

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525547	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/26/2024
NAME OF PROVIDER OR SUPPLIER Glendale Care and Rehab Center LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 6263 N Green Bay Ave Glendale, WI 53209	

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 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15406</p> <p>Based on interview, record review, and policy review, the facility failed to identify resident concerns as grievances and failed to provide a written response/resolution after receiving a grievance for 2 of 10 sampled residents (R2 and R3).</p> <p>Findings include:</p> <p>Review of the facility's policy titled, Resident and Family Grievances, dated 01/2024 and provided by the facility revealed, It is the policy of this facility to support each resident's and family member's right to voice grievances without discrimination, reprisal, or fear of discrimination or reprisal . Social Services has been designated as the Grievance Official . Grievance may be voiced in the following forums . a verbal complaint to a staff member or Grievance Official . The staff member receiving the grievance will record the nature and specifics of the grievance . forward the grievance form to the Grievance Official as soon as practicable . In accordance with the resident's right to obtain a written decision regarding his or her grievance, the Grievance Official will issue a written decision on the grievance to the resident or representative at the conclusion of the investigation .</p> <p>1. R2 was admitted to the facility on [DATE]. The MDS (Minimum Data Set) dated 09/03/24 indicated R2 was cognitively intact.</p> <p>During an interview on 11/26/24 at 8:53 AM, R2 stated on 11/16/24 (weekend) she and other residents in the dining room were served undercooked, bloody, and inedible chicken pieces. R2 stated she was not able to get anything else to eat and was hungry following the meal. R2 stated she reported the incident about undercooked chicken and the lack of alternates being available to DM C (Dietary Manager). R2 stated it was a formal complaint and there had been no follow up since it was reported.</p> <p>During an interview on 11/26/24 at 8:10 AM, DM C stated R2 had complained to him recently about undercooked chicken. DM C stated he was not working the day it was served but the next day he worked, he talked to [NAME] D and looked at the leftover pieces in the walk-in refrigerator. DM C stated the bigger pieces were a little pink but did not look bloody.</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
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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 11/26/24 at 2:57 PM, the DM stated the report of undercooked chicken occurred on 11/16/24 when [NAME] D was on duty. DM C stated [NAME] D reported to him one person complained about undercooked chicken and a CNA (Certified Nursing Assistant) brought the resident's tray back. DM C stated he checked the temperature log for the chicken and it was satisfactory. DM C stated he did not interview any additional residents or staff and verified he did not initiate a grievance form for R2.</p> <p>During an interview on 11/26/24 at 4:23 PM, SS F (Social Services) verified she was the Grievance Official. SS F stated grievances could come to her in numerous ways such as from a nurse, CNA, or resident coming to her with a concern. SS F stated it was important that grievances were logged to ensure they were handled in accordance with the facility's process and to ensure satisfactory resolution. SS F stated she was not aware of the report of undercooked chicken as a grievance had not been initiated. SS F stated the DM C should have initiated the grievance form or should have let social services know and she or her counterpart would have initiated one.</p> <p>During an interview on 11/26/24 at 5:56 PM, NHA A (Nursing Home Administrator) stated she had received a message from DON B (Director of Nursing) that the chicken served on 11/16/24 was red in the center. NHA A stated she went to the facility the next day on Sunday and met with [NAME] D. NHA A stated [NAME] D informed her there was no issue. NHA A stated she talked to a few residents who denied there was a concern. NHA A verified she had not interviewed any of the staff who served the chicken meal to the residents on 11/16/24. NHA A stated the incident was handled informally and did not go through the grievance process. NHA A stated that she concluded only R2 was affected.</p> <p>2. R3 was admitted to the facility on [DATE] with a diagnosis of dementia.</p> <p>During an interview on 11/25/24 at 9:52 AM, R3's Family Member stated she had concerns with how the facility handled R3's laundry, with missing clothing, and with a meal tray being left in R3's room with gnats swarming around it. Family Member stated she was not satisfied with the outcome of some of the grievances and stated she had not received a written response from the facility for any of the grievances she had filed:</p> <p>~06/12/24 R3's Family Member had concerns with missing clothing, ripped clothing, R3 being put to bed with pillows that did not have pillowcases, mixing up outfits, and that R3's laundry was going to the facility's laundry when she preferred to do the laundry. The form indicated the issues were addressed, the grievance was resolved on 06/13/24, and the concerned party was satisfied.</p> <p>~07/18/24 R3's Family Member had concerns with another resident's food tray being left in R3's room and had gnats flying around it. The form indicated the issue was addressed and the grievance was resolved on 07/18/24. The form did not indicate that the concerned party had been notified of the result or whether she was satisfied.</p> <p>~09/27/24 R3's Family Member had concerns with a missing outfit and two denim skirts. The investigation revealed the missing clothing was not listed on the inventory sheets. Family Member was educated on the importance of inventorying and labeling clothing. The request for reimbursement was denied because the items were not listed on the inventory sheets and the facility did not launder R3's laundry. Family Member was contacted on 10/01/24 and was not satisfied with the resolution.</p> <p>(continued on next page)</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>~10/01/24 R3's Family Member had a concern regarding R3's dirty laundry. Family Member was offered for R3's clothing to be laundered by the facility which Family Member refused. Family Member was contacted on 10/01/24 with the resolution which she was not satisfied.</p> <p>~10/02/24 R3's Family Member had a concern regarding a missing shirt and bottoms for R3. The investigation revealed the shirt had been replaced at a previous clothing drive and there were no inventory sheets with the shirt or bottoms noted. The family did R3's laundry. Family Member was notified on 10/03/24 and was not satisfied with the resolution.</p> <p>During an interview on 11/26/24 at 4:23 PM, SS F (Social Service) stated she was not R3's social worker and R3's social worker was out. SS F stated R3's Family Member had filed several grievances. SS F stated the facility reimbursed families/residents for missing clothing if the clothing was documented on an inventory sheet and the item could not be found. SS F stated families/residents were notified of the results of the grievance verbally; however, nothing was provided in writing.</p> <p>During an interview on 11/26/24 at 5:34 PM, NHA A (Nursing Home Administrator) stated she was aware of all of R3's Family Member's grievances and signed off on the grievance forms. NHA A stated Family member made complaints about missing clothing that the facility did not have logged on inventory sheets and the facility would not reimburse the Family Member for those items. NHA A stated the results of grievances were provided verbally, typically by a phone call; however, not in writing.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15406</p> <p>Based on observation, interview, and record review, the facility did not ensure that foods were prepared in a way that prevented the risk of foodborne illness for 5 of 10 sampled residents (R2, R5, R7, R8, R10).</p> <p>Interview with residents found that juices from the chicken served on 11/16/24 was red and touched all other foods on their plates. There was no investigation to determine what may have happened/how the food could have been under cooked, the number of residents who may have been affected, or to determine what steps need to be taken in order to avoid potential food borne illness.</p> <p>Findings include:</p> <p>~During an interview on 11/26/24 at 8:53 AM, R2 stated on 11/16/24 (weekend) she and other residents in the dining room were served undercooked chicken pieces. R2 stated the blood from the chicken contaminated the noodles, vegetables, and everything else on the plate.</p> <p>R2 was admitted on [DATE]. The Minimum Data Set (MDS) dated [DATE] indicated R2 was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 15 out of 15.</p> <p>~During an interview on 11/26/24 at 12:40 PM, R7 and R10 stated they were served uncooked chicken recently for lunch. R7 stated there was, blood coming onto the noodles .bright red blood . R10 stated, There was no way I could eat it. R7 and R10 stated there was nothing else available to eat. R10 stated her family was very upset about it. R7 and R10 verified the DM was not in the facility when it occurred.</p> <p>R7 was admitted to the facility on [DATE]. The MDS dated [DATE] indicated R7 had a BIMS score of 15 out of 15 indicating she was intact in cognition.</p> <p>R10 was admitted to the facility on [DATE]. The MDS dated ,d+[DATE] indicted R10 had a BIMS of 15.</p> <p>~During the resident group interview on 11/26/25 at 1:45 PM with R2, R5, R7, and R8, the residents complained about undercooked, inedible, chicken, the lack of an alternate, and that they went hungry due to not being able to eat their meals and no other food being available, which occurred on 11/16/24.</p> <p>R5 was admitted to the facility on [DATE]. The MDS dated [DATE] indicated R5 was cognitively intact with a BIMS of 14.</p> <p>R8 was admitted to the facility on [DATE]. The MDS dated [DATE] indicated R5 was cognitively intact with a BIMS of 15.</p> <p>Review of the Week at a Glance for General Week 4 menu revealed on 11/16/24 the supper (evening) meal consisted of baked chicken, herbed noodles, seasoned corn, and frosted cake. The alternate meal was meatballs with gravy.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 11/26/24 at 8:10 AM, DM C (Dietary Manager) stated R2 had complained to him recently about undercooked chicken. The DM stated he was not working the day it was served, but the next day he worked he talked to [NAME] D and looked at the leftover pieces in the walk-in refrigerator. The DM stated the bigger pieces were a little pink but did not look bloody. DM C stated the cook denied the chicken was undercooked.</p> <p>During an interview on 11/26/24 at 2:57 PM, DM C stated the report of undercooked chicken occurred on 11/16/24 when [NAME] D was on duty. DM C stated [NAME] D reported to him one person complained about undercooked chicken and a CNA (Certified Nursing Assistant) brought the resident's tray back. The chicken pieces served were legs and thighs, The DM stated he checked the temperature log for the chicken and the temperature for the chicken was satisfactory. The DM stated he did not interview any additional residents or staff related to the concern of undercooked chicken.</p> <p>During an interview on 11/26/25 at 3:44 PM, RD E (Registered Dietitian) stated she had not heard about undercooked chicken. RD E stated undercooked chicken could result in an outbreak of food borne illness and it would be important to investigate what the menu item was, how it was cooked, and what changes might need to be made in the future.</p> <p>During an interview on 11/26/24 at 5:03 PM, DON B (Director of Nursing) stated a CNA had informed her that the chicken served on 11/16/24 was not cooked and the food was returned to the kitchen. DON B stated she contacted NHA A (Nursing Home Administrator) and informed her of what the CNA reported to her.</p> <p>During an interview on 11/26/24 at 5:56 PM, NHA A stated she had received a message from DON B that the chicken served on 11/16/24 was red in the center. NHA A stated she went to the facility the next day (Sunday 11/17/24) and met with [NAME] D. NHA A stated [NAME] D informed her there was no issue. NHA A stated she talked to a few residents who denied there was a concern. NHA A stated the incident was handled informally and did not go through the grievance process. NHA A verified she had not interviewed any of the CNAs who served the chicken meal to the residents on 11/16/24. NHA A stated she concluded that only R2 had a concern with the chicken.</p>		