STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525549	A. Building B. Wing	04/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Square Health Care Center	5404 W Loomis Rd Greendale, WI 53129

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 40533 Based on interview, observation and record review, the facility did not ensure 1 (R1) of 4 residents reviewed for quality of care received with treatments and care provided to facility residents. R1 was having pain across his chest and his rib area. R1 was given Tylenol by Med Tech (MT)-D. Med Tech-D did not alert a Registered Nurse to assess the resident's cardiac status, did not obtain vital signs and did not ask the resident what level of pain (on a 0 to 10 scale) he was at. MT-D charted that the medication was effective but he did not return to the resident to ask the resident if the medication was effective. No MD was updated on the resident's chest pain and possible change of condition. Findings include: Surveyor reviewed facility's Notification of Changes Policy with an implementation date of 3/1/19. Documented was: POLICY 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, a reported to the attending physician or delegate (hereafter designated as the physician). The resident and/or their representative will be educated about treatment options and supported to make an informed choice about care preferences when there are multiple care options available. All pertinent information will be made available to the provider by the facility staff. Nurses and other care staff are educated to identity changes in a resident's status and define changes that require notification of the resident and/or their representative, and the resident's physician, to ensure best outcomes of care for the resident . OVERVIEW OF COMPONENTS OF THE POLICY 1. Requirements for notification of resident, the resident representative and their physician: 1) An accident involving the resident, which results in injury and has the potential for requiring physician intervention. (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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2) A significant change in the resident's physical, mental, or psychosocial status. 3) A significant change includes deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications . Notification is provided to the physician to facilitate continuity of care and obtain input from the physician about changes, additions or discontinuation of treatments . PROCEDURE 1. The nurse will immediately notify the resident, resident's physician and the resident representative(s) for the following (list is not all inclusive): a. An accident involving the resident, which results in injury and has the potential for requiring physician intervention. b. A significant change in the resident's physical, mental, or psychosocial status that is a deterioration in the health, mental or psychosocial status in either life threatening conditions or clinical complication. c. A need to alter treatment significantly (a need to discontinue or change an existing form of treatment due to adverse consequences, or to commence a new form of treatment . 3. Document the notification and record any new orders in the resident's medical record. 4. Educate the resident and/or representative about the proposed plan to treat, manage or monitor the resident's change in condition . R1 was admitted to the facility 12/11/23 with diagnoses that included Aftercare for Right Femur Fracture, COPD, Respiratory Condition Due to Other Specific External Agents, Diabetes Mellitus 2, Acute Respiratory Failure with Hypoxia, Atrial Fibrillation, Coronary Artery Disease, Edema and Hypertension. Surveyor reviewed R1's MDS (Minimum Data Set) Assessment with an assessment reference date of 12/14/23. Documented under Cognition was a BIMS (brief interview mental status) score of 11 which indicated moderate cognitive impairment. Surveyor reviewed R1's Comprehensive Care Plan with an initiation date of 12/12/23. Documented was: Focus: Impaired Cardiovascular status related to: Cardiac Dysrhythmia's, Congestive Heart Failure (CHF), Coronary Artery Disease (CAD), Hypertension Goal: Will be free of Symptoms (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interventions: - Assess breath sounds as necessary and report abnormalities - Assess productive/nonproductive cough, SOB/exertional dyspnea, dyspnea at rest, paroxysmal night dyspnea, or orthopnea - Diet as ordered - Elevate lower extremities as indicated - Encourage activity and mild exercise to tolerance - Head of bed elevated - Lab work or X-rays as ordered by physician - Listen to patient when verbalizing concerns over disease symptoms and address issues raised - Medications as ordered by physician and Observe use and effectiveness - Monitor oxygen saturation - Monitor weight and report significant changes - Observe and report headaches, flushing, nosebleeds, nausea, shortness of breath - Observe and report signs of chest pain, edema, SOB, abnormal pedal pulse, restlessness, and fatigue - Observe for abnormal vital signs and report - Observe for changes in condition - Observe for changes in stamina and endurance and report any changes Surveyor reviewed R1's Progress Notes. Documented on 3/3/24 at 8:59 PM was administration of 650 mg of Tylenol by MT-D. Documented under Note was [Patient complained of] pain across his chest and his rib area. Documented on 3/3/24 at 9:22 PM by MT-D was a follow up assessment that stated Effective. Surveyor reviewed R1's Electronic Medical Record. There was no Registered Nurse (RN) assessment done on R1 after R1 complained of chest pain. There was no update to any MD notifying them of R1's chest pain. There was no numerical level of pain taken by MT-D noting how severe R1's pain was. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/8/24 at 2:55 PM Surveyor interviewed MT-D. Surveyor asked about R1's pain on 3/3/24. MT-D stated it was on both sides of his ribs and spread across his chest. Surveyor asked if he got a number level of pain. MT-D stated no. Surveyor asked if he went back and reassessed his pain as Effective as he had charted. MT-D stated no, he passed that on to the night shift nurse. Surveyor asked when administering a pain med how long do you wait to evaluate its effectiveness. MT-D stated about an hour and that is why he had night shift assess, he left at 10:00 PM. Surveyor asked if he reported the chest pain to a nurse. MT-D stated no, he did not think about it as chest pain, more as rib pain. On 4/9/24 at 10:27 AM Surveyor interviewed Agency Licensed Practical Nurse (LPN)-E. Surveyor asked if MT-D reported R1 was having rib and chest pain. LPN-E stated no. Surveyor asked LPN-E if MT-D instructed her to do a follow up pain assessment on R1. LPN-E stated no. LPN-E stated she took over the medication cart MT-D had on PM shift but no report on R1 was given. On 4/9/24 at 11:15 AM Surveyor interviewed MD-C. Surveyor asked if a resident was having pain across his chest and his rib area would he want to be notified. MD-C stated yes. Surveyor asked if a resident states this should there be an RN assessment completed. MD-C stated yes. Surveyor asked if he would like any other information at the time of assessment. MD-C stated a set of vital signs. On 4/9/24 at 11:29 AM Surveyor interviewed Director of Nursing (DON)-B. Surveyor asked if a resident stated he was having pain across his chest and his rib area to a Med Tech would you expect them to update a Nurse? DON-B stated yes; review the information with the nurse to get some direction. Surveyor asked if she knew MT-D never followed up with the resident and that Effective was documented but not verified. DON-B stated she did not know that. Surveyor asked in that case would you update the MD. DON-B stated someone should have followed up with the resident and if it was not effective, then yes. Surveyor noted that MD-C stated he would have liked to be updated in this case. DON-B stated then they will update him.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident’s drug regimen must be free from unnecessary drugs. 40533 Based on interview and record review, the facility did not ensure that 1 (R1) of 3 residents reviewed for medications were adequately monitored for Warfarin side effects. R1 was admitted to the facility with an order for Warfarin daily. The facility did not implement a care plan or orders to monitor for any adverse side effects that could result from taking an anticoagulant. Findings include: Surveyor reviewed facility's High Risk Medications - Anticoagulants with an implementation date of 3/1/19. Documented was: POLICY This facility recognizes that some medications, including anticoagulants, are associated with greater risks of adverse consequences than other medications. This policy addresses the facility s collaborative, systematic approach to managing anticoagulant therapy for efficacy and safety . Policy Explanation and Compliance Guidelines: 1. Anticoagulants shall be prescribed by a physician or other authorized practitioner with clear indications for use. Examples include prevention and treatment of deep vein thrombosis, pulmonary embolism, atrial fibrillation with embolization, stroke or management of myocardial infarction. 2. Target symptoms (i.e. lab values) and goals for use (i.e. prevention or treatment) of anticoagulants shall be documented in the resident's medical record. Duration of use shall be appropriate to the resident's condition and indication for use. 3. Routine labs, including baseline and subsequent labs, shall be ordered for each resident requiring anticoagulant medication. Results shall be communicated to the physician in a timely manner. a. Lab results within normal limits and within the target range for the individual resident shall be communicated via normal/routine procedure. b. Lab results that are outside the normal limits or target range for the individual resident, but not critical values, shall be communicated to the physician within 24 hours. c. Lab results that are considered critical values per facility lab specificity shall be communicated to the physician immediately upon receipt of the critical lab value, but no greater than 2 hours. 4. The resident's plan of care shall alert staff to monitor for adverse consequences. Risks associated with anticoagulants include: a. Bleeding and hemorrhage (bleeding gums, nosebleed, unusual bruising, blood in urine or stool) (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. Fall in hematocrit or blood pressure c. Thromboembolism 5. The resident's plan of care shall include interventions to minimize risk of adverse consequences. Examples include (depending on the medication): a. Limit venipunctures and injections, as possible. Be aware of the need to apply pressure following these procedures. b. Use soft toothbrush and electric razors. c. Limit intake of foods high in vitamin K: broccoli, cabbage, collard greens, spinach, kale, turnip greens, and brussel sprouts. d. Avoid cranberry juice and cranberry products. e. Caution resident/family about alcohol use while taking anticoagulants. f. Educate resident/family on risks of bleeding, dietary modifications, and symptoms to report to nurse/physician. g. Avoid (strenuous) activities that may lead to injury. 6. A licensed pharmacist shall review each resident's medication regimen at designated intervals as needed. Irregularities are reported and addressed in accordance with facility policy for medication regimen reviews and addressing irregularities. R1 was admitted to the facility 12/11/23 with diagnoses that included Aftercare for Right Femur Fracture, COPD, Respiratory Condition Due to Other Specific External Agents, Diabetes Mellitus 2, Acute Respiratory Failure with Hypoxia, Atrial Fibrillation, Coronary Artery Disease, Edema and Hypertension. Surveyor reviewed MD orders for R1. R1 had an order for Warfarin from admission to discharge that had a dose changed frequently by MD-C. There was an order with a start date of 12/15/23 that documented Monitor for [signs and symptoms] of bleeding every shift for bleeding. This order did not specify what the bleeding was from or where and did not specify an anticoagulant. Surveyor reviewed R1's Care Plan. There was no care plan directing staff to monitor for side effects of anticoagulation therapy. On 4/9/24 at 11:15 AM Surveyor interviewed MD-C. Surveyor asked if staff should be monitoring for signs of side effects of anticoagulation therapy. MD-C stated yes, at a minimum bleeding and bruising. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/9/24 at 11:29 AM Surveyor interviewed Director of Nursing (DON)-B. Surveyor asked if staff should be monitoring for signs of side effects of anticoagulation therapy. DON-B stated yes. Surveyor asked what should they be looking for. DON-B stated signs and symptoms pf bleeding and bruising, change in condition and cardiac symptoms. Surveyor asked if there should be orders and a care plan. DON-B stated yes.