

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525541	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/20/2025
NAME OF PROVIDER OR SUPPLIER Holton Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 645 N Church St Elkhorn, WI 53121	

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 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36246</p> <p>Based on record review, interview and policy review, the facility failed to ensure that an Agency Certified Nurse Aide (Agency CNA) possessed the information and skill set necessary to recognize an important change in condition for one of four sample residents (Resident (R) 1) when R1 experienced chest pain during the night and the Agency CNA did not report it to the nurse on duty. Failure to report a residents change in condition has the potential to cause harm to residents.</p> <p>Findings include:</p> <p>Review of the facility's policy titled, Acute Condition Changes-Clinical Protocol, revised in March 2018, indicated .Direct care staff, including nursing assistants will be trained in recognizing subtle but significant changes in the resident (for example, a decrease in food intake, increased agitation, changes in skin color or condition) and how to communicate these changes to the Nurse. The policy indicated .The nursing staff will contact the physician based on the urgency of the situation. For emergencies, they will call or page the physician and request a prompt response (within approximately one-half hour or less).</p> <p>Review of the Resident Face Sheet located in R1's electronic medical record (EMR) under the Demographics tab indicated R1 was admitted to the facility on [DATE], with diagnoses which included traumatic arthropathy, left knee-patellar instability, atherosclerotic heart disease of native coronary artery without angina pectoris, and atherosclerosis of coronary artery bypass graft(s) without angina pectoris-history of coronary artery bypass graft (CABG) four times.</p> <p>Review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/15/24 and located in R1's EMR under the MDS 3.0 tab indicated R1 had a Brief Interview for Mental Status (BIMS) score of five out of 15 which revealed R1 was severely cognitively impaired.</p> <p>Review of a statement provided by the facility and written by Skilled Nursing Facility (SNF) Certified Nurse Aide (CNA) 10 indicated that on the morning of 11/27/24 she was scheduled as the day aide on R1's nursing care unit. The statement indicated CNA10 received a report from the Agency CNA that had worked the night shift on that unit. The statement indicated that the Agency CNA told her that R1 had been up all night with chest pain and CNA10 asked if the Agency CNA had reported this to the nurse on duty that night, Licensed Practical Nurse (LPN) 3, and the Agency CNA replied that she had not reported it. The statement indicated that CNA10 reported it right away to the nurse coming on duty.</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 525541	If continuation sheet Page 1 of 4

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 03/20/25 at 10:53 AM, CNA10 stated she was the CNA on that unit for the day on 11/27/24, and when getting report from the Agency CNA, she mentioned that R1 had been up all night with chest pain. CNA10 stated she asked the Agency CNA if she had reported it to the nurse that had been on duty, and she said no. CNA10 stated she reported it to LPN3 right away.</p> <p>Review of the statement provided by the facility, from LPN3 indicated that between 7:15 and 7:20 AM on 11/27/24, she was told that R1 had experienced chest pain all night. The statement indicated that LPN3 questioned R1 about chest pain and R1 was able to tell LPN3 that she was short of breath and had pain in the middle of the chest (by pointing to the location). The statement indicated the physician, and the family member were notified and R1 was sent to the hospital.</p> <p>Review of a Progress Note, dated 11/27/24 at 7:48 AM, located in R1's EMR under the Resident Progress Notes indicated that R1 told LPN3 that she was having shortness of breath and chest pain overnight, the chest pain was located in the middle of the chest, radiating to the shoulders and the arms felt more weak than usual. The Progress Note indicated R1 denied having nausea, headache, dizziness, jaw pain or back pain. The Progress Note indicated R1's temperature was 97.3 degrees Fahrenheit with an oxygen concentration of 92% on room air, a blood pressure of 94/56, with a pulse of 91 beats per minute. The Progress Note indicated that the Physician was notified and R1 was sent to the hospital via ambulance.</p> <p>During an interview on 03/19/25 at 1:30 PM, the Family Member (FM) said R1 told a CNA that she was having chest pain and asked for help. The Family Member said this was not documented and said, they do not get it. The Family Member said that she was not saying the outcome would have been different, because R1 had been through a lot medically.</p> <p>During an interview on 03/20/25 at 11:45, the Medical Director said he was R1's physician. The Medical Director said the Agency Aide did not inform the Nurse on duty on the night shift but as soon as the day nurse was made aware of the information and assessed R1, he was notified. He said R1 had multiple co-morbidities and was terribly ill and frail, in general, for a long time. The Medical Director said the incident did not cause harm to R1 and said he did not feel that the outcome would have been different if he had been notified earlier. The Medical Director said that as soon as they discovered it, they acted, called us, and sent her out.</p> <p>Review of the Orientation Packet provided by the facility, that was received by the Agency CNA indicated the packet did not include the [Facility Name] Physician Notification Practice Guidelines from AMDA [American Medical Directors Association] which included guidelines relative to when staff should report things to a Nurse on duty and what to look for.</p> <p>Review of the [Facility Name] Physician Notification Practice Guidelines from AMDA indicated .Chest pain that is new onset, or recurrent, which is not relieved in 20 minutes by previously ordered Nitroglycerin pills x three doses, accompanied by a change in vital signs, diaphoresis, nausea, vomiting or shortness of breath should be reported immediately .</p> <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 03/20/25 at 9:00 AM, the Administrator said the facility used an Orientation Packet for facility staff as well as all Agency personnel that worked in the facility. The Administrator said that the Agency CNA that provided care on R1's nursing care unit on 11/27/24 received the packet and her signature, dated 09/17/24, was found on the document when it was reviewed. The Administrator said that the Agency CNA involved in this incident was no longer allowed to work at the facility. The Administrator also said that LPN3 was no longer employed at the facility. The Administrator said the packet had been revised to include information related to what needed to be reported and when. She said the revised packet has been provided to all Nursing Agencies that had their staff working at the facility.</p>		

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<p>F 0947</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention.</p> <p>36246</p> <p>Based on review of the facility policy and interview, the facility failed to ensure that seven of the 34 Skilled Nursing Facility (SNF) Certified Nurse Aides (CNA) 6, CNA9, CNA11, CNA13, CNA25, CNA29, and CNA33 reviewed for Continuing Education Requirements of 12 hours every 12-month period. Failure to ensure all CNAs receive the required ongoing education has the potential to decrease the quality of care for residents residing at the facility.</p> <p>Findings include:</p> <p>Review of the facility's policy titled, Continuing Educating Certified Nurse Aides, dated August 2022, indicated All nurse aide personnel participate in 12 hours continuing education per employee employment year. It further indicated Annual continuing education credits are no less than 12 hours per employee employment year.</p> <p>Review of the Continuing Education Records provided by the Administrator indicated seven CNAs were overdue for completing the 12-hour requirement as of 03/19/25.</p> <ol style="list-style-type: none"> 1. Review of CNA6's Continuing Education Record indicated CNA6 had a date of hire (DOH) of 03/01/23. Based on the facility policy and date of hire, CNA6 should have completed her 12 hours by 03/01/25. 2. Review of CNA9's Continuing Education Record indicated CNA9 had a DOH of 03/13/24. Based on the facility policy and date of hire, CNA9 should have completed her 12 hours by 03/13/25. 3. Review of CNA11's Continuing Education Record indicated CNA11 had a DOH of 02/17/21. Based on the facility policy and date of hire, CNA11 should have completed his 12 hours by 02/17/25. 4. Review of CNA13's Continuing Education Record indicated CNA13 had a DOH of 03/07/22. Based on the facility policy and date of hire, CNA13 should have completed her 12 hours by 03/07/25. 5. Review of CNA25's Continuing Education Record indicated CNA25 had a DOH of 03/01/23. Based on the facility policy and date of hire CNA25 should have completed her 12 hours by 03/01/25. 6. Review of CNA29's Continuing Education Record indicated CNA29 had a DOH of 03/04/21. Based on the facility policy and date of hire, CNA29 should have completed her 12 hours by 03/04/25. 7. Review of CNA33's Continuing Education Record indicated CNA33 had a DOH of 03/27/24. Based on the facility policy and date of hire, CNA33 should have completed her 12 hours by 03/27/25. <p>During an interview on 03/19/25 at 3:40 PM, the Administrator stated she was aware that some of the CNAs had not met the 12 hours every 12-month period, determined by their employee year, date of hire, for continuing education according to the facility policy and regulation.</p>		