STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525561	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/01/2025

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 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. 49044 Based on observation, interview, record review, and facility document and policy review, the facility failed to ensure staff used the appropriate method of transferring residents, which affected 1 (Resident #3) of 4 residents reviewed for falls. Specifically, staff transferred the resident using only one staff person on two separate occasions, and used an improper lift during one of those occasions, which resulted in the resident falling on both occasions. Findings included: A facility policy titled, Lift Machine, Using a Mechanical, revised 07/2017, revealed, The purpose of this procedure is to establish the general principles of safe lifting using a mechanical lifting device. It is not a substitute for manufacturer's training or instructions. The policy's General Guidelines included 1. At least two (2) nursing assistants are needed to safely move a resident with a mechanical lift, 3. Types of lifts that may be available in the facility are: a. Floor-based full body sling lifts; b. Overhead full body sling lifts; and c. Sit-to-stand lifts, and 4. Lift design and operation vary across manufacturers. Staff must be trained and demonstrate competency using specific machines or devices utilized in the facility. A facility policy titled, Falls - Clinical Protocol, revised 03/2018, revealed, 5. The staff will evaluate, and document falls that occur while the individual is in the facility; for example when and where they happen, and observations of the events, etc [et cetera]. A facility policy titled, Falls and Fall Risk, Managing, revised 03/2018, revealed, Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. A Resident Face Sheet revealed the facility admitted Resident #3 on 06/15/2022. According to the Resident Face Sheet, the resident had a medical history that included diagnoses of muscle wasting and atrophy; cognitive communication deficit; anemia; morbid (severe) obesity due to excess calories; vascular dementia, severe, without behavioral disturbance; psychotic disturbance, mood disturbance, and anxiety; and pain. (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: 525561	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/01/2025
NAME OF PROVIDER OR SUPPLIER East Troy Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 3271 North St East Troy, WI 53120	

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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 - Minimal harm or potential for actual harm Residents Affected - Few	An annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/05/2025, revealed Resident #3 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident had intact cognition. The MDS indicated the resident was dependent on staff for moving from a seated position to a standing position, for transferring to and from their bed to a chair or wheelchair, and with toilet transfers. The MDS indicated the resident had active diagnoses that included arthritis. Per the MDS, the resident had experienced one non-injury fall since the previous assessment. Resident #3's Care Plan included a problem statement initiated 06/16/2022, that indicated the resident was at risk for falling related to their new to nursing home placement, weakness, and their impaired mobility. The Care Plan indicated the resident had a history of falls, which included a witnessed fall on 10/12/2024 and a fall on 02/09/2025. Interventions directed staff to have signs posted in the resident's room to remind staff to transfer the resident with two staff members at all times (initiated 02/12/2025); re-educate staff on the proper transfer device to be used to transfer the resident, a Sara Steady, with two staff assisting. The Care Plan indicated the resident's knees must be touching/together before the resident being lifted; indicated that if the resident's knees start to spread, start over and make sure the resident's knees remain stable and together; (initiated 10/13/2024 and edited 02/10/2025). The Care Plan revealed a problem statement initiated 12/05/2022, that indicated the resident had a restorative nursing program in place, which included sit-to-stand exercises using a Sara Steady to maximize tolerance. Interventions directed staff to make sure the resident's legs were in line with the leg supports on the Sara Steady, ask the resident to reach for the second bar on the Sara Steady, and tell the resident to squeeze their legs together while pulling their self up (initiated 02/25/2025); monitor the resident's tolerance of the program; and adjust the program if the resident was unable to participate or if improvements were noted (initiated 12/05/2022). The Care Plan revealed a problem statement initiated 02/06/2025, that indicated the resident experienced symptoms of fatigue, weakness, and confusion related to anemia. Interventions directed staff to assist the resident with activities of daily living during periods of lethargy (initiated 02/06/2025) and observe the resident for weakness and provide safety measures, which included assistance with ambulation, transferring, and fall precautions (initiated 02/06/2025). Resident #3's care card titled, Resident Profile, revealed an approach that indicated the resident was to be transferred with the assistance of two staff using a Sara Steady only. The record indicated the resident could transfer from bed to and from the wheelchair and from their wheelchair to and from the toilet with the use of a Sara Steady, with a start date of 09/25/2024. The care card included an approach to re-educate staff on the proper transfer device to be used to transfer the resident, indicating that a Sara Steady was to be used with assistance from two staff, with a start date of 10/13/2024. The record indicated the resident's knees must be touching together before the resident being lifted; and if their knees start to spread, staff were to start over and make sure the knees remained stable and together. The record indicated an approach to ensure the resident's legs were in line with the leg supports on the Sara Steady, with directions for staff to ask the resident to reach for the second bar on the Sara Steady, and tell the resident to squeeze their legs together as they pulled their self up. Resident #3's Occupational Therapy [OT] OT Progress Report, for the service timeframe from 09/12/2024 through 10/10/2024 revealed the resident's baseline on 09/12/2024 was that the resident required assistance from two staff to use a Sara Steady. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An Event Report revealed that, on 10/12/2024 at 4:00 PM, Resident #3 had a witnessed fall. The report indicated Resident #3 was transferring to the bathroom with an EZ stand when the resident's legs began to feel weak and buckled. The report indicated staff assisted with lowering the resident to the ground. Per the report, Resident #3 was free from injury and denied pain. The report indicated that Resident #3 was unable to support themselves in an EZ stand lift. The report indicated that safety devices/interventions in place at the time of the fall included the use of a Sara Steady with the assistance of two staff. Per the report, immediate measures taken following the fall included to educate staff on the use of a Sara Steady lift. An Incident Report, dated 10/12/2024 and signed by Registered Nurse (RN) A, indicated that a certified nurse aide (CNA) was transferring the resident to the bathroom via an EZ stand lift when Resident #3's knees buckled. The report indicated the resident was lowered to the floor by staff. An Ad Hoc [completed for a particular purpose] QAPI [Quality Assurance and Performance Improvement] Meeting/Four Point Plan of Correction Agenda and Summary, dated 10/14/2024, indicated that a resident was lowered to the floor by staff from an EZ-stand lift and indicated that staff needed to use Sara Steady lift. The document indicated the Root Cause(s) was due to the resident being transferred with an EZ-stand lift. Per the document, interventions included to re-educate staff on the importance of following the care plan, indicating that staff needed to use the Sara Steady lift. A handwritten facility document, dated 10/15/2024, provided as part of the facility's investigation of Resident #3's fall revealed,[Resident #3's room and name] All Transfers Use Sara Steady with 2 Staff Or Hoyer Lift Only! No Easy Stand. Sign when starting shift. The document included 22 staff signatures to indicate they reviewed the information. During an interview on 04/01/2025 at 10:30 AM, the Nursing Scheduler stated that the name of the CNA assigned to Resident #3 on 10/12/2024 listed on the assignment sheet was contracted Agency Certified Nurse Aide (ACNA) P. The Nursing Scheduler pulled up ACNA P's profile on her calendar and pointed out that the facility had blocked her from working at the facility anymore on 10/14/2024. The Nursing Scheduler stated, and the profile showed that they blocked her because of an unsafe transfer causing a resident to fall. Resident #3's Occupational Therapy Treatment Encounter Note(s) revealed a note, dated 12/04/2024, that indicated that staff were instructed to use a Hoyer lift to transfer the resident as needed, and recommended using two staff to transfer the resident with a Sara Steady lift. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An Event Report revealed that on 02/09/2025 at 10:26 AM, Resident #3 was lowered to the ground during a transfer from their wheelchair to a recliner using the Sara Steady. The report indicated the CNA stated that the resident's knees came out of the back knee holders, and the resident began to slide to the floor. Per the report, the CNA called for assistance and the resident was lowered to the ground with the assistance of three staff members. The report indicated that there were no injuries noted, and the resident did not hit their head. The note indicated that safety devices/interventions in place at the time of the fall included that two staff were to provide assistance with a gait belt. The Notes section of the report indicated that Resident #3 required the use of a Hoyer lift with the assistance of two staff until further assessment. The report indicated that an Education sheet was provided to staff regarding the resident's prior transfer status, which was the assistance of two staff (at all times) with a gait belt and Sara Steady, and reminders to call for assistance with transfers at all times. The Evaluation portion of the report indicated the fall was attributed to one staff transferring and indicated that education was provided. An Incident Report, dated 02/09/2025 and signed by CNA O, revealed she received a call over a two-way radio indicating that help was needed in Resident #3's room. The report indicated that when she entered the room, she noted that Resident #3 was sliding down out of their recliner. Per the report, staff tried to get the resident to stand up so they could reposition the resident, but Resident #3 was unable to stand, so staff guided the resident to sit on the floor. An Incident Report, dated 02/09/2025 and signed by CNA G, revealed Resident #3 was being transferred with a Sara Steady lift. The report indicated that the lift was locked, and Resident #3 was positioned over the recliner. The report indicated the resident's knees came out of the back knee holders and the resident began to slide to the floor. Per the report, CNA G called a nurse to the room, and CNA O also came, and they lowered the resident to the floor. An Ad Hoc QAPI/Four Point Plan of Correction Agenda and Summary, dated 02/10/2025, revealed that a resident had an assisted fall to ground in room. The document indicated that one staff member was transferring the resident at the time of the fall. The form indicated the that the Root Cause(s) revealed the resident required two people to assist with transfers and the transfer was attempted with one person. The document revealed, Education was provided. A typed facility document titled, [Resident #3's room number and name] Resident transfers with assist of 2 (AT ALL TIMES) with the Sara Steady. Please ask for assistance with transfers and always use a gait belt. *Currently [the resident] is a hoyer [sic] transfer with 2 assist until further evaluation. PLEASE SIGN BELOW. The document revealed 19 staff signed the sheet to indicate they reviewed the information. During an interview on 04/01/2025 at 10:38 AM, the CNA Supervisor stated that the difference between the EZ stand and the Sara Steady was the EZ stand was mechanical and the Sara Steady was more of a staff-guided transfer lift, where staff put a gait belt on the resident and assisted them to stand. She stated the EZ stand was all mechanical. She stated physical therapy staff evaluated the residents and made the decision on what lift was used for each resident. (continued on next page)

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	525561	A. Building B. Wing	04/01/2025

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/01/2025 at 12:30 PM, the Occupational Therapist stated that therapy staff determined a resident's transfer status upon admission or with any declines in status. She stated she had worked with Resident #3. The Occupational Therapist stated that she had provided a lot of education with the staff about how to transfer the resident with the Sara Steady and to always use two staff. She stated Resident #3 wanted to use that lift because the resident could still use the toilet, but the resident's knees tended to turn outward if there were not two staff there to ensure the resident was appropriately positioned in the lift. She stated Resident #3 needed two people, I've made that very clear. She stated she worked with the resident between 08/22/2024 and 12/04/2024, and during that time, they worked on using the Sara Steady with staff. She stated she had worked with Resident #3 from 02/10/2025 to 02/25/2025 after the resident was downgraded to requiring a Hoyer lift after slipping out of the lift, but had been upgraded back to the Sara Steady. During an interview on 04/01/2025 at 1:21 PM, Licensed Practical Nurse (LPN) N stated Resident #3 was transferred incorrectly once and fell . She stated that when Resident #3 fell , the re-education was only a paper to read. She stated that the she assisted the CNA with lowering Resident #3 to the floor during the most recent fall because the resident did not have the gait belt on. She stated two staff were always supposed to be used to transfer the resident using the Sara Steady. During an interview on 04/01/2025 at 3:00 PM, the Director of Nursing (DON) stated she expected staff to transfer residents according to the care cards, which were located inside the resident's closet. She stated staff did not always follow the care cards, and she could see that from some of the falls they had had. She stated they provided a lot of education with staff at the nurses' meetings. The DON stated the nurses had to call her with each fall. She stated that whenever it was a preventable fall, they put up a sign-up sheet and had the nurse reviewed it with staff, and staff would sign off that they had been educated. She stated that with Resident #3's falls, they just educated the staff who were on the shift at the time of the falls. She stated they had had issues with staff not knowing which residents needed to have one or two staff for transfers. She stated the CNA Supervisor provided the retraining, but she did not know if she documented all the staff's retraining, and stated that she thought it was only with the staff on duty who transferred the resident. She stated they provided a yearly education skills fair and retraining was provided after a fall when the resident was not transferred correctly. During an interview on 04/01/2025 at 3:33 PM, the Administrator stated she expected staff to follow the facility policy regarding transfers. She stated that Hoyer lifts and EZ stand lifts always required a two-person assist, and staff should reference the resident's care card when using a Sara Steady lift. She stated regarding Resident #3's fall in February 2025, the CNA admitted she transferred the resident by herself and that was not their policy. She stated the CNA knew about the care card.

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F 0867

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.

49044

Based on interview, facility document review, and facility policy review, the facility failed to establish an effective Quality Assurance and Performance Improvement (QAPI) program that obtained program feedback, utilized data, took action to conduct structured, systematic investigations, and analyzed underlying causes or contributing factors of problems affecting facility-wide processes that impacted quality of care, quality of life, and resident safety. Specifically, the facility QAPI program failed to track and trend falls.

Findings included:

A facility policy titled, Quality Assurance and Performance Improvement (QAPI) Program, revised 02/2020, revealed, This facility shall develop, implement, and maintain an ongoing, facility-wide, data-driven QAPI Program that is focused on indicators of the outcomes of care and quality of life for our residents. The Policy Interpretation and Implementation revealed, The objectives of the QAPI Program are to: 1. Provide a means to measure current and potential indicators for outcomes of care and quality of life. 2. Provide a means to establish and implement performance improvement projects to correct identified negative or problematic indicators. 3. Reinforce and build upon effective systems and processes related to the delivery of quality care and services. 4. Establish systems through which to monitor and evaluate corrective actions. The policy revealed the Implementation included 2. The QAPI plan describes the process for identifying and correcting quality deficiencies. Key components of this process include: a. Tracking and measuring performance; b. Establishing goals and thresholds for performance measurement; c. Identifying and prioritizing quality deficiencies; d. Systematically analyzing causes of systemic quality deficiencies; e. Developing and implementing corrective action or performance improvement activities; and f. Monitoring or evaluating the effectiveness of corrective action/performance improvement activities, and revising as needed. 3. The committee meets monthly to review reports, evaluate data, and monitor QAPI-related activities and make adjustments to the plan.

A facility document titled, All Falls for Facility, for the timeframe from 10/01/2024 through 03/31/2025, revealed that there were 37 falls during the time period.

During an interview on 03/31/2025 at 1:45 PM with the Director of Nursing (DON) and Administrator, the DON stated she did not really track or trend falls because she did not think there was much of a pattern. The Administrator stated they usually talked about falls in the QAPI meetings. At this time, the DON printed the All Falls for Facility report for the previous six months, which revealed who fell , what time they fell , and the location of the fall. After looking through the list, the DON stated they did have a lot of falls overnight and on the evening shift.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/01/2025 at 4:40 PM, the DON stated that to get ready for the QAPI meetings, she reviewed falls, printed out the previous three months of falls, and looked at the time of day of the falls. She stated she did not look at the days of the week, as that did not seem to have any bearing. She stated she looked at when they occurred and if the resident was experiencing some sort of illness like an urinary tract infection or upper respiratory infection. She stated that she normally wrote out the falls and handed them out, but she did not for the previous quarter. She stated that she did not know why she did not. During an interview on 04/01/2025 at 4:35 PM, when the Administrator was asked how the DON was tracking and trending falls at the facility she stated, She's clearly not. She stated she expected the DON to be tracking and trending falls. She stated that it should be a large part of their QAPI meetings.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 49044 Based on facility document review and interview, the facility failed to establish a training program to include an effective system of communication with contracted agency staff related to the level of care a resident requires. Findings included: During an interview on 04/01/2025 at 4:35 PM, the Administrator stated that contracted agency staff were required to read resident care information contained in a binder prior to their first shift, and were to use care cards to determine a resident's transfer status. She stated she would provide the agency binder. An untitled facility document provided by the Administrator from a binder the facility used for agency staff, dated 01/06/2025, revealed, Topic: Care Cards. The document revealed, Care Cards are in residents [sic] rooms in their closet. Cares must be done according to the care card to meet the residents [sic] needs in the safest way possible. The document revealed that Agency CNAs (ACNAs) signed the document; however, ACNA K and ACNA M had not signed the document. During an interview on 03/31/2025 at 5:30 PM, ACNA K stated she was an agency CNA and worked at the facility on a regular basis. She stated she received report either from staff on the prior shift or a nurse. She stated she did not remember signing forms in a binder when she first began working at the facility. During a telephone interview on 04/01/2025 at 2:40 PM, ACNA M stated she worked as an agency CNA and worked at the facility often. She stated she conducted walking rounds with staff and asked questions regarding how to provide care to the residents. She stated the facility did not conduct much, if any, training with agency staff. She stated that it was fairly difficult to know how to take care of the residents. She stated that some facilities did really well with providing information regarding facility policies, but this facility did not. During an interview on 04/01/2025 at 10:49 AM, Licensed Practical Nurse (LPN) B stated that staff were to refer to care cards in residents' closets to determine what level of assistance a resident required for transfers. During an interview on 04/01/2024 at 3:00 PM, the Director of Nursing (DON) stated she expected staff to transfer residents according to the care cards, which were located inside a resident's closet. She stated staff did not always follow the care cards, noting she could determine that from some of the falls residents had experienced. She stated the facility provided a substantial amount of education with staff during nurses' meetings. The DON stated the nurses were required to call her after each resident fall. She stated that whenever it was a preventable fall, they posted a sign-up sheet and had the nurse review it, noting staff then signed off that they had been educated. (continued on next page)

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/01/2025 at 5:30 PM, the Administrator stated the agency staff binder was clearly not working. When she provided the sign-in sheet for education on the care cards she stated, Clearly, we have more agency staff than had signed off on the sheet. She stated that when she went to retrieve the agency binder, she stopped to ask three agency staff if they knew about the care cards in the resident closets, and two of the three did not.