

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525535	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/06/2025
NAME OF PROVIDER OR SUPPLIER  Augusta Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  901 Bridge Creek Lane Augusta, WI 54722	

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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47657</b></p> <p>Based on interviews and record reviews, the facility did not consult with a physician as indicated by ordered parameters with a significant weight change for 2 of 2 residents (R) R4 and R14.</p> <p>This is evidenced by:</p> <p>The facility policy titled, Notification of Changes Policy, last updated on 01/10/25, states: It is the policy of this facility that changes in a resident's condition or treatment, are immediately shared with the resident and or the resident representative, according to their authority, and reported to the attending or delegate.</p> <p>Example 1</p> <p>R4 was admitted to the facility on [DATE] with diagnoses of congestive heart failure, chronic kidney disease and diabetes mellitus type 2.</p> <p>R4's annual Minimum Data Set (MDS), dated [DATE], Section K, indicated R4's weight of 193# and no indication of a physician-prescribed weight loss or weight gain regimen.</p> <p>R4's orders, dated 12/14/2023, state to obtain weight daily and notify physician if more than 3 lbs in 1 day or 5 lbs in 1 week.</p> <p>R4 has an order dated 12/12/23 for Spironolactone 25mg every morning for edema.</p> <p>On 02/05/25 at 11:58 AM, Surveyor reviewed R4's weight record and noted the following:</p> <p>01/28/25 = 205.8 pounds</p> <p>01/29/25= 213.4 pounds (a gain of over 7 pounds)</p> <p>01/30/25 = 217.4 pounds (a gain of 4 pounds)</p> <p>On 02/05/25 at 12:21 PM, Surveyor interviewed Certified Nursing Assistant (CNA) L regarding expectation of when to obtain R4's weights. CNA L stated R4 is a daily weight.</p> <p>(continued on next page)</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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525535	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/06/2025
NAME OF PROVIDER OR SUPPLIER  Augusta Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  901 Bridge Creek Lane Augusta, WI 54722	
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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 02/05/25 at 12:31 PM, Surveyor interviewed Registered Nurse (RN) M regarding process of obtaining weights, following physician orders of notifying weight outside of parameters. RN M stated that a CNA obtains the weights and places in a notebook. The nurse will then transfer the information into the resident record. When this is done, the system shows the last weight recorded for comparison. If a resident has an order for notifying the MD for specific parameters, then a fax will be sent to the MD for further instructions. RN M was not aware of MD notified of weight gain of R4 outside the parameters or any new orders.</p> <p>On 02/05/25 at 3:33 PM, Director of Nursing (DON) B provided Surveyor with 2 fax documents dated 01/12/25 and 02/5/25 to R4's MD with a report of past month weights. The fax face sheet or weight report identified the significant weight loss above parameters as ordered but the facility did not provide any information pointing out the weight gain per MD order. Surveyor interviewed DON B regarding expectation of following MD orders of notifying the MD if more than 3lbs in 1 day or 5 lbs in 1 week. DON B stated the expectation would be to follow the orders and contact the MD.</p> <p>Example 2</p> <p>R14 was admitted to facility on 12/03/24 and has a Brief Interview for Mental Status (BIMS) of 11 out of 15, indicating mildly impaired cognitive level.</p> <p>R14's admission MDS with target date of 12/09/24, Section K: weight 149# (note: this was an incorrect entry into MDS).</p> <p>R14's care plan, dated 12/12/14, stated R14 is at nutritional risk due to diagnosis of hypertensive heart disease chronic kidney disease, congested heart failure, obesity, and chronic obstructive pulmonary disease. With a goal of not have significant weight gain or weight loss through the next review period of 03/10/25.</p> <p>On 02/04/25 at 10:11 AM, Surveyor reviewed R14's weight record which showed on 12/05/24 R14 weighed 250.2# and on 02/04/24 R14 weighed 227.8#, giving a total weight loss of 22.4# in 2 months.</p> <p>On 02/06/25 at 10:25 AM, Surveyor interviewed DON B regarding concerns of weight loss of R14 without documentation, assessments or notification to identify the significant weight loss. DON B stated there is no documentation related to identifying weight loss and there has not been any notification to physician or dietician. DON B confirmed the physician or dietician was not notified of weight change.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525535	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/06/2025
NAME OF PROVIDER OR SUPPLIER  Augusta Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  901 Bridge Creek Lane Augusta, WI 54722	

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 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 31086</p> <p>Based on record review and interview, the facility did not accurately code the Minimum Data Set (MDS) assessments for 3 of 12 residents (R) reviewed. (R4, R29 and R32).</p> <p>The facility did not accurately code R4, R29 and R32's MDS assessment with correct number of falls that occurred during the referenced time frame.</p> <p>This is evidenced by:</p> <p>Example 1</p> <p>R4 was admitted on [DATE] and current diagnoses included, in part, type 2 diabetes mellitus with diabetic nephropathy, epilepsy, age-related osteoporosis, peripheral vascular disease, congestive heart failure, malignant neuroendocrine tumors, malignant neoplasm of liver, chronic kidney disease stage 3b and depression.</p> <p>Review of MDS dated [DATE] an annual assessment documented Brief Interview of Mental Status (BIMS) score of 15, indicating R4 is cognitively intact. Section J documented R4 having 1 fall with no injury, 1 fall with injury not major and 2 or more with major injury. The previous MDS was completed on 08/31/24.</p> <p>Review of fall history during the period between 08/31/24 the previous MDS to 11/27/24 MDS. On 09/23/24, R4 had a fall with no injury. On 09/10/24, R4 had a fall with a small bump to the top of head. No further falls were documented during this time frame.</p> <p>MDS Section J1900 requires documentation of the number of falls since admission or prior assessment, whichever is more recent. Between prior MDS on 08/31/24 and 11/27/24 R4 only had 1 fall with no injury and 1 fall with injury not major. The MDS dated [DATE] was incorrectly coded of R4 having 2 or more falls with major injury.</p> <p>Example 2</p> <p>R32 was admitted to the facility on [DATE] and current diagnoses included, in part, malignant neoplasm of bladder, atherosclerotic heart disease of coronary artery, anxiety disorder, chronic obstructive pulmonary disease, and restlessness and agitation.</p> <p>Review of MDS dated [DATE] a quarterly assessment documented a BIMS of 15 and 1 fall with no injury. The previous MDS was completed on 08/24/24.</p> <p>Review of fall history documented R32 having no falls during the period between 08/24/24 the previous MDS to 11/20/24 MDS.</p> <p>On 02/05/25 at 1:25 PM, Surveyor interviewed Director of Nursing (DON) B about R32's falls between 08/24/24 and 11/20/24. DON B indicated R32 did not have any falls between those dates.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525535	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/06/2025
NAME OF PROVIDER OR SUPPLIER  Augusta Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  901 Bridge Creek Lane Augusta, WI 54722	
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 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 02/05/25 at 3:40 PM, Surveyor interviewed DON B about R4 and R32's MDS being coded incorrectly. DON B indicated the MDS was coded incorrectly and starting the month of October the facility had a consulting company in the facility to assist with MDS coding and training the new MDS staff.</p> <p>49353</p> <p>Example 3</p> <p>R29 was admitted to the facility on [DATE] with pertinent diagnoses of dementia, polyosteoarthritis, and macular degeneration.</p> <p>R29's most recent Minimum Data Set (MDS) significant change assessment dated [DATE] noted R29 had 2 or more falls since admission with no injury and no falls with minor or major injury. R29 had a recent surgery repair of fractures of the pelvis, hip, leg, knee, or ankle.</p> <p>Surveyor reviewed R29's electronic medical record and noted the following:</p> <p>On 12/19/24, R29 had a fall in the facility resulting in a left femur fracture and sent to the hospital for surgical repair of fracture. R29 readmitted to the facility on [DATE].</p> <p>On 02/06/25 at 2:12 PM, Surveyor interviewed Director of Nursing (DON) B regarding MDS assessment. Surveyor asked DON B if R29 had a fall in the facility on 12/19/24 that resulted in a left femur fracture and surgical repair. DON B stated yes. Surveyor asked DON B why the MDS did not reflect this fall with major injury. DON B stated she was unable to state reason why MDS was coded incorrectly as the MDS Coordinator is currently on vacation. DON B had no explanation for why R29 was not coded correctly for having a fall with a major injury on the most recent MDS.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525535	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/06/2025
NAME OF PROVIDER OR SUPPLIER  Augusta Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  901 Bridge Creek Lane Augusta, WI 54722	
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 - 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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49353</p> <p>Based on interview and record review, the facility did not ensure the resident environment remained as free of accidents as possible for 2 of 4 residents (R29, R4) reviewed for accidents.</p> <p>The facility did not complete a thorough investigation of falls for root cause and implement interventions to prevent further falls. R29 had a fall on 12/19/24 that resulted in a left femur fracture and surgical repair. This example is cited at actual harm.</p> <p>The facility did not complete a thorough investigation of falls to determine staff following plan of care, root cause, monitor for trends, and re-assess interventions to prevent further accidents for R4.</p> <p>This is evidenced by:</p> <p>The facility Fall Evaluation, Intervention, and Reporting policy updated/reviewed 10/10/24 states: All residents will be evaluated for fall risk within 24 hours of admission, with ongoing monitoring as needed, and per CMS guidelines. Residents who sustain a fall will be evaluated at time of event and the following 72 hours.</p> <p>Procedure:</p> <p>A. All residents will be evaluated for fall risk upon admission.</p> <p>B. Care plan to be developed with appropriate approach and interventions for all admits.</p> <p>C. A fall evaluation will be completed quarterly by the MDS coordinator/Nurse, with resident falls and as needed.</p> <p>D. Care plans are reviewed to assure appropriate interventions are in place quarterly, with every fall, and as needed.</p> <p>a. In the event of a resident fall:</p> <p>5. Update RN/DON or designee to discuss and implement intervention.</p> <p>6. Complete fall packet and update care plan.</p> <p>8. Complete detailed progress note to include time of fall, location of fall, root cause of fall, residents range of motion, pain, injury, how you assisted off of floor, RN notification, MD notification, POA notification, and new intervention.</p> <p>10. Open and complete fall evaluation and pain evaluation.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525535	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/06/2025
NAME OF PROVIDER OR SUPPLIER  Augusta Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  901 Bridge Creek Lane Augusta, WI 54722	

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 - Actual harm</p> <p>Residents Affected - Few</p>	<p>11. All falls will have an interdisciplinary team (IDT) root cause analysis to assure comprehensive care plan is appropriate and is up-to-date.</p> <p>Example 1</p> <p>R29 was admitted to the facility on [DATE] with pertinent diagnoses of dementia, polyosteoarthritis, and macular degeneration.</p> <p>R29's most recent Minimum Data Set (MDS) dated [DATE] noted a Brief Interview for Mental Status (BIMS) score of 00 indicating severe cognitive impairment, is usually understood by others, and usually understands others. R29 was noted to have lower range of motion impairment on one side, used assistive devices of a walker and wheelchair, and was a dependent assist with walking 10 feet. R29 had 2 or more falls since admission with no injury and no falls with minor or major injury. R29 had a recent surgery repair of fractures of the hip.</p> <p>R29's care plan dated 11/10/24 included the following:</p> <p>PROBLEM: Activity of daily living (ADL) self-care performance deficit related to dementia.</p> <p>GOAL: R29 will maintain current level of function in cares through review date (01/21/25).</p> <p>INTERVENTIONS: Assist of 1 and front wheel walker for stand pivot transfer and ambulation, use cues for each step of turning sequence, and check on resident frequently.</p> <p>PROBLEM: R29 has had an actual fall with minor injury due to unsteady gait.</p> <p>GOAL: R29 will resume usual activities without further incident through review date.</p> <p>INTERVENTIONS:</p> <ul style="list-style-type: none"> <li>- 02/12/24: Offer toileting approx. q2hr (every 2 hours).</li> <li>- 04/29/24: Keep bed at mid to low height as R29 likes to sit on the edge of it.</li> <li>- 05/11/24: Wear gripper socks to bed at night to prevent slipping when getting up.</li> <li>- 08/18/24: Educate resident to ensure that she can feel the bed on the back of her legs prior to sitting.</li> <li>- 08/29/24: PM (evening)- Non-skid strips added to floor by bed where R29 stands to get out of bed.</li> <li>- 08/29/24: AM (morning)- Signage hung on wall to remind staff to make sure R29 has gripper socks on, as R29 sometimes dresses herself and does not remember to put on gripper socks.</li> <li>- 09/4/24: Use NH (nursing home) gripper socks at all times when in bed as they have better grip than one resident had on.</li> </ul> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525535	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/06/2025
NAME OF PROVIDER OR SUPPLIER  Augusta Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  901 Bridge Creek Lane Augusta, WI 54722	
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 - Actual harm</p> <p>Residents Affected - Few</p>	<p>- 09/9/24: Discuss with family potential of moving resident's room closer to staff for more frequent visualization. (Family declines change of room as they feel it would increase confusion and it is further for her to walk to the dining room.</p> <p>- 10/1/24: Staff to ensure that R29's walker is next to her bed when resident is in bed.</p> <p>- 10/2/2024: Hourly Checks initiated.</p> <p>- Fall on 10/13/24: Sleep study to start at midnight tonight (10/14) so staff can schedule NOC (night) toileting.</p> <p>- 10/24/24: Re-educate staff on new toileting schedule.</p> <p>- 12/28/24: Leave bathroom door cracked and light now at nighttime so resident can locate bathroom easily.</p> <p>- Provide activities that promote exercise and strength building where possible. Provide 1:1 activities if bedbound.</p> <p>- Sleep study initiated to establish toileting program.</p> <p>- Staff to check on R29 hourly and document.</p> <p>Surveyor reviewed R29's falls documentation and noted the following:</p> <p>The facility utilized a falls documentation system that included incident location, incident description, immediate action taken, injuries, pain, level of consciousness, predisposing environmental factors, physiological factors, situation factors, witness statements, and notifications.</p> <p>R29's falls are documented as follows in part .</p> <p>09/19/24 at 11:12 PM; fall without injury. MD (Medical Doctor)/POA (Power of Attorney) notified. Investigation determined poor lighting as possible cause.</p> <p>Of note: No intervention was put into place and care plan was not updated.</p> <p>10/02/24 at 7:01 AM; fall with swelling noted on back of head; MD/POA notified and declined evaluation at hospital. No other injuries noted. Care plan updated to include hourly checks.</p> <p>Of note: No investigation completed to determine root cause. Surveyor was unable to verify hourly checks were completed as noted being initiated on care plan on 10/02/24 or thereafter.</p> <p>10/13/24 at 5:50 AM; fall with complaint of bilateral leg pain. MD/POA notified. No other injuries noted. Sleep study ordered with plan to implement overnight toileting schedule.</p> <p>Of note: No investigation completed to determine root cause of fall. Care plan not updated. No documentation provided of results of sleep study.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525535	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/06/2025
NAME OF PROVIDER OR SUPPLIER  Augusta Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  901 Bridge Creek Lane Augusta, WI 54722	
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 - Actual harm</p> <p>Residents Affected - Few</p>	<p>10/24/24 at 2:00 AM; fall without injury. MD/POA notified. Care plan stated to educate staff on new toileting schedule, but no schedule noted.</p> <p>Of note: No investigation completed to determine root cause. No new/revised intervention implemented to prevent further falls. Care plan not updated.</p> <p>10/30/24 at 2:45 PM; fall without injury. MD/POA notified.</p> <p>Of note: No investigation completed to determine root cause of fall. No new/revised intervention implemented to prevent further falls. Care plan was not updated.</p> <p>11/24/24 at 9:49 PM; fall without injury. MD/POA notified. Determined walker and wheelchair were not in reach. Implemented every 2 hour toileting schedule.</p> <p>Of note: Toileting schedule was already in place on 02/12/24. No new/revised interventions implemented to prevent further falls. Care plan was not updated.</p> <p>12/05/24 at 1:41 PM; fall without injury. MD/POA notified.</p> <p>Of note: No investigation completed to determine root cause of fall. No new/revised interventions implemented to prevent further falls.</p> <p>12/10/24 at 8:31 AM; fall without injury. MD/POA notified.</p> <p>Of note: No investigation completed to determine root cause of fall. No new/revised interventions implemented to prevent further falls.</p> <p>12/19/24 at 10:54 PM; fall with major injury. R29 was found on floor in dining room. Sent to ER for evaluation and found left femur fracture. admitted to hospital for surgical repair. MD/POA notified.</p> <p>R29's hospital record for emergency room visit, states in part .</p> <p>On 12/20/24 at 6:04 a.m.</p> <p>History of present illness: Her workup in the emergency room .remarkable for findings of left femoral neck base fracture on one view x-ray .</p> <p>Surgical report dated 12/21/24 states in part .</p> <p>Open Reduction Internal Fixation (ORIF) left hip</p> <p>Of note: R29 had 8 falls prior to the fall on 12/19/24 with no investigation of root cause and/or new/revised interventions to prevent falls. This resulted in R29's fall on 12/19/24 causing a femoral neck fracture.</p> <p>R29 returned to the facility on [DATE].</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525535	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/06/2025
NAME OF PROVIDER OR SUPPLIER  Augusta Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  901 Bridge Creek Lane Augusta, WI 54722	

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 - Actual harm</p> <p>Residents Affected - Few</p>	<p>12/27/24 at 9:47 PM; fall without injury. MD/POA notified.</p> <p>Of note: No investigation completed to determine root cause of fall. Care plan updated to leave bathroom door cracked and light now at nighttime so resident can locate bathroom easily.</p> <p>01/02/25 at 2:00 PM; fall without injury. MD/POA notified.</p> <p>Of note: No investigation completed to determine root cause of fall. No new/revised interventions implemented to prevent further falls.</p> <p>01/15/25 at 5:00 PM; fall without injury. MD/POA notified.</p> <p>Of note: No investigation completed to determine root cause of fall. No new/revised interventions implemented to prevent further falls.</p> <p>On 02/06/25 at 2:21 PM, Surveyor interviewed Director of Nursing (DON) B regarding falls documentation. DON B stated that prior to the start of survey on 02/04/25, the facility did not have a procedure in place for investigating resident falls to determine root cause and implement appropriate interventions. DON B stated she recognized that not having a fall investigation process in place likely contributed to R29's repeated falls. DON B stated that a new plan of correction was being worked on and would be discussed with Quality Assurance Performance Improvement (QAPI) team to ensure falls are investigated to include root cause analysis, interventions, and follow-up for efficacy.</p> <p>31086</p> <p>Example 2</p> <p>R4 was admitted on [DATE] and current diagnoses included, in part, type 2 diabetes mellitus with diabetic nephropathy, epilepsy, age-related osteoporosis, peripheral vascular disease, congestive heart failure, malignant neuroendocrine tumors, malignant neoplasm of liver, chronic kidney disease stage 3b and depression.</p> <p>Review of MDS dated [DATE] an annual assessment documented Brief Interview of Mental Status (BIMS) score of 15 out of 15, indicating R4 is cognitively intact. R4 has no impairments to upper or lower extremities, R4 requires staff to setup assistance for upper and lower dressing, and personal hygiene. R4 requires maximum staff assistance to apply footwear. The MDS documented R4 having 1 fall with no injury, 1 fall with injury not major and 2 or more with major injury.</p> <p>Review of R4's care plan documented in part:</p> <p>R4 is High, risk for falls r/t Confusion , Gait/balance problems, Incontinence, Vision/hearing problems R4 does not always recall to lock her brakes which has resulted in falls. R4 requires re-educated for using call light for staff assist during transfers. 1/30/25 Lost balance while getting into lounge chair. Date Initiated: 04/08/2024 Revision on: 01/30/2025</p> <p>Approaches in part:</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525535	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/06/2025
NAME OF PROVIDER OR SUPPLIER  Augusta Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  901 Bridge Creek Lane Augusta, WI 54722	
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 - Actual harm</p> <p>Residents Affected - Few</p>	<p>-12/20/23 Educate R4 on locking brakes before transfers. Date Initiated: 07/15/2024 Revision on: 07/16/2024</p> <p>-12/20/23 Educate R4 on locking w/c brakes prior to transferring to the toilet. Date Initiated: 04/08/2024 Revision on: 07/16/2024</p> <p>-1/26/24 Staff to check w/c brakes are on when R4 is sitting in recliner Date Initiated: 07/15/2024 Revision on: 07/15/2024</p> <p>-1/27/24 Gripper socks on resident feet to help prevent her from slipping Date Initiated: 07/15/2024 Revision on: 01/31/2025</p> <p>-1/30/25 Reeducated on necessity of wearing gripper socks. Date Initiated: 01/31/2025</p> <p>-1/31/24 Educated on safe transfers, R4 was able to teach back safe transfers Date Initiated: 07/15/2024 Revision on: 07/16/2024</p> <p>-1/31/24 OT reeducated R4 that her wheelchair brakes are working, R4 provided teach back. Date Initiated: 07/15/2024 Revision on: 07/16/2024</p> <p>-2/5/24 Offer R4 to rest in recliner at approx. 2100 to prevent her from falling asleep in wheelchair causing her to fall to floor Date Initiated: 07/15/2024 Revision on: 07/15/2024</p> <p>-3/22/24 PT to eval and treat due to recent falling. Date Initiated: 07/15/2024 Revision on: 07/16/2024</p> <p>-4/18/24 Staff to check on R4 at start of NOC shift to assist with getting R4 into recliner safely. Date Initiated: 07/15/2024 Revision on: 07/15/2024</p> <p>-4/6/24 Check brakes for proper functioning when locking. Date Initiated: 07/15/2024</p> <p>-4/7/24 Brake extensions added to wheelchair brakes. Date Initiated: 07/15/2024 Revision on: 07/16/2024</p> <p>-6/30/24 Dycem in recliner and wheelchair. Date Initiated: 07/15/2024</p> <p>-6/4/24 Staff to check on R4 hourly when in recliner to assure w/c is locked and in proper placement next to recliner Date Initiated: 07/15/2024 Revision on: 07/15/2024</p> <p>-9/10/24 Encourage R4 to leave door open for better visualization when not on isolation precautions. Date Initiated: 02/05/2025</p> <p>-Be sure R4's call light is within reach and encourage her to use it for assistance as needed. R4 needs prompt response to all requests for assistance. 1/30/25 Call light placed closer to resident for calling for staff assistance. Date Initiated: 07/16/2024 Revision on: 01/30/2025</p> <p>-Make sure R4 has both socks on prior to transfers and to call for assistance if she notices that she is missing her sock. Date Initiated: 09/25/2024</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525535	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/06/2025
NAME OF PROVIDER OR SUPPLIER  Augusta Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  901 Bridge Creek Lane Augusta, WI 54722	

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 - Actual harm</p> <p>Residents Affected - Few</p>	<p>-Non-Skid strips applied to floor in front of recliner to aid in prevention of fall. Date Initiated: 07/16/2024 Revision on: 07/16/2024</p> <p>On 01/30/25, a post fall investigation fall risk assessment score of 75 meaning at high risk for falls.</p> <p>Review of R4's fall investigations:</p> <p>On 01/26/24 at 1:15 a.m., R4 fell in room was found sitting on the floor with no injuries. R4 stated transferring from recliner to wheelchair and missed the wheelchair and sat on the floor. R4 was barefoot and her wheelchair brakes were not locked. Care plan was updated for staff to ensure wheelchair brakes are on when resident is sitting in recliner.</p> <p>On 01/27/24 at 10:36 p.m., R4 fell in room from wheelchair with no injuries. R4 took socks off and wheelchair was not locked. The care plan intervention from 1/26/24 was not followed.</p> <p>On 01/31/24 at 12:05 a.m., R4 fell in room and found sitting on the floor in front of her recliner with no injuries. Wheelchair in front of resident and brakes were on. R4 stated she was just trying to transfer from recliner to wheelchair but she stood up and slid out and she sat on the floor. R4 was wearing grippy socks at the time. R4 then demonstrated how she transfers from recliner to wheelchair on her own and did correctly. Care plan was updated on 01/31/24 to include educated on safe transfers. The facility did not determine a root cause of the fall as to why R4 was self transferring.</p> <p>On 03/21/24 at 9:48 p.m., R4 fell in room sitting upright on the floor next to her recliner with no injuries. On 03/22/24, physical therapy to evaluate and treat due to recent falling. The facility did not determine a root cause of the fall, no new interventions were initiated and no documented therapy recommendations.</p> <p>On 04/6/24 at 9:40 p.m., R4 fell in room found between her recliner and her wheelchair with no injuries. Wheelchair right brake was locked and left brake partially locked. Facility determined wheelchair brakes were not fully engaged. Interventions to check brakes for proper functioning when locking.</p> <p>On 04/7/24 at 10:25 p.m., R4 fell in room while transferring from recliner to bathroom. R4 hit the back of her head. R4 had one sock on right foot and no sock on the left and wheelchair was not locked and brakes were not tight enough. Brake extensions added to wheelchair brakes. This fall has the same issue with functioning of wheelchair brakes.</p> <p>On 04/18/24 at 11:05 p.m., R4 fell in room while transferring from recliner to wheelchair with no injuries R4 was wearing gripper socks and wheelchair brakes were locked. Care plan update Staff to check on resident at start of NOC shift to assist with getting resident into recliner safely. The facility did not determine the root cause of the fall.</p> <p>On 06/4/24 at 12:10 a.m., R4 fell in room out of recliner and wheelchair was not locked. R4 had no injuries. Care plan was updated with Staff to check on R4 hourly when in recliner to assure wheelchair is locked and in proper placement next to recliner. Care plan intervention of locking w/c brakes was not followed.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525535	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/06/2025
NAME OF PROVIDER OR SUPPLIER  Augusta Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  901 Bridge Creek Lane Augusta, WI 54722	
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 - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 06/30/24 at 11:25 p.m., R4 fell in room in front of her recliner with no injuries. R4 was not wearing nonslip footwear. R4 was wearing one regular sock on right foot and left foot bare as resident had removed her leg wrap and socks prior to self-transfer. R4 did not use walker for transfer. R4 stated that she did try to grab onto her wheelchair, but the brakes were not on the wheelchair and it moved with her as she slid to the floor. Care plan updated to have dycem non-slip into seat of resident recliner chair and wheelchair to help prevent resident from slipping off of surfaces. The facility did not investigate to determine if staff followed the care plan of hourly checks of wheelchair placement and locked, and proper footwear.</p> <p>On 09/10/24 at 9:15 p.m., R4 fell in room was found lying next to recliner with no injuries. A small bump to the top of R4's head. Intervention was to keep track of hours of sleep. The facility did not identify a root cause of the fall and did not evaluate hours of sleep to determine further interventions.</p> <p>On 09/23/24 at 8:45 p.m., R4 fell in room and was found lying in front of recliner with no injuries. The root cause was R4 not wearing shoes or socks at the time of fall, wheelchair brakes were locked and R4 uses many blankets when sitting in her recliner. Therapy assessed and R4 is independent to transfer. Resident education on importance of making sure that she had both socks on prior to transfers and to call for assistance.</p> <p>On 01/30/25 at 10:00 p.m., R4 fell in room was found sitting in front of recliner with no injuries. Facility's intervention was to re-educate R4 on the importance of wearing her gripper socks for safety when transferring. The facility did not identify a root cause of the fall and did not assess the repeated intervention of wearing socks to be appropriate.</p> <p>Surveyor's review of R4's falls identified the facility did not complete a full investigation of when staff last observed the resident, determine if staff followed plan of care, determine root cause of the fall, review for patterns/trends, and re-assess the plan of care.</p> <p>On 02/05/25 at 2:15 PM, Surveyor interviewed Director of Nursing (DON) B about the fall root cause. The consulting company came in to assist in September and found where to document in risk management. The root cause is noted at the bottom of the incident report. Surveyor reviewed with DON B, R4's incident reports from 09/10/24 documented on 09/16/24 Nursing to follow up on the bump on top of her head. Resident denied pain over the weekend. Nursing is also keeping track of the hours of sleep that she is getting on every shift since resident has been known to fall asleep frequently while in wheelchair. Resident has previously refused sleep studies. Surveyor asked when you collected the data of hours of sleep did you assess the data and what was the response and any changes. DON B said she will get that information.</p> <p>On 02/06/25 at 8:50 AM, Surveyor interviewed Assistant Director of Nursing (ADON) D about fall investigations with root cause and interventions. ADON D indicated the root cause is talked about in morning meetings on every fall and they go over the interventions and will update the care plan. The care plan should be updated when staff put interventions in place and this has been missed. The consulting company is in the facility reviewing and putting things in place and showing where to document in risk management. When a fall occurs, the nurse will put the note into risk management with the intervention. The nurse will call the manager on call or DON B and will discuss what intervention to put into place and then the team will review the fall in the morning.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525535	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/06/2025
NAME OF PROVIDER OR SUPPLIER  Augusta Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  901 Bridge Creek Lane Augusta, WI 54722	

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 0689  Level of Harm - Actual harm  Residents Affected - Few	On 02/06/25 at 12: 25 p.m., Surveyor interviewed DON B about the fall investigation, root cause, and intervention of R4. Surveyor reviewed with DON B the fall investigations are not complete and did not determine if staff are following care plan, root cause of falls, assessing interventions. DON B indicated the facility does have a plan going forward for documenting and assessing the falls.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525535	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/06/2025
NAME OF PROVIDER OR SUPPLIER  Augusta Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  901 Bridge Creek Lane Augusta, WI 54722	
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 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 31086</p> <p>Based on interview and record review, the facility did not ensure residents (R) with indwelling Foley catheters received care and treatment consistent with professional standards of practice to prevent complications or urinary tract infections from the catheter. For 1 of 1 resident (R32) reviewed with a Foley catheter.</p> <p>R32's Foley catheter was changed on a routine monthly basis without clinical indications and not following professional standards of practice.</p> <p>This is evidenced by:</p> <p>The Centers for Disease Control and Prevention (CDC), Healthcare Infection Control Practices Advisory Committee (HICPAC), Guideline for prevention of catheter-associated urinary tract infections 2009, read in part, E. Changing indwelling catheters or drainage bags at routine, fixed intervals is not recommended. Rather, it is suggested to change catheters and drainage bags based on clinical indications such as infection, obstruction, or when the closed system is compromised.</p> <p>Facility's policy titled, Catheter Care, Urinary with the revised date of 09/24, documented in part, Changing Catheters, 1. Changing indwelling catheter every 30 days, PRN, or as ordered by physician. It is suggested to change catheters and drainage bags based on clinical indications such as infection, obstruction, or when the closed system is compromised. Noted references of HICPAC, Guideline for Prevention of Catheter-Associated Urinary Tract Infections 2009.</p> <p>R32 was admitted to the facility on [DATE] and current diagnoses included, in part, malignant neoplasm of bladder, atherosclerotic heart disease of coronary artery, anxiety disorder, chronic obstructive pulmonary disease, and restlessness and agitation. 02/04/25 12:05 PM has a catheter with no concerns or infections, has a leg bag.</p> <p>Physician orders documented on 10/22/24: Change 22 french 30 cc balloon catheter per N home protocol every 30-90 days our protocol is (30 days) and prn if becomes occluded one time a day starting on the 22nd and ending on the 22nd every month for permanent Foley placement for bladder cancer change monthly and prn if becomes occluded hospice provide supplies.</p> <p>Original order from hospice dated 03/13/24 documented, Change Foley catheter 22 French with 30 ml balloon change as needed.</p> <p>Record review did not identify physician rationale or clinical indications for the need to change the Foley catheter every 30 days.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525535	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/06/2025
NAME OF PROVIDER OR SUPPLIER  Augusta Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  901 Bridge Creek Lane Augusta, WI 54722	
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 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 02/06/25 at 11:13 AM, Surveyor interviewed Director of Nursing (DON) B about the rationale or clinical indication for the change of R32's Foley catheter on a monthly basis. DON B indicated the only note to change the catheter was from hospice order to follow facility protocol. DON B understands a needed medical rationale or clinical indications to change the catheter every 30 days and there was not a medical rationale found to change R32's Foley catheter monthly. DON B indicated the Medical Director will be doing her own research before the policy would be changed.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525535	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/06/2025
NAME OF PROVIDER OR SUPPLIER  Augusta Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  901 Bridge Creek Lane Augusta, WI 54722	
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 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>47657</p> <p>Based on record review and interviews, the facility did not ensure acceptable parameters of nutritional status, such as usual body weight or desirable body weight range by recognizing or assessing a significant weight loss for 1 of 1 resident (R14) reviewed.</p> <p>This is evidenced by:</p> <p>The facility policy titled: Notification of Changes Policy, last updated on 01/10/25, states in part, Nurses and other care staff are educated to identify changes in a resident's status and define changes that require notification of the resident and/or their representative, and their resident's physician, to ensure best outcomes of care for the resident.</p> <p>R14 was admitted to facility on 12/03/24 and has a Brief Interview for Mental Status (BIMS) of 11 out of 15, indicating mildly impaired cognitive level.</p> <p>R14's admission assessment Minimum Data Set (MDS) with target date of 12/09/24, Section K: weight 149# (note: this was an incorrect entry into MDS).</p> <p>R14's care plan, dated 12/12/14, stated R14 is at nutritional risk due to diagnoses of hypertensive heart disease chronic kidney disease, congested heart failure, obesity, and chronic obstructive pulmonary disease. With a goal of not have significant weight gain or weight loss through the next review period of 03/10/25</p> <p>On 02/04/24 at 10:11 AM, Surveyor reviewed R14's weight record which showed on 12/05/24 R14 weighed 250.2# and on 02/04/24 R14 weighed 227.8#, giving a total weight loss of 22.4# in 2 months.</p> <p>On 02/05/25 at 2:47 PM, Surveyor interviewed R14 regarding weight loss. R14 stated being happy about the weight loss and stated appetite is good and is not concerned with weight loss.</p> <p>On 02/06/25 at 10:25 AM, Surveyor interviewed Director of Nursing (DON) B regarding concerns of weight loss of R14 without documentation, assessments or notification to identify the significant weight loss. DON B stated there is no documentation related to identifying weight loss and there has not been any notification to physician or dietician. DON B confirmed the physician or dietician was not notified of weight change.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525535	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/06/2025
NAME OF PROVIDER OR SUPPLIER  Augusta Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  901 Bridge Creek Lane Augusta, WI 54722	
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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>49353</p> <p>Based on observation and interview, the facility did not ensure staff followed procedures for the accurate administration of medication for 1 of 1 resident (R25).</p> <p>Staff administered multiple medications at once via gastrostomy tube.</p> <p>This is evidenced by:</p> <p>Facility policy titled, Gastrostomy Intermittent Tube Feeding/Medication, with no date states in part:</p> <p>Policy: Licensed nursing staff will feed/provide medication through a resident's gastrostomy tube following orders of the physician.</p> <p>Procedure:</p> <p>12. Pour 1 ounce (30 cc) of room temperature water into the syringe barrel to check for patency. If water flows freely, the gastrostomy tube is patent.</p> <p>13. Administer medications at this time, as ordered by the physician.</p> <p>- Administer one medication at a time.</p> <p>- After each medication, flush the gastrostomy tube with a small amount of water.</p> <p>On 02/05/25 at 7:14 AM, Surveyor observed Licensed Practical Nurse (LPN) F training LPN G on medication administration. Surveyor observed LPN F instruct LPN G to remove R25's 6 ordered medications from the blister packs, crush them per order, and place all 6 medications into cup together. LPN F told LPN G to add approximately 50 ml of water to the cup with the crushed medications. LPN F then connected the syringe to R25's gastrostomy tube, checked for residual, and flushed the tube with 200 ml of water. LPN F then administered the 6 crushed medications through the gastrostomy tube, followed with an additional 50 ml of water.</p> <p>On 02/05/25 at 7:32 AM, Surveyor interviewed LPN F regarding medication administration. Surveyor asked LPN F if it was standard practice to administer all medications at once through the gastrostomy tube. LPN F stated yes, because it gets flushed with the 200 ml of water it is ok.</p> <p>On 02/06/25 at 2:25 PM, Surveyor interviewed Director of Nursing (DON) B regarding medication administration observation. Surveyor asked DON B what the expectation is for administering medications via gastrostomy tube. DON B stated that each medication should be administered one at a time and the tube flushed between each medication. Surveyor informed DON B of observation of all medications being administered at one time. DON B stated this was not the expected practice as it could potentially cause harm to the resident. DON B stated that follow-up education would be completed with staff on the safe administration of medications via gastrostomy tube.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525535	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/06/2025
NAME OF PROVIDER OR SUPPLIER  Augusta Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  901 Bridge Creek Lane Augusta, WI 54722	
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 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>47657</p> <p>Based on observation and interview, the facility did not ensure controlled drugs were stored in separately locked, permanently affixed compartments for 1 of 2 med storage units.</p> <p>Observation of a controlled medication stored in the unlocked refrigerator located in the medication room.</p> <p>Findings include:</p> <p>The facility policy, titled Controlled Substances, dated 04/24, states: .3. Controlled substances are stored in the medication room in a locked container, separate from containers for any con-controlled medications.</p> <p>On 02/05/25 at 9:01 AM, Surveyor observed medication storage area near E dining room with Licensed Practical Nurse (LPN) F. Surveyor observed the medication room door was locked; however, the refrigerator was unlocked with an open 30ml bottle of Lorazepam for R11. LPN F stated the refrigerator should have a lock, but not that long ago we got a new refrigerator, and they never replaced the lock.</p> <p>On 02/05/25 at 12:00 PM, Surveyor interviewed Doirector of Nursing (DON) B regarding finding of a bottle of opened Lorazepam in refrigerator which was not locked in med room. DON B stated she was made aware of the findings, and stated they recently got a new refrigerator and had ordered a lock, but it hadn't been installed, and maintenance is working on that at this moment.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525535	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/06/2025
NAME OF PROVIDER OR SUPPLIER  Augusta Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  901 Bridge Creek Lane Augusta, WI 54722	
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 0791</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide or obtain dental services for each resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49353</p> <p>Based on interview and record review, the facility did not ensure residents received routine dental services for 1 of 1 resident (R25) reviewed.</p> <p>This is evidenced by:</p> <p>State Operations Manual Appendix PP states in part:</p> <p>The facility must assist residents in obtaining routine and 24-hour emergency dental care. The facility must provide or obtain from an outside resource, in accordance with S483.70(f) of this part, the following dental services to meet the needs of each resident:</p> <p>(i) Routine dental services (to the extent covered under the State plan.</p> <p>R25 was admitted to the facility 04/07/23 with pertinent diagnoses of hemiplegia and hemiparesis (immobility/weakness) following cerebral vascular accident (stroke), malignant neoplasm of brain (tumor), dementia, dysphagia, and depression.</p> <p>R25's most recent Minimum Data Set (MDS) quarterly assessment dated [DATE] noted a Brief Interview for Mental Status (BIMS) score of 00 indicating severe cognitive impairment, is sometimes understood, and sometimes understands. R25 has impaired range of motion on both side of upper and lower extremities and is dependent assist for oral hygiene.</p> <p>Surveyor reviewed R25's medical record and did not locate any dental service notes.</p> <p>On 02/04/25 at 12:46 PM, Surveyor interviewed R25's Activated Power of Attorney (APOA) regarding dental care and services. APOA stated that facility staff have not provided dental care since R25 was admitted .</p> <p>On 02/06/25 at 2:43 PM, Surveyor interviewed Medical Records (MR) E regarding dental services. Surveyor asked if R25 had received any dental services since admission. MR E stated no. Surveyor asked MR E why these services had not been provided. MR E stated she had asked R25's APOA if he would like R25 to see a dentist and R25's APOA declined. Surveyor asked if MR E had documentation of this declination of dental services. MR E stated no.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525535	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/06/2025
NAME OF PROVIDER OR SUPPLIER  Augusta Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  901 Bridge Creek Lane Augusta, WI 54722	
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 0814</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Dispose of garbage and refuse properly.</p> <p>46694</p> <p>Based on observations and interviews, the facility failed to ensure the facility's garbage was properly stored in the dumpster. The failure had the potential to promote a breeding ground for pests and rodents affecting all 39 residents within the facility.</p> <p>Findings:</p> <p>On 02/04/25 at 8:15 AM, during initial tour of the kitchen, Surveyor asked [NAME] (I) to show surveyor where the dumpsters were located. [NAME] I led Surveyor out the back of the facility where the dumpster was. The dumpster was overflowing with black garbage bags, and black garbage bags were piled against the dumpster all over the ground in front of and around the dumpster. Surveyor asked [NAME] I about this, and [NAME] I indicated the facility is in outbreak. The facility has always used Styrofoam containers during an outbreak.</p> <p>On 02/04/25 at 11:45 AM, Surveyor asked Dietary Director (DD) H about the dumpsters overflowing and garbage on the ground. DD H indicated the garbage gets picked up twice a week on Tuesday and Thursday. The facility is in outbreak right now and we are using Styrofoam containers instead of plates. Surveyor asked, If there was an outbreak that occurred on Friday and the dumpster filled up over the weekend and you noticed this when you came in Monday morning, could you call and have the dumpster emptied right away Monday? DD H replied, I don't know about that I will have to talk to our Nursing Home Administrator (NHA) and get back to you.</p> <p>On 02/04/25 at 11:50 AM, Surveyor asked Director of Nursing (DON) B about the dumpsters being full of garbage on the ground. DON B indicated the garbage gets picked up once a week on either Tuesday or Wednesday. Surveyor asked, If there was an outbreak that occurred on Friday and the dumpster filled up over the weekend and you noticed this when you came in Monday morning, could you call and have the dumpster emptied right away Monday? DON B replied, I don't know about that I will have to talk to our Nursing Home Administrator (NHA) A and get back to you.</p> <p>On 02/04/25 at 3:18 PM, Surveyor went to ask NHA A about the dumpsters and found DD H was also in NHA A's office. NHA A replied, Look, I can get another dumpster. It will cost us an extra \$700 to do it. But, look, we are trying to keep our residents safe and so we give them their meals in the Styrofoam to keep them safe. Surveyor informed NHA A that as we review the kitchen we also look for pest control practices and we make sure that the dumpster area is clean. The facility cannot have garbage lying outside of the dumpster and the dumpster so full that you cannot close the lid.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525535	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/06/2025
NAME OF PROVIDER OR SUPPLIER  Augusta Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  901 Bridge Creek Lane Augusta, WI 54722	
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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49353</p> <p>Based on observation and interview, the facility did not maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of communicable diseases and infections for 3 of 5 care observations for residents (R) (R13, R192, R6).</p> <p>Staff did not complete appropriate hand hygiene while providing care for R13's personal cares.</p> <p>Staff did not complete appropriate hand hygiene while providing care for R192.</p> <p>Staff used a contaminated scissors and used dirty gauze to complete wound care for R6.</p> <p>This is evidenced by:</p> <p>Facility policy titled, Handwashing/Hand Hygiene, with a revised date of 10/23 stated in part: This facility considers hand hygiene the primary means to prevent the spread of healthcare-associated infections.</p> <p>Indications for Hand Hygiene</p> <p>1. Hand hygiene is indicated:</p> <p>f. before moving from work on a soiled body site to a clean body site on the same resident;</p> <p>Example 1</p> <p>R13 was admitted to the facility on [DATE] with pertinent diagnoses of cerebral vascular accident (stroke), hemiplegia and hemiparesis (impaired movement) affecting left non-dominant side, obesity, and dementia.</p> <p>R13's most recent Minimum Data Set (MDS) annual assessment dated [DATE] noted a Brief Interview for Mental Status (BIMS) score of 15 indicating cognition intact, is dependent assist with toileting hygiene and personal cares, and always incontinent of bowel and bladder.</p> <p>R13's care plan dated 06/27/24 included: ADL self-care performance deficit with interventions of providing incontinence cares in bed with assist of 1-2.</p> <p>On 02/05/25 at 8:24 AM, Surveyor observed Certified Nursing Assistant (CNA) C provide R13 with incontinence care. CNA C gathered supplies at bedside, completed hand hygiene, and donned gloves. CNA C positioned R13 on left side and cleaned peri-area after bowel movement. CNA C then completed the remainder of R13's personal cares, transferred R13 with hooyer lift to recliner, placed blanket and personal items in reach of R13 without removing gloves and completing hand hygiene.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525535	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/06/2025
NAME OF PROVIDER OR SUPPLIER  Augusta Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  901 Bridge Creek Lane Augusta, WI 54722	
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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 02/05/25 at 10:30 AM, Surveyor interviewed CNA C regarding observation during cares. Surveyor asked CNA C why she didn't change her gloves after completing peri-cares after a bowel movement. CNA C shrugged and stated she didn't know. Surveyor asked if she should have changed her gloves before moving on to other cares for the resident. CNA C stated yes, she should have.</p> <p>On 02/06/25 at 2:21 PM, Surveyor interviewed Director of Nursing (DON) B regarding observation of cares. Surveyor asked DON B what the expectation would be for hand hygiene during personal cares. DON B stated that staff are expected to remove gloves, wash or disinfect hands, and don new gloves after completing peri-cares before moving on to the next body part. Surveyor informed DON B of observation of CNA C not completing hand hygiene during cares. DON B stated disappointment as staff are frequently educated on infection control. DON B stated recognition of the risk of infection by not completing appropriate hand hygiene and stated re-education with staff would be completed.</p> <p>47657</p> <p>Example 2</p> <p>On 02/06/25 at 8:09 AM, Surveyor observed CNA C conduct morning cares on R192.</p> <p>CNA C placed wash basin in sink, turned on hot water to run, put on a pair of clean gloves (no hand hygiene conducted prior) and assisted R192 to sit on edge of bed. CNA C applied a gait belt around R192's waist, picked up walker, placed in front of R192 and assisted R192 to stand and pivot to wheelchair.</p> <p>CNA C wheeled R192 to bathroom and assisted using gait belt with transfer from wheelchair to toilet.</p> <p>On 02/06/25 at 8:15 AM, Surveyor observed CNA C remove contaminated gloves, and without hand hygiene, put on clean gloves and removed gait belt from around R192's waist, removed pajamas and urine-soaked incontinent products</p> <p>CNA C removed the gait belt from around R192's waist, removed pajama top and urine-soaked incontinent product. CNA C removed gloves and changed to clean gloves. No hand hygiene was completed in between glove change.</p> <p>On 02/06/25 at 8:17 AM, Surveyor observed CNA C add water and clean washcloths to wash basin and handed washcloth to resident to wash own.</p> <p>On 02/06/25 at 8:19 AM, Surveyor observed CNA C continue cares without conducting hand hygiene or changing gloves. CNA C washed R192's back and upper torso, washing under breasts, rinsed and dried with towel, grabbed a bottle of powder, placed on gloves, applied powder under R192's breast, applied deodorant and applied shirt.</p> <p>On 02/06/25 at 8:22 AM, Surveyor observed CNA C continue cares, remove contaminated gloves, and without conducting hand hygiene, place on a clean pair of gloves and wash and dry R192's legs. CNA C applied lotion to R192's legs, removed contaminated gloves, placed on a clean pair without conducting hand hygiene and applied clean incontinent product, socks, shoes and pulled clean pair of pants to R192's knees.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525535	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/06/2025
NAME OF PROVIDER OR SUPPLIER  Augusta Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  901 Bridge Creek Lane Augusta, WI 54722	
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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 02/06/25 at 8:26 AM, Surveyor observed CNA C, without removing gloves or conducting hand hygiene, apply gait belt around R192's waist, move wheelchair close to R192, and assist R192 to stand while CNA C held onto gait belt and conducted peri care on R192.</p> <p>On 02/06/25 at 8:28 AM, CNA C stated to Surveyor, R192 is prone to urinary tract infections, while pulling up clean incontinent product and pants. CNA C assisted R192 to turn and sit in wheelchair, removed gait belt, removed contaminated gloves, and used hand sanitizer to assist with grooming R192 for the day.</p> <p>On 02/06/25 at 8:35 AM, Surveyor interviewed CNA C regarding expectation of facility of when to conduct hand hygiene during cares. CNA C stated after removing gloves. Surveyor shared observation of no hand hygiene conducted after glove changes during cares. CNA C confirmed she had not conducted hand washing or used sanitizer.</p> <p>46694</p> <p>Example 3</p> <p>On 02/05/25 at 6:35 AM, Surveyor observed wound care on R6's left lower leg by Licensed Practical Nurse (LPN) F. LPN F performed proper hand hygiene and put on a gown and single use gloves for this procedure. LPN F then removed a pair of bandage scissors from a box of dressings. LPN F then used that scissors to cut and remove the bandage from R6's left lower leg. LPN F then removed the dirty gloves, performed hand hygiene then put on a clean pair of gloves. LPN F took a stack of sterile 4x4 dressings and soaked them with normal saline and wiped R6's posterior left leg. LPN F used the same dirty 4x4's and cleaned the open and draining wound on the back of R6's left lower leg. LPN F then took the dirty bandage scissors used to cut off the dressing and cut the zeroform gauze and aquacel dressing that LPN F placed onto the open wound. LPN F secured the dressing with an abdominal dressing and covered with 4-inch kling wrap and secured this with tape.</p> <p>On 02/05/25 at 6:59 AM, Surveyor informed LPN F that the bandage scissors were not sanitized before or after procedure. LPN F replied, I should have sanitized after I cut off the bandage and before I cut the sterile dressings. Surveyor then replied, Also, I noticed that you wiped the front of the left leg where there was no open area and wiped with the same saline soaked gauze the open area on the back or side of the left calf. LPN F replied, I should have used a clean gauze for the open area.</p>		