B (Director of Nursing) and asked if resident weights are monitored. DON B stated weights are reviewed by the nurses and the dietician. Surveyor asked when physicians are updated on changed in weight. DON B stated physician is updated with weight change of 3-5 pounds and that notification is documented in the progress notes. Surveyor asked about R17's weights. DON B stated that R17 was on isolation in December and was not weighed during that time. DON B stated following isolation R17's weight was down. Surveyor asked if DON B would expect the facility to notify the physician of a change from 222.4 pounds to 196.8 pounds (a 25.6 pound / 11.5% loss between 11/27/24 and 12/18/24). DON B stated yes. Surveyor asked for documentation of physician notification. No documentation was provided. On 1/30/25 at 1:18 PM, Surveyor interviewed NP D (Nurse Practitioner) and asked if NP D would expect to be notified of a resident's weight loss. NP D stated yes. Surveyor asked if facility had notified of R17's weight loss from 11/19/24 to 12/18/24. NP D stated no, not that I am aware of. Surveyor asked if NP D would expect to be notified of this weight loss. NP D stated yes. Example 2: R17's Progress Note, dated 11/24/24 at 3:20 PM, states: Res (resident) has one large incontinent BM (bowel movement) this morning with moderate to large amount of blood noted. Denies any rectal pain and no hemorrhoids noted. B/P (blood pressure) 108/54. On 1/29/25 at 9:47am, Surveyor interviewed RN C (Registered Nurse) and asked what would be done if bleeding were noted from a resident. RN C stated the resident would be assessed and the physician would be notified. On 1/29/25 at 2:45 PM, Surveyor interviewed DON B (Director of Nursing) and asked if a physician should be updated of a resident having moderate to large amount of blood following a bowel incontinence. DON B stated yes. DON B stated that the resident was sent to the hospital for evaluation at approximately 5:30 PM and returned to the facility at approximately 9:00 PM. Surveyor asked if the facility notified the physician in the morning when the bleeding was noted. DON B stated no. Surveyor asked if facility would be expected to notify the physician at the time of the bleeding. DON B stated yes. On 1/30/25 at 1:18 PM, Surveyor interviewed NP D (Nurse Practitioner) and asked if NP D would expect the facility to notify the provider of a resident having an episode of bowel incontinence with moderate to large amount of blood noted. NP D stated yes. Surveyor asked when NP D would expect notification of a bleeding episode noted in the morning. NP D stated right away in the morning.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49434 Based on interview and record review, the facility failed to ensure the medication regimen was free from unnecessary medications for 1 of 5 residents (R23) reviewed for unnecessary medications. R23 receives an antidepressant for sleep without an appropriate diagnosis. R23 did not have a sleep assessment conducted prior to medication administration. This is evidenced by: The facility policy entitled, Psychotropic Medication dated 5/2020, states, in part: .1. The indication for any psychotropic medication will be thoroughly documented in the clinical record to include an appropriate supporting diagnosis and identification of behavioral symptom(s) being treated. The medical record must show documentation of adequate indication and diagnosed condition . 2. A Psychotropic Drug Assessment will be completed on admission, quarterly, a new medication or renewal order, an irregularly identified in the pharmacist's medication regimen review and with changes of condition . The assessment will be reviewed by the IDT (Interdisciplinary Team) helps to identify resident's needs, goals, comorbid conditions, and prognosis to determine factors (including medications and new or worsening medical conditions) that are affecting signs, symptoms, and test results. This evaluation process is important when selecting initial medications and/or non-pharmacological approaches and when deciding whether to modify or discontinue a current medication. Attempt to identify underly cause for behavioral symptom(s) .4. Based upon individualized assessment, determine non-pharmacological approaches that can be implemented prior to the use of psychotropic medications . R23 was admitted to the facility on [DATE] with diagnoses that include, in part: fatty liver, pulmonary embolism (blood clot in the lungs), dementia, Wernicke's encephalopathy (memory disorder most often caused by alcohol), alcohol dependence, and panlobular emphysema (disorder causing damage to all lobes of the lung making it difficult to breathe). R23's Physician Orders, dated 1/17/25, include, in part: Trazadone (antidepressant medication often used for sleep) 50 MG, Give by mouth one time daily for sleep. Take 50 MG daily at bedtime. Start date: 10/7/24. Order status: Active. (Of note: Patient does not have a diagnosis of insomnia and there is no diagnosis associated with this medication) Surveyor requested the sleep assessment for R23 that was conducted prior to ordering and administering the Trazadone. Surveyor was provided a document titled, SNF-ADMIT/READMIT TOOL, dated 10/1/24 at 7:04 AM. In the section titled, Sleep, questions were asked regarding R23's sleep patterns are marked trouble staying asleep, wakes in night. The usual bedtime is indicated to be between 8:00 PM and 8:30 PM. The usual hours of sleep states, depends 4 to 5. The usual waking time is indicated to be between 5:00 AM and 6:00 AM. The preference for AM and PM naps are both marked, not really. (Of note: The facility reports this is the only sleep assessment conducted for R23) (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Physician Notification, dated, 10/1/24, states, Resident having difficulty sleeping, and pain in BLE (bilateral lower extremities). No PRNs (as needed medications) available if there is anything we can get? Thanks! A reply was made to this notification that was signed on 10/3/24, which provided the order for 50 MG of Trazadone by mouth at bedtime. A progress note, indicated to be effective on 10/5/24 at 5:00 AM, indicates R23 was restless and had difficulty sleeping. R23 had to be assisted back to her room and settled into her recliner. (Of note: In the SNF-ADMIT/READMIT TOOL, conducted on 10/1/24, R23 indicated she usually wakes up between 5:00 AM and 6:00 AM) On 10/7/24 at 1:13 PM, a progress note is written that states, Resident received new orders for trazadone at bedtime. (Of note, no other progress notes are written describing the patient's sleep patterns or habits during this time period.) On the Behavior Monitoring and Interventions Report from admission on 9/30/24 through 10/8/24, Insomnia is marked as a behavior only once on 10/7/24 at 5:25 AM. On 1/30/25 at 2:20 PM, Surveyor interviewed DON B (Director of Nursing). Surveyor asked DON B how the facility assesses a resident's sleep upon admission. DON B indicates, they initiated behavior monitoring if they are on psychotropics, but states, I really don't have a process. DON B indicates if a resident is having trouble sleeping, staff should be notifying the doctor. DON B also indicates melatonin, or other medications should be attempted prior to starting hypnotics. DON B also states R23 did have an assessment upon admission and did not sleep well prior to admission. Surveyor asked DON B how the facility monitors residents' sleep. DON B indicates they track sleep on the Behavior Monitoring and Interventions section of the EMR (electronic medical record), and staff are expected to document insomnia, but there is no actual sleep hours tracking. Surveyor asked DON B if the facility uses sleep diaries. DON B states, no. Surveyor asked DON B how R23's sleep was on admission. DON B indicates her sleep was not good, she was very restless and had a couple falls. Surveyor asked DON B if the facility was tracking R23's sleep. DON B indicates staff were tracking her sleep by marking insomnia in the Behavior Monitoring and Interventions section of the EMR. Surveyor asked DON B if there should be documentation if a resident is experiencing insomnia. DON B states, there should be a progress note or physician notification. DON B also indicates the facility was aware the hospital was using Seroquel (antipsychotic medication) for sleep and did not think melatonin would be effective. Surveyor asked DON B if a sleep assessment should be conducted prior to starting trazadone for sleep. DON B states, probably, and indicates she would leave that up to the provider.