STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525548	A. Building B. Wing	12/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Peabody Manor	2600 S Heritage Woods Dr Appleton, WI 54915

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	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47248 Based on staff interview and record review, the facility did not ensure the resident environment remained as free of accident hazards as possible for 1 resident (R) (R9) of 1 sampled resident. R9 fell during an EZ Stand transfer on 7/8/24. Following the fall, R9's care plan was updated with an intervention to transfer R9 with the assistance of two staff for all EZ Stand transfers. On 12/8/24, Certified Nursing Assistant (CNA)-G transferred R9 via EZ Stand without a second staff present. R9 fell during the transfer and sustained a right tibial plateau fracture. R9 was assessed by therapy and a recommendation was made to transfer R9 with two staff and a Hoyer lift. R9's care plan was not properly updated. Findings include: The facility's Resident Plan of Care Policy, revised 7/15/24, indicates: The purpose of this policy is to outline the standards and processes for providing high quality, person-centered care to all residents through a plan of care to promote continuity of care, communication among team members, resident safety, and safeguard against an adverse event .The following elements of a resident's plan of care may be kept in the resident's medical record: a. Nursing care (i.e., self-care deficit, restorative, fall prevention, skin injury, elimination, pain, and other specific needs as identified) .Documentation will include the following: .individualized interventions. The Interdisciplinary Team (IDT) will update/document a plan of care following an incident or event that causes a change in the plan of care or resident's condition . The facility's Resident Fall and Injury Prevention Policy, revised 10/22/24, indicates: The purpose of this policy is to outline the standards and processes to monitor long-term care environments and resident safety to prevent resident falls and injuries .Interventions will be assessed and added to the resident plan of care as needed .E. Post Fall Care and Post Fall Huddle: 1. If a resident fall occurs, team members will .d. Review the plan of care and update with new fall interventions . On 12/17/24, Surveyor reviewed R9's medical record. R9 had diagnoses including tibial plateau fracture-right (12/8/24), restless leg syndrome, lymphedema, and primary osteoarthritis of both knees. R9's Minimum Data Set (MDS) assessment, dated 11/15/24, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R9 was not cognitively impaired. R9 was R9's own decision maker. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525548	A. Building B. Wing	12/18/2024

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Peabody Manor	2600 S Heritage Woods Dr Appleton, WI 54915

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	R9's medical record indicated R9 fell on [DATE] during an EZ Stand transfer. Nursing staff indicated R9 coughed, appeared to lose consciousness, and slid out of the EZ Stand. R9's care plan was updated with an intervention for the assistance of two staff during all EZ Stand transfers. The facility's EZ Stand slings were replaced to ensure the slings secured properly. R9 did not sustain an injury during the fall. R9's medical record indicated R9 fell on [DATE] during an EZ Stand transfer and sustained a right knee tibial plateau fracture. The facility's investigation indicated CNA-G transferred R9 with an EZ Stand lift without a second staff present. R9 indicated R9's knee buckled and R9 began to fall which caused the EZ Stand to tip over. R9 fell to the floor on R9's left side and the EZ Stand was in contact with R9's right knee. R9 had pain and bruising and was sent to the emergency room (ER). An X-ray identified the fracture. The facility's investigation indicated an intervention was initiated on 12/8/24 to use a Hoyer lift when R9 felt weak. A progress note, dated 12/11/24, indicated R9 was assessed by physical therapy staff for use of a lift. Documentation indicated R9 required a Hoyer lift with the assistance of two staff for all transfers. A Hoyer lift was determined to be the most appropriate and safest transfer technique due to R9's history of falls in the EZ Stand. On 12/17/24, Surveyor reviewed R9's care plan which stated the following, Please don (put on) my air splint on my L (left) ankle when I get up in the morning before using EZ stand lift .I transfer with assist of 2 people and Hoyer lift. I must have air splint on my L ankle to stand with the lift. Bathroom needs met with urinal and bed pan. I must have air splint on my L ankle to stand with the lift. On 12/17/24 at 1:24 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B. NHA-A and DON-B indicated a care plan intervention was added for two staff with all EZ Stand transfers following R9's fall on 7/8/24 because R9 had periods of unconsciousness during transfers. NHA-A indicated medical tests were completed to rule out ongoing medical issues and stated the intervention was initiated to ensure safety during transfers. DON-B indicated CNA-G did not follow R9's care plan on 12/8/24 and did not have a second staff present when CNA-G transferred R9 with the EZ Stand. During the investigation, CNA-G confirmed there was not a second staff present during the transfer. Following the fall, DON-B indicated R9's fall prevention care plan was updated on 12/11/24 with an intervention to use a Hoyer lift for all transfers following a physical therapy assessment of R9. DON-B confirmed R9's care plan should not include verbiage about donning a splint for EZ Stand lift use and indicated R9 should only be transferred with a Hoyer lift. DON-B indicated the EZ Stand portion of the care plan was forgotten and should have been removed. DON-B indicated R9's care plan would be revised to remove the verbiage that R9's left leg splint should be applied prior to EZ Stand transfers. On 12/17/24 at 3:00 PM, Surveyor interviewed NHA-A who indicated an investigation was completed following R9's fall on 12/8/24. NHA-A indicated staff were educated on transfers and following care plans and stated the lift manufacturer came to the facility to ensure all lifts were in proper working order. NHA-A indicated the facility provided staff training but possibly should have focused more time on the care plan to ensure R9's care plan was updated properly.