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	01/08/2025

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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48391 Based on observation, interview, and record review the facility did not ensure 1 (R8) of 4 residents reviewed with pressure injuries had the necessary care and treatment to prevent and heal pressure injuries. R8 developed a facility acquired, unstageable pressure injury to their right great toe despite being at risk for the development of pressure injuries. R8's skin was not assessed upon admission and an individualized care plan was not developed based upon R8's risks and care needs. Assessments by the contracted wound care provider incorrectly identified the location of the wounds. Facility wound assessments were not comprehensive. Findings include: The facility's policy titled, Wound Management documents: . In the absence of treatment orders, the licensed nurse will notify the physician to obtain treatment orders. This may be the treatment nurse, or the assigned licensed nurse in the absence of the treatment nurse. Treatment decisions will be based on: Etiology of the wound: Pressure injuries will be differentiated from non-pressure injuries, such as arterial, venous, diabetic, moisture or incontinence related skin damage. Surgical, Incidental, Atypical Characteristics of the wound: Pressure injury stage (or level of tissue destruction if not a pressure injury) Size - including shape, depth, and presence of tunneling and/or undermining. Volume and characteristics of exudate (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
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F 0686 Level of Harm - Actual harm Residents Affected - Few	Presence of pain Presence of infection or need to address bacterial bioburden Condition of the tissue in the wound bed Condition of peri-wound skin Location of the wound Goals and preferences of the resident/representative Guidelines for dressing selection may be utilized in obtaining physician orders. The guidelines are to be used to assist in treatment decision making. Due to unique needs and situations of individuals, the guidelines may not be appropriate for use in all circumstances. The facility will follow specific physician orders for providing wound care. Treatments will be documented on the treatment administration record (TAR) The effectiveness of treatments will be monitored through ongoing assessment of the wound. Considerations for needed modifications include: Lack of progression towards healing Changes in the characteristics of the wound. Changes in the residence goals and preferences, such as at end of life or in accordance with his/her rights. R8 was admitted to the facility on [DATE] and has diagnoses that include muscle wasting and atrophy, epilepsy, dysphagia, abnormalities in gait and mobility, dementia, adult failure to thrive, and peripheral vascular disease. R8's hospital discharge paperwork dated 11/27/24 documents R8 as having the following pressure injuries: Left great toe wound that is unstageable with eschar and necrotic tissue. Treatment orders include betadine on Monday, Wednesday, and Friday and to keep open to air. Right heel wound that is unstageable with eschar, skin intact, and necrotic. Treatment orders include paint with betadine, cover with gauze and secure with Kerlix dressing on Monday, Wednesday, and Friday. Surveyor notes the facility did not place treatment orders until 12/2/24. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 1/7/25, at 9:53 am, Surveyor interviewed Licensed Practical Nurse (LPN) - H who indicated nurses will typically get wound care orders from the hospital discharge paperwork with a newly admitted resident. LPN-H states they will call the hospital if they do not receive wound care orders and will also contact the facility provider for wound care orders. LPN- H states the facility nurse will contact the provider service (name of telehealth provider) for orders if it is after hours. LPN- H states every resident receives a comprehensive skin assessment by the facility nurse on the day of admission R8's facility admission medical records include a Clinical Admission assessment dated [DATE], identifying R8 as having a right heel wound present on admission that is painful. Surveyor notes there are no measurements, staging, or properties for the right heel wound on admission. Surveyor also notes the left great toe wound is not identified or documented by the facility on the Clinical Admission Assessment. Surveyor notes no comprehensive skin assessments being completed on admission on 11/27/24. R8's Admission Minimum Data Set (MDS) with an assessment reference date of 12/1/24 documents R8 is dependent with rolling left to right, chair and bed transfers, and shower/tub transfers. R8's MDS documents R8 as being at risk for pressure injuries and has one unstageable pressure injury and one Deep Tissue Injury (DTI). R8 was documented as having a Brief Interview for Mental Status (BIMS) score of 15 indicating R8 is cognitively intact. R8's care plan, dated 11/27/24, documents: A physical functioning deficit related to mobility impairment and self-care impairment (date initiated 11/29/24). Interventions include: (R8) requires a Hoyer lift with assistance of two for transfers (date initiated 11/29/24). (R8) requires total assistance for bed mobility (date initiated 11/29/24). (R8) has altered skin integrity with wounds to his left toe and right heel upon admission and wounds to his right toe. (R8) refuses to wear heel boots (date initiated 11/29/24). Interventions include: (R8) requires an air mattress (date initiated 11/29/24). Conduct weekly skin inspection (date initiated 11/29/24). (R8) will wear bilateral heel boots at all times. Staff will encourage (R8) to wear them (date initiated 12/19/24). Monitor for signs and symptoms of infection such as swelling, redness, warm discharge, odor, notify physician of significant findings (date initiated 11/29/24). Provide pressure reduction/relieving mattress (date initiated 11/29/24). (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Weekly wound evaluation (date initiated 11/29/24). Surveyor reviewed R8's Braden Scale's (a clinical tool used to assess a resident's risk for developing pressure injuries) which document the following: 11/27/24 R8 is high risk for developing pressure injuries. 12/4/24 R8 is at moderate risk for developing pressure injuries. 12/11/24 R8 is at high risk for developing pressure injuries. 12/25/24 R8 is at high risk for developing pressure injuries. 1/1/25 R8 is at moderate risk for developing pressure injuries. Surveyor noted R8's Braden Scales dated 12/4/24 and 1/1/25 document R8 is independent with rolling/moving in bed which is not reflected in R8's other assessments and impacted the overall score to assess R8's overall risk for developing pressure injuries with the Braden tool. Surveyor reviewed R8's medical record which documents a provider progress note dated 11/30/24, with wound care instructions to the right heel and left great toe. Surveyor notes orders were not present on R8's Medication Administration Record (MAR) or TAR until 12/2/24. On 12/2/24 R8 was seen and evaluated by a contracted wound care provider. The documentation of this visit indicates the following: *Unstageable right heel DTI pressure injury with necrosis that was present on admission per staff. Measuring 6 cm x 3.8 cm x not measurable, with a surface area of 22.80 cm. 100% thick adherent black necrotic tissue (eschar) is present. Recommendations to apply betadine once daily and to off-load wound. *Unstageable right great toe DTI pressure injury that was noted on admission per staff. Measuring 1.3 cm x 1. 8 cm x not measurable, with a surface area of 2.34 cm. Skin is intact with purple/maroon discoloration present. Recommendations to apply betadine once daily and off-load wound. Surveyor notes the hospital discharge documentation identified R8 as having unstageable pressure injuries on the right heel and left great toe at the time of discharge that were noted to have eschar present. There is no comprehensive assessment of the wounds by the facility to support the present upon admission statement. Additionally, it was not assessed upon admission that R8 had a pressure injury on their right great toe. Surveyor noted treatment orders were now initiated for R8 despite having recommended treatment orders since admission on 11/27/24. On 12/9/24 R8 was seen and evaluated by a contracted wound care provider. The documentation of this visit indicates the following: (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	*Unstageable right heel DTI pressure injury with necrosis that was present on admission per staff. Measuring 6 cm x 3.2 cm x not measurable, with a surface area of 19.20 cm. 100% thick adherent black necrotic tissue (eschar) present. Wound progress has improved evidence by decreased surface area. Recommendations to apply betadine once daily and to off-load wound. *Unstageable right great toe DTI pressure injury that was noted on admission per staff. Measuring 1.3 cm x 1. 8 cm, x not measurable, with a surface area of 2.34 cm. Skin is intact with purple/maroon discoloration and wound progress at goal. Recommendations to apply betadine once daily and to off-load wound. Surveyor notes the wound care progress note for R8 documents the DTI was identified as the right great toe instead of the left great toe in error. *A new unstageable DTI of the right first toe pressure injury measuring 1.2 cm x 1.6 cm x not measurable with a surface area of 1.76 cm. Skin is intact with purple/maroon discoloration. Recommendations to apply betadine once daily and off-load wound. Surveyor notes this is a new facility acquired pressure injury for R8. Review of R8's care plan indicates no revisions were made to the care plan to help prevent further decline or development of pressure injuries to R8's toes. On 12/16/24 R8 was seen and evaluated by a contracted wound care provider. The documentation of this visit indicates the following: *Unstageable right heel DTI pressure injury with necrosis that was present on admission per staff. Measuring 5.9 cm x 3.2 cm x not measurable, with a surface area of 18.88 cm. 100% thick adherent black necrotic tissue (eschar) present. Wound progress has improved as evidence by decreased surface area. Recommendations to apply betadine once daily and to off-load wound. Unstageable DTI of the right first toe pressure injury measuring 1.1 cm x 1.6 cm x not measurable, with a surface area of 1.76 cm. Skin is intact with purple/maroon discoloration. Duration of wound > 11 days. Recommendations to apply betadine once daily and off-load wound. *Unstageable left great toe DTI pressure injury that was noted on admission per staff. Surveyor notes the wound care progress note for R8 documents the DTI now being corrected to be the left great toe that was noted in the hospital discharge documents at the time of discharge from the hospital. This area measures 2 cm x 1.8 cm, x not measurable, with a surface area of 3.60 cm. Skin is intact with purple/maroon discoloration and wound progress is not at goal. Recommendations to apply betadine once daily and to off-load wound. Surveyor notes this wound is not at goal and measurements are greater than the previous week. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The first facility wound assessment was completed on 12/18/24 by Licensed Practical Nurse (LPN)- O which documents R8 having a right heel wound that was present on admission. Surveyor notes there are no measurements or detailed characteristics assessed regarding the right heel wound. Surveyor also noted the left great toe and right first toe pressure injuries are not identified on the 12/18/24 facility skin assessment. Surveyor noted the facility skin assessment being completed by LPN- O with no registered nurse (RN) assessment. Surveyor noted this is the first facility wound assessment initiated by facility nursing staff despite R8 being admitted to the facility on [DATE]. Additional review of R8's medical record indicates the same assessment forms were documented dated 12/22/24, 12/29/24, and 1/5/25 which documented the same details as the 12/18/24 assessment completed by LPN-O. Surveyor noted the facility assessment sheets Surveyor noted these assessments were not completed upon current standards of practice and did not include a comprehensive assessment by an RN. Surveyor reviewed R8's TAR and noted missed wound care treatments on 12/19/24 and 12/20/24. On 12/23/24 R8 was seen and evaluated by a contracted wound care provider. The documentation of this visit indicates the following: *Unstageable right heel DTI pressure injury with necrosis that was present on admission per staff. Measuring 5.9 cm x 3.2 cm x 0.1 cm, with a surface area of 18.88 cm. 90% thick adherent black necrotic tissue (eschar) and 10% granulation tissue present. Wound progress is at goal. Recommendations to apply betadine once daily and to off-load wound. *Unstageable DTI of the right first toe pressure injury measuring 1.1 cm x 1.6 cm x not measurable, with a surface area of 1.76 cm. Skin is intact with purple/maroon discoloration. Duration of wound > (greater than) 18 days. Wound progress is at goal. Recommendations to apply betadine once daily and to off-load wound. *Unstageable left great toe DTI pressure injury that was noted on admission per staff. Measuring 2 cm x 1.8 cm, x not measurable, with a surface area of 3.60 cm. Skin is intact with purple/maroon discoloration and wound progress is at goal. Recommendations to apply betadine once daily and to off-load wound. On 12/30/24 R8 was seen and evaluated by a contracted wound care provider. The documentation of this visit indicates the following: *Unstageable right heel DTI pressure injury with necrosis that was present on admission per staff. Measuring 5.9 cm x 3.2 cm x 0.1 cm, with a surface area of 18.88 cm. 90% thick adherent black necrotic tissue (eschar) and 10% granulation tissue present. Wound progress is at goal. Recommendations to apply betadine once daily and to off-load wound. *Unstageable DTI of the right first toe pressure injury measuring 1.1 cm x 1.6 cm x not measurable, with a surface area of 1.76 cm. Skin is intact with purple/maroon discoloration. Duration of wound > 25 days. Wound progress is at goal. Recommendations to apply betadine once daily and to off-load wound. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	*Unstageable left great toe DTI pressure injury that was noted on admission per staff. Measuring 1.9 cm x 1. 8 cm, x not measurable, with a surface area of 3.42 cm. Skin is intact with purple/maroon discoloration and wound progress is improved as evidenced by decreased surface area. Recommendations to apply betadine once daily and to off-load wound. On 1/7/25, at 8:32 am, Surveyor observed R8 laying on his back in bed with his head of the bed up approximately 45 degrees. R8 was sleeping and appeared to be comfortable with his heels resting directly on the bed and not off loaded. Surveyor observed R8's blankets to be resting directly on top of his toes and heel boots were observed on a shelf across the room. On 1/7/25, at 9:16 am, Surveyor interviewed R8 who stated he does not like wearing his heel boots due to pain. R8 indicates the heel boots cause him a lot of pain. R8 was noted to have his heels resting directly on his bed with his blankets directly on his toes. On 1/8/25, at 9:15 AM, Surveyor observed R8's wound care with LPN- D. Surveyor entered the room and R8 was observed lying in bed on his back with head of bed up approximately 45 degrees. R8's heels were observed to be floated with a pillow and blankets laying directly across R8's toes and feet. R8's right great toe revealed a dime size necrotic/black area on the tip of the toe, slightly medial, with no redness to the surrounding area and no odor. R8's left great toe revealed a nickel sized necrotic/black area on the tip of the toe with no redness to the surrounding area and no odor. R8's left heel displayed no redness and no signs or symptoms of pressure injury. R8's right heel revealed a large necrotic/black area on the back of the heel. The black area extended to the lateral side of the heel to the achilles area. Surveyor observed LPN- D applied betadine to R8's right heel, left great toe, and right great toe. On 1/8/25, at 9:46 am, Surveyor interviewed Director of Nursing (DON)- B and Assistant Director of Nursing (ADON)- C regarding concerns with R8's pressure injuries. Surveyor discussed R8 was admitted to the facility on [DATE], with no comprehensive skin assessment on admission, R8 did not have wound care treatment orders implemented until 12/2/24, and R8 developed a facility acquired DTI to his right first toe. Surveyor discussed R8's contracted wound care assessments documenting inaccurate pressure injury sites on 12/2/24 and 12/9/24. DON-B and ADON-C acknowledged the contracted wound care provider had inaccurately documented their assessment indicating the wrong toe/location on R8. Surveyor asked about R8's facility skin assessments not identifying R8's DTIs to his right great toe and left great toe, and all of R8's facility skin assessments being completed without an RN assessment. No additional information or clarification was provided at this time by DON-B or ADON-C. DON- B and ADON- C understood the concerns and had no additional information.

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F 0689 Level of Harm - Minimal harm or potential for 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** 48391 Based on observation, interview, and record review the facility did not ensure 1 (R8) of 4 residents reviewed for accidents received adequate supervision and assistance devices to prevent residents from sustaining falls. On 12/22/24, at 6:50 am, R8 sustained an unwitnessed fall and was found by facility staff lying on the floor with his left arm stuck in his bed rail. The facility did not complete a bed rail assessment prior to R8 having bed rails (cross-reference F700). The facility did not complete a thorough fall investigation, determine a root cause for his fall, complete reassessments to determine if bed rails continue to be appropriate for R8, and create a care plan with interventions in a timely manner. Findings include: The facility's Fall Risk Assessment that is not dated, documents: Each resident will be assessed for the risks of falling and will receive care and services in accordance with the level of risk to minimize the likelihood of falls. 1. The facility utilizes a standardized risk assessment for determining fall risk. The risk assessment categorizes residents as a high risk with a score of 10 or greater. The risk assessment will be completed upon admission, quarterly, or when a significant change is identified. 2. Upon admission, the nurse will complete a fall risk assessment along with the admission assessment to determine the resident's level of fall risk. 3. The nurse will initiate interventions on the resident's baseline care plan if the resident indicates high risk. 4. Each resident's risk factors, and environmental hazards will be evaluated when developing the residents comprehensive plan of care. 5. When any resident experiences a fall, the facility will: Assess the resident. Complete an event documentation report. Complete a fall risk assessment. Notify physician and family. Review the residence care plan and update as indicated. Document all assessments and actions. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	If a fall is witnessed, obtain witness statement. R8 is a [AGE] year-old resident who was admitted to the facility on [DATE]. R8's diagnoses include muscle wasting and atrophy, epilepsy, dysphagia, abnormalities in gait and mobility, dementia, adult failure to thrive, and peripheral vascular disease. R8's Admission Minimum Data Set (MDS) completed on 12/1/24 documents that R8 is dependent with rolling left to right, chair and bed transfers, and shower/tub transfers. R8's MDS documents no falls in the last month prior to admission. R8's MDS documents no bed rail in use. R8 was documented as having a Brief Interview for Mental Status (BIMS) score of 15 indicating R8 is cognitively intact. R8's care plan, dated 11/27/24, documents: A physical functioning deficit related to mobility impairment and self-care impairment (date initiated 11/29/24). Interventions include: (R8) requires a Hoyer lift with assistance of two for transfers (date initiated 11/29/24). (R8) requires total assistance for bed mobility (date initiated 11/29/24). (R8) is at risk for falls related to new environment (date initiated 12/4/24). Interventions include: Call light and personal items available and in reach or provider reacher (date initiated 12/8/24). Keep environment well lit and free of clutter (date initiated 12/8/24). Keep personal items within reach (date initiated 12/8/24). (R8) experienced a fall from bed (date initiated 12/22/24). Interventions include: Bed in low position (date initiated 12/22/24). Call light within reach (date initiated 12/22/24). Educate staff on proper linen for air mattress. Staff to continue toilet program every two to three hours and as needed (date initiated 12/22/24). (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor reviewed the facility fall investigation dated 12/22/24 for R8. The fall investigation documents Licensed Practical Nurse (LPN)- I was called into R8's room on 12/22/24 at 6:50 am. R8 was observed to be in a sitting position leaning against the enable bars. R8 appeared to have slid out of bed and was noted on the air mattress. R8 was last checked and changed on 12/22/24 at 4:45 am. R8 was wrapped in sheets and staff lowered R8 to the floor for safety. R8 was assessed and Hoyer lifted back to bed. R8's call light was attached to his bed linen. R8 stated he was trying to contact staff and stated he did not know where his call light was. The facility fall investigation indicates R8's Power of Attorney (POA) and provider were notified on 12/22/24 of R8's fall. Predisposing environmental factors identified furniture. Predisposing situation factors were identified as ambulating without assistance and responding to toileting needs. Staff statements were obtained, and the Interdisciplinary Team (IDT) met which states an interview was obtained from R8 who indicates he was beginning to fall, and he put his arm through the side rail in an attempt to prevent the fall. A post fall intervention of toileting every 2-3 hours was determined after the IDT met on 12/22/24. Surveyor noted the facility fall investigation does not state whether the call light was within reach of R8 at the time of the fall. Surveyor also noted discrepancies with the position of how R8 was discovered after the fall. Initially the fall investigation noted R8 being found in a sitting position leaning against the enabler bars but later states R8 was lowered to the floor by facility staff. Surveyor notes there is no mention of R8 having his arm stuck in the bed rail in the incident description which is documented in a facility progress note dated 12/22/24 and R8 provided a statement in an interview stating his arm was stuck in the bed rail. Surveyor notes the root cause is not clearly identified and investigated in the fall investigation. On 1/6/25, at 10:42 am, R8 was observed in bed unattended with assist bed rails observed on both sides of the bed. On 1/7/25, 8:32 am, R8 was observed in bed unattended with assist bed rails observed on both sides of the bed. On 1/7/25, at 9:16 am, Surveyor interviewed R8 who states he had his left arm stuck in his bed rail recently. R8 denies pain or injury. Surveyor asked R8 what happened and R8 stated he was unsure how it happened, but his left arm got stuck in his bed rail, so he put himself on the floor to help get his arm out of the bed rail. R8 denies any further incidents with his bed rails and states he hangs on to them when staff are providing cares. On 1/7/25, at 10:07 am, Surveyor interviewed Director of Therapy (DOT)- G who states therapy does an initial assessment with each resident which also includes an assessment to determine bed rail needs. DOT- G indicates therapy starts the assessment and nursing completes and signs off on the assessment if the resident passed the bed rail assessment. Therapy then notifies maintenance to place the bed rails. Surveyor asked DOT- G if a bed rail assessment should be completed prior to bed rails being applied to the resident's bed and DOT- G stated yes, an assessment is required prior to any bed rails being placed on a resident's bed. Surveyor asked DOT- G what she would expect if a resident has an incident or injury related to a bed rail. DOT- G states she would expect the handrails to be removed and re-evaluated. DOT- G states it makes her wonder if the resident had a decline in function or other determining factors that may have contributed to an incident involving a bed rail. Surveyor asked DOT- G if she was aware of R8 having his arm stuck in his bed rail on 12/22/24. DOT- G replied she was not aware of R8 having any incidents with his bed rail. DOT- G acknowledged R8 still having bed rails currently on his bed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/7/25, at 12:59 am, DOT- G notified Surveyor, therapy was notified that R8 had moved from bed A to bed B in his room and the bed rails were already present on bed B. Nursing staff then notified therapy of bed rails being on R8's bed on 12/23/24 and requested a bed rail assessment to be completed by therapy. DOT- G states she was aware of R8 having a fall but was not aware of R8 having his arm stuck. DOT- G indicates R8 braced himself while sliding out of bed and the nurse popped the bed rail off the bed to get R8's arm out. Surveyor then asked if therapy would complete another bed rail assessment and DOT- G stated no, therapy determined R8 was safe for bed rails on 12/23/24. DOT- G states R8 was using his bed rail to prop himself and lowered himself down. DOT- G indicates the next bed rail assessment would be completed quarterly or by nursing requests. On 1/7/25, at 1:43 pm, Surveyor interviewed Licensed Practical Nurse (LPN)- I who states the Certified Nursing Assistant (CNA) notified her that R8 was sliding to the floor and nursing staff assisted him to the floor. LPN- I indicates when she entered R8's room, she found R8 with his buttocks off the bed with his left arm hanging in the bedrail. Nursing staff lowered the resident to the floor, and she was able to take off the bed rail by unscrewing it. LPN- I indicates R8 did not sustain any injury or pain and that R8 was attempting to sit on the side of the bed and use the bathroom. LPN- I states she contacted (name of telehealth provider)who was the provider on call and placed the device on the side table for the provider to view R8's position. LPN- I states it was determined the wrong bed linen was used with the mattress and bed rail. LPN- I indicates a fitted sheet can make the mattress deflate and areas of imbalance can occur. LPN- I states R8's care plan was updated to indicate R8 requires a flat sheet. LPN- I then stated R8 is independent and will use his grab bar to move side to side independently. On 1/8/25, at 9:15 am, Surveyor observed R8 during wound care. Surveyor asked R8 if he was able to grab his bed rails to roll himself side to side, R8 stated, not by himself. R8 required assistance by staff to grab on to the bed rail to roll himself on his side. On 1/7/25, at 1:40 pm, Surveyor interviewed Certified Nursing Assistant (CNA)- J who indicated she is familiar with R8 and works with him often. CNA- J states R8 is unable to roll himself side to side independently. CNA- J indicates staff will roll R8 to his side and R8 will then hang on to the bed rail during cares. On 1/7/25, at 3:03 pm, at end of day meeting, Surveyor shared information above with Nursing Home Administrator (NHA)- A and Director of Nursing (DON)- B. DON-B stated facility staff did not lower R8 to the floor and R8's arm was through the bed rail and was not stuck. Surveyor reviewed the facility progress note dated 12/22/24 which documents R8 having his left arm stuck in the bed rail. DON- B again stated R8's arm was not stuck and was through the bed rail but not stuck in the bed rail. Surveyor shared concerns with NHA- A and DON- B with the facility not having a thorough investigation, discrepancies with statements, interviews, and investigations identifying a thorough root cause analysis. NHA- A and DON- B acknowledge and shared no additional information.

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	01/08/2025

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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48391 Based on observation, interview and record review, the facility did not assess the risk of entrapment and review the risks and benefits for 1 (R8) of 1 residents observed having bed rails. R8, who is dependent on staff for mobility, was observed to have a half side rail/grab bars on both sides of the bed and did not have a completed side rail risk assessment. Findings include: The facility's Bed Rail Policy dated 10/1/22, documents it is the policy of the facility to utilize a person-centered approach when determining the use of bed rails. Appropriate alternative approaches are attempted prior to installing or using bed rails. If bed rails are used, the facility ensures correct installation, use, and maintenance of the bed rails. As part of the resident's comprehensive assessment, the following components will be considered when determining the resident's needs, and whether or not the use of bed rails meet those needs. The resident assessment must include an evaluation of the alternatives that were attempted prior to the installation or use of a bed rail and how these alternatives fail to meet the resident's assessed needs. The resident assessment must also assess the residence risk from using bedrail's. The resident assessment should assess the resident's risk of entrapment between the mattress and bed rail or in the bed rail itself. Informed consent from the resident or resident representative must be obtained after appropriate alternatives have been attempted prior to installation and use of bed rails. Upon receiving informed consent, the facility will obtain a physician's order for the use of the specified bed rail and medical diagnosis, condition, symptom, or functional reason for the use of the bed rail. The facility will continue to provide necessary treatment and care to the resident who has bed rails in accordance with professional standards of practice and the resident's choices. Responsibilities of ongoing monitoring and supervision are specified as follows: the interdisciplinary team will make decisions regarding when the bed rail will be used or discontinued, or when to revise the care plan to address any residual effects of the bed rail. R8 is a [AGE] year-old resident who was admitted to the facility on [DATE]. R8's diagnoses include muscle wasting and atrophy, epilepsy, dysphagia, abnormalities in gait and mobility, dementia, adult failure to thrive, and peripheral vascular disease. R8's Admission Minimum Data Set (MDS) completed on 12/1/24 documents that R8 is dependent with rolling left to right, chair and bed transfers, and shower/tub transfers. R8's MDS documents no bed rail in use. R8 was documented as having a Brief Interview for Mental Status (BIMS) score of 15 indicating R8 is cognitively intact. R8's care plan, dated 11/27/24, documents: A physical functioning deficit related to mobility impairment and self-care impairment (date initiated 11/29/24). (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interventions include: (R8) requires a Hoyer lift with assistance of two for transfers (date initiated 11/29/24). (R8) requires total assistance for bed mobility (date initiated 11/29/24). Surveyor reviewed R8's medical record which documents on 12/22/24, R8 had his left arm stuck in his bed rail and staff were unable to remove his arm from the bed rail. Facility staff contacted the provider who gave orders for the facility to contact Emergency Medical Services (EMS). Surveyor reviewed R8's medical record which documents a bedrail/mattress safety assessment completed on 12/23/24 indicating R8 was determined safe to have for assist bed rails. Surveyor noted this was after the fall on 12/22/24. On 1/6/25, at 10:42 am, R8 was observed in bed unattended with assist bed rails observed on both sides of the bed. On 1/7/25, 8:32 am, R8 was observed in bed unattended with assist bed rails observed on both sides of the bed. On 1/7/25, at 9:16 am, Surveyor interviewed R8 who states he had his left arm stuck in his bed rail recently. R8 denies pain or injury after his left arm got stuck. R8 denies any further incidents with his bed rails and states he hangs on to them when staff are providing cares. On 1/7/25, at 10:01 am, Surveyor interviewed Assistant Director of Nursing (ADON)- C who states therapy works with residents within the facility to determine resident's needs for bed rails. ADON- C states therapy completes the bedrail assessment and notifies nursing staff if bedrail's are determined to be safe. On 1/7/25, at 10:07 am, Surveyor interviewed Director of Therapy (DOT)- G who states therapy does an initial assessment with the resident to determine bed rail needs. DOT- G indicates therapy starts the assessment and nursing completes and signs off on the assessment if the resident passed the bed rail assessment. Therapy then notifies maintenance to place the bed rails. Surveyor asked DOT- G if a bed rail assessment should be completed prior to bed rails being applied to the resident's bed and DOT- G stated yes, an assessment is required prior to any bed rails being placed on a resident's bed. On 1/7/25, at 12:59 am, DOT- G notified Surveyor, therapy was notified that R8 had moved from bed A to bed B in his room and the bed rails were already on bed B. Nursing staff then notified therapy of bed rails being on R8's bed on 12/23/24 and requested a bed rail assessment to be completed by therapy. On 1/8/25, at 9:15 am, Surveyor observed R8 during wound care. Surveyor asked R8 if he was able to grab his bed rails to roll himself side to side, R8 said not by himself. R8 required assistance by staff to grab on to the bed rail to roll himself on his side. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/7/25, at 1:40 pm, Surveyor interviewed Certified Nursing Assistant (CNA)- J who indicates she is familiar with R8 and works with him often. CNA- J states R8 is unable to roll himself side to side independently. CNA- J indicates staff will roll R8 to his side and R8 will then hang on to the bed rail during cares. On 1/7/25, at 3:03 pm, Surveyor notified Nursing Home Administrator (NHA)- A, Director of Nursing (DON)- B, and ADON- C with concerns of R8 having bed rails on his bed prior to an assessment being completed. NHA- A, DON- B, and ADON- C acknowledged and provided no additional information.