STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525561	A. Building B. Wing	08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
East Troy Manor	3271 North St East Troy, WI 53120

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22692 Based on interview and record review, the facility did not ensure 1 of 1 resident (R291) reviewed with a significant change in condition had a comprehensive assessment performed consistent with professional standards of nurse practice (N6, Wisconsin Nurse Practice Act,) the comprehensive person-centered care plan, and the resident's choices. *On [DATE], R291 was having increased difficulty with transfers and eating. The difficulty continued to worsen and on [DATE] at approximately 12:41 a.m., R291 required use of a mechanical lift and had difficulty speaking. The Registered Nurse (RN) on duty did not take vital signs (other than an undocumented pulse oximetry) and did not perform a comprehensive assessment into the change in condition. There was no physician notification of the change in condition. On [DATE] at approximately 7:50 a.m., R291 became unresponsive and was transferred and admitted into the hospital with a diagnosis of severe sepsis. R291 subsequently expired while in the hospital on [DATE]. The facility's failure to perform a comprehensive assessment into a change in condition created a finding of immediate jeopardy that began on [DATE]. Surveyor notified NHA (Nursing Home Administrator) A of the immediate jeopardy on [DATE] at 3:05 p.m. The immediate jeopardy was removed on [DATE] when the facility began implementing their action plan. The deficient practice continues at a scope/severity of D (potential for more than minimal harm/isolated) as the facility continues to implement its action plan. Findings include: The facility's policy and procedure titled Change of Resident Condition Physician/NP Notification (no date) was reviewed and documents: During hours when the office is not open, the attending physician or physician on call should be notified of any change in condition, change in health status, or incident that includes but is not limited to: Change in basic vital signs, significant change in mental status or other conditions as deemed necessary. According to N6.03(1), Wisconsin Nurse Practice Act, a registered nurse (RN) shall utilize the nursing process in the execution of general nursing procedures in the maintenance of health, prevention of illness or care of the ill. The nursing process consists of the steps of assessment, planning, intervention, and evaluation. This standard is met through performance of each of the following steps of the nursing process: (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 - Immediate jeopardy to resident health or safety Residents Affected - Few	(a) Assessment. Assessment is the systematic and continual collection and analysis of data about the health status of a patient culminating in the formulation of a nursing diagnosis. (b) Planning. Planning is developing a nursing plan of care for a patient which includes goals and priorities derived from the nursing diagnosis. (c) Intervention. Intervention is the nursing action to implement the plan of care by directly administering care or by directing and supervising nursing acts delegated to L.P.N.s or less skilled assistants. (d) Evaluation. Evaluation is the determination of a patient's progress or lack of progress toward goal achievement which may lead to modification of the nursing diagnosis. R291 was admitted to the facility on [DATE] with diagnoses that included Transient Ischemic Attack, Vascular Dementia, Chronic Kidney Disease stage 3, Chronic Obstructive Pulmonary Disease, and Diabetes type 2. R291 had an Activated HCPOA (Power of Attorney) for healthcare with advanced directives for a full code, hospitalization , and antibiotics if needed. R291's Initial Minimum Data Set (MDS) dated [DATE] documented R291 needed supervision of one with ambulation and standing/transfers and had a Brief Interview for Mental Status (BIMS) Score of 12, indicating that R291 was moderately cognitively impaired. R291's quarterly MDS dated [DATE] documented her BIMS score remained unchanged at a 12. On [DATE], R291's care plan titled Activities of Daily Living functional status with a start date of [DATE] and current on [DATE] was reviewed and documented: independent with assist of wheeled walker. R291's progress note dated [DATE] at 11:46 AM written by LPN (Licensed Practical Nurse)-E documented: R291 is having difficulty transferring and standing up. She was a max (maximum) assist with cares. She was also a max assist with transferring using a gait belt and w/w (wheeled walker) this morning. She is refusing activities and refusing to eat meals in the dining room today. Continues to c/o (complain of) RUE (right upper extremity) and left flank pain. Scheduled analgesics given as ordered, states that oxycodone doesn't work. R291 moaning throughout the shift. Refusing ice packs to left flank. Will continue to monitor. Nurse Practitioner in facility and updated. R291's progress note dated [DATE] at 1:08 PM written by LPN-E documented: R291 initially refused her lunch stating, I don't know why, but I can't do anything. C/o (complained of) RUE pain at times. When her sister visited, she fed resident her lunch. R291's baseline is set-up for meals and she is able to feed herself. Earlier in the morning R291 was applying make-up and hair spray while sitting in front of the bathroom sink in her w/c (wheelchair). She has been requiring assist of one with transfers, as she states that she cannot stand up on her own. NP (Nurse Practitioner) in facility and updated. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R291's progress note dated [DATE] at 12:47 AM written by RN-E documented: R291 was incontinent of urine while sitting in her chair. R291 is unable to use her voice. R291 told CNA that she is unable to walk or use her arms. Used the Sara Steady (mechanical lift) to transfer and R291 was kicking her leg off of the machine and started to shake stated, No, I can't do this. R291 was put in a brief and placed in bed. Daughter came to visit with her aunt and daughter was crying uncontrollably, asked to speak with the nurse. When asking her what's wrong, daughter asked, Is my mom dying? Reassurance given. Asked daughter if she would like to have the resident sent to the hospital and she stated No. Offered her hospice services and she declined at this time. There were no vital signs documented and no documentation of a nurse assessment. R291's progress note dated [DATE] at 8:11 AM written by Director of Nurses (DON)-E documented: R291 was found unresponsive by dietary staff, sternal rub applied with no reaction, Blood sugar 149 BP (blood pressure) ,d+[DATE] HR (heart rate) 124, RR (respiratory rate) 20 could not get an oxygen level, O2 (oxygen) applied via NC (nasal cannula) at 3 LPM (liters per minute), Lungs course diminished at the base. skin was warm to touch, fingertips were blue. 911 was called at 0750 am and were here and gone by 805 am. Daughter/POA called and updated, resident was sent to hospital per daughter who will meet her there. Surveyor reviewed R291's medical record for vital signs and the last vital signs documented were on [DATE]. No others were documented until R291 was found unresponsive on [DATE]. On [DATE] at 9:56 AM, Surveyor interviewed Director of Nurses (DON)-B who indicated Registered Nurse (RN)-E should have done a full set of vitals with R291's change of condition on [DATE] and did not. On [DATE] at 10:30 AM, Surveyor interviewed R291's activated power of attorney for healthcare (HCPOA)-J who indicated she knew R291 was getting worse on the night of [DATE] but RN-E assured her that R291 was fine and she was overreacting. Due to this conversation, the HCPOA-J told RN-E she didn't want R291 sent to the hospital because she was assured R291 was acting this way because her dementia was progressing. On [DATE] at 12:27 PM, Surveyor interviewed NP (Nurse Practitioner)-I who indicated she was not made aware of changes to R291's transfer status or her difficulty talking. NP-I indicated a full set of vital signs should have been taken with R291's change of condition and stated she (NP-I) would have probably ordered for R291 to be sent to the hospital if she had been notified. On [DATE] at 2:39 PM, Surveyor interviewed RN (Registered Nurse)-E who indicated she did not call R291's physician on [DATE] when R291 had trouble talking and transferring. RN-E indicated she did not know if R291 was faking her condition. RN-E indicated R291 was having trouble transferring and had a hoarse voice. RN-E indicated that she checked R291's O2 level and it was 96% (this was not charted) but did not check her b/p, temperature, or pulse. RN-E indicated she saw R291 several times during the shift and R291 was talking at the time. When asked, RN-E indicated signs of sepsis would include high heart rate, low blood pressure, increased lethargy, decreased appetite, and elevated temp. RN-E indicated R291 was having a decline and she did not take vitals other than her oxygen level and she should have done a thorough assessment with a full set of vitals. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 8:47 AM, Surveyor interviewed LPN-D who indicated R291's pain and confusion was getting worse so she called NP-I on [DATE]. LPN-D indicated it was new for R291 to need help eating and R291 was really shaky. LPN-D indicated she didn't get vitals on R291 but did call NP-I. LPN-D indicated she never knew R291 to need a mechanical lift for transfers and she would call her physician and let therapy know if that happened. On [DATE] at 11:56 AM, Surveyor interviewed Medical Director (MD)-H who is also R291's primary physician. MD-H indicated he would expect to be called with R291's change of condition and he was not. MD-H indicated he would expect the nurse to take a full set of vitals before calling him as irregular vitals would be a main indicator of possible sepsis. On [DATE], Surveyor reviewed R291's hospital medical record which documented: R291 admitted to the emergency roiagnom on [DATE] at 8:44 AM. diagnosed with Severe Sepsis and Acute Metabolic Encephalopathy. Chief complaint of altered mental status. R291 was unable to provide history secondary to acute metabolic encephalopathy and somnolence. Family reported concerns to staff at the skilled nursing facility where she lives but there was no intervention per family. Temperature 104.2, heart rate ,d+[DATE]s, respiratory rate 30, Oxygen level 95% on room air. Urinalysis positive for infection. [NAME] blood cell 17.10 (normal ,d+[DATE].8), Lactic acid 3.3 (normal 0XXX,d+[DATE].7). Sinus tachycardia. Severe sepsis criteria is noted as heart rate above 90, respiratory rate above 20, temperature above 100.4, white blood cell count above 12, and lactate above 2. Hospital social worker notes dated [DATE] at 12:32 PM documented: HCPOA states she has concerns about how the nurse treated R291 last night (at the facility.) She wanted R291 brought to the hospital last night but the night nurse stated R291 was likely faking. Has had issues with this nurse in the past. admitted to the Intensive Care Unit on [DATE] at 3:05 PM. The discharge note from the hospital for R291 dated [DATE] documented: Diagnosis: septic shock, streptococcal bacteremia, aortic valve vegetation embolic strokes, from septic emboli, acute on chronic toxic metabolic encephalopathy, due to sepsis as well as embolic strokes from septic emboli. R291 was admitted to the hospital what initially thought sepsis secondary to the urinary tract infection, but unfortunately further investigation showed septic emboli, with multiple infarcts. Finding were discussed with R291's family who decided on comfort measures. Transitioned to in-house hospice. R291 expired with hospice services on [DATE] at 11:04 AM. Surveyor requested additional information, if available, as to why R291 was not given a thorough assessment including vital signs when she experienced a change in condition and why R291's physician was not consulted, however, none was provided. The facility's failure to complete ongoing, thorough assessments including taking and recording vital signs and the failure to notify the primary physician when a resident was experiencing a significant change in condition resulted in a reasonable likelihood for serious harm, thus leading to a finding of immediate jeopardy. Surveyor notified NHA-A of the immediate jeopardy on [DATE] at 3:05 p.m. The facility removed the immediate jeopardy on [DATE] when they began implementing the following action plan: (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Change of Condition policy has been reviewed by DON and modified with the following modifications: - Examples of Change of Condition - Use of Interact tools - include the change of condition pathways and Stop and Watch - VS will be taken immediately or a soon as possible with any change of condition. Once VS and immediate assessment is completed, MD will be notified. VS will be taken a minimum of every 4 hours and more frequently as indicated by the change in condition or MD order. - All changes in condition will be listed on the 24-hour report board Nurse practitioner will provide education to all nurses related to recognition of physiological changes of condition as well as behavioral responses that may indicate a physiological change in condition. Education will include response including interventions, notifications, and documentation. This education will be taped and all nurses not present will be required to view the in-service prior to their next working shift. Nurse involved in incident was part of the NP's education and was also provided one on one education by the DON and ADON on physiological change of condition and behavioral responses that may indicate a change of condition and expectations for response and notification. Interact tools have been implemented and are available electronically within the electronic medical record as well as all Interact tool change of condition pathways have been printed and are located at each nursing station. All licensed staff have been educated on the use of Interact tools as well as their location. All direct care staff will be educated on the Stop and Watch Early Warning tool as well as reporting any resident change of condition to a nurse. Post tests will be given following the education to ensure competency. Medical Director consulted during the development of this corrective action plan. The DON and ADON will review progress notes and 24-hour report board daily for any changes of condition to ensure audits will continue daily for 1 month with ad hoc training provided as necessary for any missed opportunities. Audits will continue 3 x per week for 2 months. All audits and results will be brought to the quality improvement committee for review.