

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 08/15/2024
NAME OF PROVIDER OR SUPPLIER East Troy Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16584</p> <p>Based on record review and staff interviews, the facility did not always ensure that 1 (R13) out 1 injury of unknown origin investigations reviewed were reported to the state survey agency as required.</p> <p>R13 was observed to have bruising to her inner left thigh and knee and R13 could not state how the injuries occurred. This injury of unknown origin was not reported to the state survey agency as required.</p> <p>Findings include:</p> <p>The facility's policy dated 12/20/2018 and titled Abuse , Neglect, Mistreatment and Misappropriation of Resident Property documents:</p> <p>G.) Reporting and Response</p> <p>It is the policy of this facility that abuse allegations (abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property) are reported per Federal and State Law. The alleged violations will be reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. Alleged violations will be reported immediately to the Administrator and Director of Nursing of the facility and to other officials (including State Survey Agency and adult protective services). In addition, local law enforcement will be notified of any reasonable suspicion of a crime against a resident in the facility.</p> <p>Initial reporting of allegations: If an incident or allegation is considered reportable, the Administrator or designee will make an initial (immediate or within 24 hours) report to the state survey agency. A follow-up investigation will be submitted to the State Agency within 5 working days.</p> <p>1.) R13 was admitted to the facility on [DATE] with diagnosis that included Parkinson's Disease with dyskinesia, major depressive disorder with recurrent psychotic symptoms, panic disorder, and Dementia with other behavioral disturbances.</p> <p>(continued on next page)</p>		

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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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R13's Significant Change in Status MDS (Minimum Data Set) dated 5/17/24 documents that R13 has a BIMS (brief interview for mental status) score of 14, indicating that R13 is cognitively intact. The MDS documents that R13 is dependent on staff for lower body dressing and needs substantial, requires maximum assistance from staff for personal hygiene and that R13 has limited range of motion on both sides of her upper and lower extremities.</p> <p>R13's nursing note dated 08/09/2024 at 01:29 p.m. documents, Care staff reports she was giving resident (R13) a bed bath as resident refused her shower today. Care staff reports resident had fading bruises to her left thigh and left knee. Writer went in and spoke to resident. Resident unable to say how she got the bruises. Resident denies pain and denies anyone hurting her. Resident reports she would tell writer if someone hurt her as she knows writer would take care of it. Resident thanked writer for checking on her. Writer left the room at this time.</p> <p>R13's weekly nursing summary, dated 8/9/24, documents that R13 needs 2 staff members and the use of a hooyer left for transfers. R13's skin condition is documented to be fair and bruising is not checked on the summary.</p> <p>Surveyor conducted further medical record review and noted that on 8/2/24, staff assisted R13 with a bath and completed the bath/ shower skin audit sheet. Documentation stated that R13 had a bruise on the left thigh. No information was documented as far as a description or size of the bruise. This form was signed by both the Certified Nursing Assistants whom provided assistance with R13's bath and the Nurse who signed off on the skin audit.</p> <p>On 08/14/24 at 10:32 AM, Surveyor interviewed Nursing Home Administrator (NHA)- A and Director of Nursing (DON)-B regarding R13 having bruising to her thigh and knee. Surveyor requested any type of investigation into the bruising, as the facility and resident did not indicate how the bruising was obtained.</p> <p>NHA- A stated to Surveyor that I'm still working on it. Surveyor asked NHA-A when an investigation begin.</p> <p>NHA- A stated I will admit, I started yesterday. I have not been able to get a hold of all the staff that may have worked with her. I did interview some residents though.</p> <p>Surveyor asked why an investigation was not started earlier. NHA- A stated I was not made aware of it; If I was made aware of it, I would have started an investigation and treated it like an Injury of Unknown Origin.</p> <p>NHA-A stated that she would normally find out about any incidents from the DON. DON- B then stated that she was on vacation, so she didn't not have knowledge of it either. DON- B stated that the nurse is supposed to let her know about any skin issues.</p> <p>Surveyor clarified that a bath sheet, dated 8/5/24, identified that a bruise was located on R13's inner left thigh. DON- B was to be made aware of this. Surveyor asked NHA- A if the facility submitted, to the state survey agency, that R13 obtained an injury of unknown origin. NHA- A stated that the facility did not report anything regarding R13.</p> <p>(continued on next page)</p>		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility did not provide additional information as to why they did not report, to the state survey agency within 24 hours, that R13 had an injury of unknown origin. In addition, there was no additional information provided as to why the facility did not submit, within 5 working days, the findings of their investigation to the state survey agency.		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16584</p> <p>Based on record review and staff interviews, the facility did not always ensure that they thoroughly investigated 1 (R13) out 1 injury of unknown origin investigations.</p> <p>* R13 was observed to have bruising to her inner left thigh and knee and R13 could not state how the injuries occurred. The facility was aware of the injuries but did not investigate as to how the injuries may have occurred. The bruising to the inner thigh is an area that is not vulnerable to trauma and R13 is depended on staff for activities of daily living .</p> <p>Findings include:</p> <p>The facility's policy with a revision date of 12/20/2018 and titled, Abuse , Neglect, Mistreatment and Misappropriation of Resident Property documents:</p> <p>Definitions of abuse and neglect:</p> <p>g.) Injuries of Unknown Origin : An injury should be classified as an injury of unknown source when both of the following conditions are met:</p> <p>i.) The source of the injury was not observed by any person, or the source of the injury could not be explained by the resident.</p> <p>ii) The injury is suspicious because of the extent of the injury or the location of the injury (e.g., the injury is located in an area not vulnerable to trauma) or the number of injuries observed at on particular point in time or the incidence of injuries over time.</p> <p>E. Investigation:</p> <p>b. Investigation of Injuries of Unknown Origin or Suspicious injuries: must be immediately investigated to rule out abuse:</p> <p>i.) injuries include, but are not limited to, bruising of the inner thigh, chest, face, and breast, bruises of an unusual size, multiple unexplained bruises, and/ or in an area not typically vulnerable to trauma.</p> <p>1.) R13 was admitted to the facility on [DATE] with diagnosis that included Parkinson's Disease with dyskinesia, major depressive disorder with recurrent psychotic symptoms, panic disorder, and Dementia with other behavioral disturbances.</p> <p>R13's Significant Change in Status MDS (Minimum Data Set) dated 5/17/24 documents that R13 has a BIMS (brief interview for mental status) score of 14, indicating that R13 is cognitively intact. The MDS documents that R13 is dependent on staff for lower body dressing and needs substantial, requires maximum assistance from staff for personal hygiene and that R13 has limited range of motion on both sides of her upper and lower extremities.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R13's nursing note dated 08/09/2024 at 01:29 p.m. documents, Care staff reports she was giving resident (R13) a bed bath as resident refused her shower today. Care staff reports resident had fading bruises to her left thigh and left knee. Writer went in and spoke to resident. Resident unable to say how she got the bruises. Resident denies pain and denies anyone hurting her. Resident reports she would tell writer if someone hurt her as she knows writer would take care of it. Resident thanked writer for checking on her. Writer left the room at this time.</p> <p>R13's weekly nursing summary, dated 8/9/24, documents that R13 needs 2 staff members and the use of a hoyer left for transfers. R13's skin condition is documented to be fair and bruising is not checked on the summary.</p> <p>Surveyor conducted further medical record review and noted that on 8/2/24, staff assisted R13 with a bath and completed the bath/ shower skin audit sheet. Documentation stated that R13 had a bruise on the left thigh. No information was documented as far as a description or size of the bruise. This form was signed by both the Certified Nursing Assistants whom provided assistance with R13's bath and the Nurse who signed off on the skin audit.</p> <p>On 08/14/24 at 10:32 AM, Surveyor interviewed Nursing Home Administrator (NHA)- A and Director of Nursing (DON)-B regarding R13 having bruising to her thigh and knee. Surveyor requested any type of investigation into the bruising, as the facility and resident did not indicate how the bruising was obtained.</p> <p>NHA- A stated to Surveyor that I'm still working on it. Surveyor asked NHA-A when an investigation begin.</p> <p>NHA- A stated I will admit, I started yesterday. I have not been able to get a hold of all the staff that may have worked with her. I did interview some residents though.</p> <p>Surveyor asked why an investigation was not started earlier. NHA- A stated I was not made aware of it; If I was made aware of it, I would have started an investigation and treated it like an Injury of Unknown Origin.</p> <p>NHA-A stated that she would normally find out about any incidents from the DON. DON- B then stated that she was on vacation, so she didn't not have knowledge of it either. DON- B stated that the nurse is supposed to let her know about any skin issues.</p> <p>Surveyor clarified that a bath sheet, dated 8/5/24, identified that a bruise was located on R13's inner left thigh. DON- B was to be made aware of this. Surveyor asked NHA- A if the facility submitted, to the state survey agency, that R13 obtained an injury of unknown origin. NHA- A stated that the facility did not report or investigate anything regarding R13.</p> <p>No additional information was provided as to why the facility did not thoroughly investigate R13's injury of unknown origin.</p>		

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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20025</p> <p>3) On 8/2/24, R34 experienced a change in condition and was sent to the hospital for evaluation. R34 was admitted to the hospital for UTI and C-Diff (clostridium difficile)infection. R34 returned to the facility on [DATE].</p> <p>On 8/12/24 at 3:00 p.m. during the daily exit meeting with DON-B and NHA-A, Surveyor asked for the transfer notice for R34 when he was sent to the hospital on 8/2/24.</p> <p>On 8/14/24 NHA-A spoke with Surveyor and stated they have no evidence a transfer notice was given to R34 on 8/2/24.</p> <p>4.) R17 admitted to the facility on [DATE] with primary diagnosis of Alzheimer's disease.</p> <p>R17 was sent out of the facility with a discharge, return anticipated, on 11/27/2024 through 11/29/2024 and on 03/03/2024 through 03/06/2024 per R17's Minimum Data Set (MDS).</p> <p>On 08/13/2024, at 12:15 PM, Surveyor requested transfer notification documents for R17 from NHA-A.</p> <p>On 08/14/2024, at 03:31 PM, NHA-A indicated to Surveyor that she does not have any transfer consent documentation for R17.</p> <p>No additional information was provided as to why the facility did not ensure that R2, R17, R30 and R34 received a written transfer/discharge notice that included the date of transfer, reason for transfer, location of transfer, appeal rights and contact information of the State Long-Term Care Ombudsman.</p> <p>22692</p> <p>Based on interview and record review, the facility did not ensure 4 (R2, R17, R30 and R34) of 4 sampled residents reviewed for discharge documentation received a written transfer/discharge notice that included the date of transfer, reason for transfer, location of transfer, appeal rights and contact information of the State Long-Term Care Ombudsman.</p> <p>Findings include:</p> <p>On 8/13/24, the facility's policy titled Transfer or Discharge Facility-Initiated dated 10/22 was reviewed and documented: Notice of transfer is provided to the resident and representative as soon as practicable before the transfer.</p> <p>On 08/14/24 at 12:41 PM, Nursing Home Administrator (NHA)-A was interviewed and indicated no transfers notices were given to R2, R17, R30 or R33. NHA-A indicated no one in the facility is responsible for issuing transfer notices and that is the main problem.</p> <p>(continued on next page)</p>		

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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>1.) On 8/13/24, R2's medical record was reviewed and indicated R2 was transferred and admitted to the hospital on 6/25/24 and returned to the facility on [DATE]. No transfer notice could be found in R2's medical record for the 6/25/24 transfer.</p> <p>The above finding was shared with NHA-A on 8/14/24 at 3:05 PM at the daily exit meeting. Additional information was requested as to why a transfer notice wasn't given to R2 with her transfer to the hospital on 6/25/24/24. None was provided.</p> <p>2.) On 8/13/24, R30's medical record was reviewed and indicated R30 was transferred and admitted to the hospital on 2/12/24 and returned from the hospital on 2/13/24. No transfer notice could be found in R30's medical record for the 2/12/24 transfer.</p> <p>The above finding was shared with NHA-A on 8/14/24 at 3:05 PM at the daily exit meeting. Additional information was requested as to why a transfer notice wasn't given to R30 with his transfer to the hospital on 2/12/24. None was provided.</p> <p>49845</p> <p>4 of 4 reviewed for transfer notifications</p> <p>R30, R2, R34 and R17 did not have transfer notices</p> <p>[NAME] will do based on</p> <p>Resident #17</p> <p>hospitalization</p> <p>08/12/24 01:22 PM triggered</p> <p>Hosp from 11/27/2023- 11/29/2023</p> <p>11/27/2023 07:11 PM Chest x ray shows bilat infiltrates. HCPOA called and would like sent to hospital. Rescue called and will go to WMH.</p> <p>bed hold? yea</p> <p>transfer notice? NHA08/14/24 03:31 PM does not have</p>		

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<p>F 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20025</p> <p>3.) On 8/2/24 R34 experienced a change in condition and was sent to the hospital for evaluation. R34 was admitted to the hospital for UTI and C-Diff (clostridium difficile)infection. R34 returned to the facility on [DATE].</p> <p>On 8/12/24 at 3:00 p.m. during the daily exit meeting with DON-B and NHA-A, Surveyor asked for the bed hold notice for R34 when he was admitted to the hospital on 8/2/24.</p> <p>On 8/14/24 NHA-A spoke with Surveyor and stated they have no evidence a bed hold notice was given to R34 on 8/2/24.</p> <p>No additional information was provided as to why the facility did not ensure that R2, R30, and R33 received written information of the duration of the bed hold policy, the reserve bed payment policy and the right to return to the facility upon being transferred to the hospital.</p> <p>22692</p> <p>Based on interview and record review, the facility did not ensure that 3 of 4 Residents (R2, R30, and R33) reviewed for hospitalization s received written information of the duration of the bed hold policy, the reserve bed payment policy and the right to return to the facility upon being transferred to the hospital.</p> <p>Findings include:</p> <p>On 8/13/24, the facility's policy titled Bed-holds and Returns dated 10/22 documents: All residents/representatives are provided written information regarding the facility and state bed-hold policies which addresses reserving a resident's bed during periods of absence. Residents are provided written notice about these policies at the time of transfer, or if the transfer was an emergency, within 24 hours.</p> <p>On 08/14/24 at 12:41 PM, Nursing Home Administrator (NHA)-A was interviewed and indicated no written bed hold information was given to R2, R30 or R33. NHA-A indicated no one in the facility is responsible for issuing written bed hold information and that is the main problem.</p> <p>1.) On 8/13/24, R2's medical record was reviewed and indicated R2 was transferred and admitted to the hospital on 6/25/25 and returned to the facility on [DATE]. No written bed hold information could be found in R2's medical record for the 6/25/24 transfer.</p> <p>The above finding was shared with NHA-A on 8/14/24 at 3:05 PM at the daily exit meeting. Additional information was requested as to why written bed hold information wasn't given to R2 with her transfer to the hospital on 6/25//24. None was provided.</p> <p>(continued on next page)</p>		

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<p>F 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2.) On 8/13/24, R30's medical record was reviewed and indicated R30 was transferred and admitted to the hospital on 2/12/24. No written bed hold information could be found in R30's medical record for the 2/12/24 transfer.</p> <p>The above finding was shared with NHA-A on 8/14/24 at 3:05 PM at the daily exit meeting. Additional information was requested as to why written bed hold information wasn't given to R30 with her transfer to the hospital on 2/12/24. None was provided.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16584</p> <p>Based on observation, record review and staff interview, the facility did not always ensure that 1 (R33) out 1 residents reviewed for the use of an indwelling catheter, had a plan of care developed based on the findings of the comprehensive assessment.</p> <p>R33 was admitted to the facility on [DATE] with an indwelling catheter in place. The facility did not developed a plan of care that addressed the services would be provided to R33 and her continued long-term use of the indwelling catheter.</p> <p>Findings include:</p> <p>1.) R33 was admitted to facility on 5/30/24 and readmitted on [DATE] with diagnosis that included retention of urine.</p> <p>R33's admission MDS (minimum data set) dated 6/5/24, R33 had an indwelling catheter in place at the time of admission.</p> <p>R33's Urinary Incontinence and Indwelling Catheter CAA (Care Area Assessment) dated 6/5/24 documents, Currently has catheter placed with dx of neurogenic bladder. She has indwelling catheter present without any complications. During hospital stay she had 3 failed voiding trials. Care plan will be developed- foley in place.</p> <p>R33's nursing note dated 07/25/2024 at 03:06 p.m. documents, Writer spoke with R33 regarding new orders from MD. Resident refusing to have her catheter removed for voiding trial. Resident states that she does not want the trial done until she is able to see her Urologist. The apt is scheduled with her Urologist and resident agrees to trial if her Urologist is in agreement. All other medication orders resident agrees with.</p> <p>On 8/12/24 at 9: 42 a.m., Surveyor made observations of R33 seated on her bed. At this time, it was noted that R33 had a catheter in place and the collection bag ,containing urine, that was visible from the hallway.</p> <p>R33's nursing note dated 08/12/2024 at 11:13 p.m. documents, R33's foley catheter changed. Writer removed 10 cc (cubic centimeters) of saline to deflate the bulb. Foley catheter removed. using sterile procedure new 18 fr (french) foley inserted, 10 cc saline inserted to inflate bulb to hold foley in place. Resident attempted to refuse for new foley, and writer explained to risks of not changing the foley as ordered monthly. Resident agreed to allow resident to change foley at that time. Resident c/o pressure with insertion and when foley was inserted resident denies further discomfort. Foley patent and draining clear yellow urine at this time. Collection bag was changed at this time. Will continue to monitor output and document as ordered.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Surveyor noted that R33's electronic medical record did not have a plan of care in place for the use of the indwelling catheter. There was not a plan that addressed that R33 has had some past refusals regarding a trial to remove the catheter as well as some refusals of cares. Surveyor noted that R33 has had the catheter in place since admission to the facility on [DATE].</p> <p>On 8/14/23 at approximately 3:00 p.m., Surveyor interviewed Nursing Home Administrator (NHA)- A and Director of Nursing (DON)- B regarding R33's use of the indwelling catheter. Surveyor asked if the facility had developed a plan of care for the use of the catheter, based on a comprehensive assessment, for R33 has Surveyor was unable to locate one in R33's medical record. NHA- A informed Surveyor that they would need to review R33's chart and let Surveyor know.</p> <p>On 8/15/24 at 9:00 a.m., NHA- A informed Surveyor that that the facility had not developed a plan of care that addressed the use of the indwelling catheter for R33. NHA- A stated that a care plan for R33's indwelling catheter use should have been completed upon admission and updated with any changes.</p> <p>No additional information was provided as to why the facility did not develop a comprehensive care for R33's use of the indwelling catheter.</p>

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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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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22692</p> <p>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.</p> <p>*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].</p> <p>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.</p> <p>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.</p> <p>Findings include:</p> <p>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.</p> <p>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:</p> <p>(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.</p> <p>(b) Planning. Planning is developing a nursing plan of care for a patient which includes goals and priorities derived from the nursing diagnosis.</p> <p>(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.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>(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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>There were no vital signs documented and no documentation of a nurse assessment.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>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].</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On [DATE], Surveyor reviewed R291's hospital medical record which documented: R291 admitted to the emergency roiaognom 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.</p> <p>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.</p> <p>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.</p> <p>R291 expired with hospice services on [DATE] at 11:04 AM.</p> <p>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.</p> <p>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.</p> <p>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:</p> <p>The Change of Condition policy has been reviewed by DON and modified with the following modifications:</p> <ul style="list-style-type: none"> - 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 <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>Post tests will be given following the education to ensure competency.</p> <p>Medical Director consulted during the development of this corrective action plan.</p> <p>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.</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49845</p> <p>Based on observation, interview, and record review, the facility did not ensure that 1 (R24) of 2 residents reviewed was provided adequate supervision and assistance devices to prevent accidents.</p> <p>R24 was identified by the facility as a wander/elopement risk due to altered mental status/dementia in June 2023. The facility did place a Wanderguard bracelet, however, at one point they placed it on the resident's wheelchair even when it was known resident was physically capable of standing up from her wheelchair and ambulating without assistance. Resident was able to elope from the facility and was found outside of the facility on two separate occasions, once when it was raining, and once at 1 am.</p> <p>The facility's failure to provide adequate supervision and proper assistance devices to R24 created a reasonable likelihood for serious harm, thus leading to a finding of immediate jeopardy that began on 06/27/2024. The immediate jeopardy was removed on 8/15/24, however, the deficient practice continues at a scope/severity of D (potential for more than minimal harm/isolated) as the facility continues to implement its removal plan.</p> <p>Findings include:</p> <p>The facility's policy, undated and titled: Wander/Elopement Policy & Procedure, documents in part: Elopement definition: When a resident leaves the facility property without the knowledge of the staff. Facility property is defined as: area outside of property lines/plot lines as governed by [NAME] County. Procedure: 3. Residents at risk will have an assessment done on admission, then quarterly, or if a change in condition arises. A resident at risk will have a wander guard placed around their ankle (or different area depending on resident) and placed on the wanderer list. The wanderer list is located in each nurse's station. 4. Wander guards are assessed for proper functioning and placement daily, and the main system checked by the maintenance supervisor on a weekly basis; not only functioning but also response time. 5. The residents care plan will be developed or modified by the intra disciplinary team to indicate the resident is at risk for elopements and specific individual interventions will be developed to encourage alternate behavior from attempting to exit the building. 6. Should an elopement occur: the contributing factors as well as the interventions tried will be documented in the nurse's notes and an incident report will be filled out. Update the administrator and director of nursing immediately.</p> <p>1.) R24 was readmitted to the facility on [DATE] with diagnoses to include Alzheimer's, Dementia, Anxiety, Obsessive Compulsive Disorder, and Post-Traumatic Stress Disorder.</p> <p>R24's Annual Minimum Data Set (MDS), dated [DATE], documents R24 requires partial/moderate assistance with a helper doing less than half the effort with transitions from sitting to standing. R24's MDS also documents R24 requires partial/moderate assistance to walk 10 feet and requires supervision or touching assistance when wheeling 150 feet in a corridor or similar space.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>R24's most recent Quarterly MDS dated [DATE], documents R24 has a Brief Interview for Mental Status (BIMS) score of 4, indicating that R24 is severely cognitively impaired. R24's Quarterly MDS also documents that R24 has wandering behavior that occurred 4 to 6 days of the assessment which was less than daily.</p> <p>R24's Wander/Elopement care plan, with a start date of 06/21/2023 and last revised on 07/15/2024, documents that R24 is at risk for wandering/elopement due to an altered mental status related to dementia.</p> <p>R24's physician order dated 7/29/23 documents, Monitor wander guard placement to right ankle every shift.</p> <p>R24's physician order dated 8/10/23 documents, Monitor wander guard placement to left ankle every shift.</p> <p>R24's progress note dated 08/13/2023 at 01:07 PM documents, Resident up and self-propelling around common area this AM. Resident tearful and very upset. Resident anxious and repeatedly asked staff why she is here, what is happening, where should she go, and what she should be doing. Resident very confused and anxious. Resident required 1:1 support from staff due to her emotional state and confusion.</p> <p>R24's physician order dated 8/20/23 documents, Discontinue order to monitor wander guard placement to right ankle every shift.</p> <p>R24's progress note dated 08/20/2023, at 07:39 PM documents, (R24) was up walking in hallway x 2 this shift, very limited safety awareness. She has been repeatedly asking why she is here and where her family is. Will continue to monitor.</p> <p>R24's progress note dated 09/01/2023, at 07:55 PM documents, Resident walking in hall several times without walker or staff assist. Able to re-direct her to sit in w/c (wheelchair) until staff can ambulate with her.</p> <p>R24's progress note dated 10/04/2023 at 08:20 PM documents, Resident has been looking for her daughter since after dinner. Resident began going into the closets and other resident's room. Unable to get her to calm down. Called the daughter so resident could speak to her. Resident was scared that her daughter had ran away.</p> <p>R24's progress note dated 10/28/2023 at 01:47 PM documents, Staff noted resident to be attempting to elope from facility out front door. Resident stated that she was going home. Visitors that were in the facility were leaving at this time and resident thought she should leave as well. Resident was easily redirected away from the front door. No further attempts noted.</p> <p>R24's progress note dated 11/14/2023 at 11:02 AM documents, Continues to self-transfer and walk around independently in spite of reeducation and redirection from staff. Motion alarm activated when she's in room so staff aware when she's moving around independently. Will continue to monitor.</p> <p>R24's physician order dated 11/30/24 documents, Place wander guard to left wrist for safety and due to elopement attempt.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>R24's progress note dated 11/30/2023 at 05:42 PM documents, Wanderguard replaced to left wrist.</p> <p>R24's progress note dated 01/28/2024 at 05:17 AM documents, This morning resident took sensor alarm and hid it under her pillows and then ambulated herself into the bathroom. Call light was within reach and 15 minute checks being implemented but, resident did not use call light this morning and was asleep during check. Resident assisted from bathroom back to bed and encouraged to use call light and again shown where call light located.</p> <p>R24's progress note dated 02/15/2024 at 04:48 PM documents, Call placed to 911, dnr (do not resuscitate) bracelet on right arm. Wanderguard removed from left wrist. No glasses, dentures or shoes were sent with resident.</p> <p>R24's progress note dated 03/01/2024 at 05:58 PM documents, Resident very distraught this evening. Looking for her mother, husband and children. Thinks she is leaving, refuses to sit in wheelchair, attempting to transfer self with purse and bible out of room into hallway to leave the facility. Not easily redirectable at this time.</p> <p>R24's progress note dated 03/15/2024 at 11:17 AM documents, NP (nurse practitioner) updated: Resident continues to have behaviors/confusion on PM shift. Resident requires 1:1 attention/re-direction after 4 PM which most of the time is not effective. Last evening, resident was confused/crying, and very anxious. We do not have anything to give her PRN. Awaiting response at this time.</p> <p>R24's progress note dated 03/15/2024 at 01:00 PM documents, New order received from Psych NP to increase her sertraline to 150 mg: currently scheduled 100 mg daily. POA and order updated.</p> <p>R24's progress note dated 03/23/2024 at 10:46 AM documents, Behaviors: Resident was found self-ambulating down the hallway without staff or her WC. Resident very anxious and confused. Ativan was given as re-direction and 1:1 support was not effective. PRN was effective. Resident was able to calm down, eat her meal, and then attended the activity.</p> <p>R24's progress note dated 03/27/2024 at 06:30 PM documents, 1830 Writer observed resident self-propelling in her wheelchair towards an exit door with her purse around her shoulder. Resident was looking for her son; he was going to be picking her up. Writer kindly tried to explain to Resident that her son was not in the bldg (building); and that others here were in their rooms winding down for the night.</p> <p>R24's progress note dated 03/31/2024 at 05:45 AM documents, Resident went to bed late last night & did not sleep well night before & has been up since 0300 this morning & asking about going to Chicago and what we are doing & trying to enter other resident's rooms & not being easily redirected as she is looking for her family and unable to redirect her and/or distract her thus, PRN Lorazepam given this morning which was starting to be effective at this time. Will continue to monitor resident.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>R24's progress note dated 05/15/2024 at 05:56 PM documents, Resident anxious and requesting to go home. Resident reports she lives next door. Resident asked writer to open the door leading outside so she could go home. Writer tried redirecting resident by telling her she needed to wait for family to come. Resident started talking in German and headed toward to exit door. Resident attempted to exit building at that time. Writer and admissions director redirected resident and moved resident away from exit door. Writer administered prn anxiety medication at this time. Admissions director brought her dog to see resident and resident became calm. Wander guard placed on residents wheelchair at this time and POA notified of resident's exit seeking. Resident became calm and went in to dining room for dinner. No further exit seeking attempts. Will continue to monitor.</p> <p>R24's progress note dated 05/20/2024 at 03:38 PM documents, Residents POA called and updated in regard to room change. POA in agreement. Resident will move to 132 5/21/24 once cleaned.</p> <p>On 08/14/24 at 11:12 AM, Surveyor asked NHA (Nursing Home Administrator)-A why R24 had a room change. NHA-A informed Surveyor that a deer came in through another resident's window and exited through R24's window. R24 was relocated due to the window being broken.</p> <p>R24's progress note dated 06/27/2024 at 02:58 PM documents, received from APNP for Ativan PRN (as needed) every 8 hours times 14 days for anxiety. Order entered and initiated. Will continue to monitor.</p> <p>First elopement: R24's progress note dated 06/27/2024 at 03:54 PM, Staff updated writer that resident was found outside by another residents family member in the front of the building standing on her own on the sidewalk. Resident had left her wheelchair in the building and walked out, therefore no alarm sounded d/t her wander guard is attached to her wheelchair. Updated DON and Administrator.</p> <p>R24's physician order dated 06/27/2024 documents, place wander guard to left wrist for safety.</p> <p>R24's Risk for Wandering/Elopement care plan with a start date of 6/27/2024 documents, Monitor for placement of wander guard to LEFT WRIST every shift and check function of wander guard to LEFT WRIST weekly on Monday morning.</p> <p>On 08/13/2024 at 12:20 PM, Surveyor interviewed NHA-A regarding R24 elopement attempt on 6/27/2024 as documented above. NHA-A informed Surveyor there is no investigation for R24's 06/27/2024 elopement. NHA-A stated R24's wander guard was removed from R24's wheelchair and placed on R24's left wrist at that time.</p> <p>On 08/13/2024 at 01:21 PM, Surveyor interviewed MDS coordinator-G regarding R24's wander guard placement on 05/15/2024. MDS coordinator-G informed Surveyor that R24 would not allow staff to put the wander guard on her wrist and it was extremely overwhelming for R24. MDS coordinator-G informed Surveyor that during that time, R24 rarely got out of her chair without assistance. MDS coordinator-G informed Surveyor that she figured that if the wander guard was on the wheelchair, it would still alarm if R24 went to push the door open. MDS coordinator-G informed Surveyor that she brought it up to management as well, and it was agreed to place the wander guard on R24's wheelchair.</p> <p>On 08/13/2024 at 02:56 PM, Surveyor interviewed RN-E and NHA-A regarding R24's elopement on 06/27/2024. RN-E informed Surveyor that a CNA supervisor was informed that someone went out the door and that R24 was by the door.</p> <p>(continued on next page)</p>		

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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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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>RN-E stated there were a lot of visitors coming in and out, and that R24 had parked her wheelchair and made it about 10 feet out the door, holding the railing, and that a CNA helped R24 back inside. RN-E stated that R24 was maybe outside less than 1 minute. RN-E informed Surveyor that R24's wander guard was on chair because R24 took it off.</p> <p>NHA-A informed Surveyor that R24 would get so angry about having the wander guard on.</p> <p>RN-E informed Surveyor that R24 has eloping behaviors but had not made it outside before. RN-E informed Surveyor she called NHA-A and DON-B and made them aware of R24's elopement on 6/27/2024.</p> <p>NHA-A informed Surveyor that the facility's policy does not consider an elopement to have occurred unless the resident makes it off the facility grounds.</p> <p>NHA-A informed Surveyor that a care conference with R24's son occurred where they discussed placement for R24 at a better fit facility, that is more secure for R24. RN-E informed Surveyor that R24's care conference explained safety and that R24 has not tried to remove the wander guard after putting back on because staff are telling R24 it's a heart monitor and R24 has had no other elopements.</p> <p>On 08/13/24 at 03:35 PM, Surveyor attempted to call the witness who found R24 when R24 eloped on 06/27/2024. The witness did not answer, and Surveyor left a voicemail with contact information for witness to return the call.</p> <p>Second elopement: R24's progress note dated 07/14/2024 at 12:27 AM documents, Front door alarm alerting, writer found pt in parking lot in wheelchair. Pt (patient) stated, I have a brother that doesn't live far from here. Escorted pt back inside, pt in nurse's station with writer. offered pt ice water and snack.</p> <p>R24's progress note dated 07/14/2024 at 08:18 AM documents, NOC (night) shift Nurse reported to writer that resident had an Elopement event at approximately 0130. Nurse stated that she did not hear the alarm from the front door sounding. NOC shift CNA reported that she found resident sitting in her WC in the parking lot. Resident states that she was out looking for Brother. CNA reports that resident was anxious and confused most of NOC shift. PRN medication was given at approximately 0400. Medication effective. Resident sleeping in her bed at this time. Motion sensor in place. Wanderguard in place to left wrist. Resident's Wander documents are posted in both Nurse's stations. Per Elopement Policy & Procedure, Writer initiated 15-minute checks and contacted. On call Nurse, DON (director of nursing), Administrator, MD (medical doctor), and POA (power of attorney) given update.</p> <p>R24's progress note dated 07/14/2024 at 08:36 AM documents, Writer checked proper functioning of Wanderguard System. System functioning properly. Alarm sounded and door locked. Door unlocked after 15 seconds of continuous pressure.</p> <p>R24's risk for Wandering/Elopement care plan documents, 1 hr checks Q shift. x 6 days per policy with a start date of 07/15/2024. No further revisions to care plan interventions documented.</p> <p>On 08/14/2024 at 08:17 AM, Surveyor interviewed LPN (Licensed Practical Nurse)-F regarding LPN-F's progress note documenting R24's elopement on 07/14/2024.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>LPN-F informed Surveyor that LPN-F arrived to work at 6 AM and there was an agency nurse coming off 3rd shift. LPN-F informed Surveyor that after medication count, LPN-F was going down the board and asked the 3rd shift nurse what happened for R24 to be put on the board. LPN-F informed Surveyor that during early morning hours R24 got out of the building unattended. LPN-F informed Surveyor that LPN-F then began to implement the facility's policy and procedure on elopement.</p> <p>LPN-F informed Surveyor that it was raining that night, and a CNA was coming back in from break and saw R24 in the middle of the driveway, unattended, in front of the building. LPN-F informed Surveyor the CNA was called back in to come do a witness statement. An elopement event was created, notified NHA-A, DON-B and the Medical Director. LPN-F informed Surveyor the CNA was on their 15-minute break and states R24 was outside maybe less than 15 minutes. LPN-F informed Surveyor that another agency CNA was inside at the time but did not hear the alarm.</p> <p>On 08/14/2024 at 08:28 AM, Surveyor asked NHA-A if she was aware of R24's 07/14/2024 elopement. NHA-A stated yes and provided Surveyor with R24's elopement investigation.</p> <p>The facility provided Surveyor with a copy of the wander guard manual. On the manual, DON-B noted that she called the wander guard company, and the wander guard should be placed on arm, wrist, or ankle.</p> <p>Surveyor took pictures of outside the facility. Surveyor captured pictures of the entrance to the facility, from the front door of the facility looking to the road, the posted speed limits, and name of the road in front of the facility.</p> <p>Surveyor noted the speed limit posted looking west on the road is 55 miles per hour (mph) and looking east is 45 mph. Surveyor measured the distance from the front door of the facility to the edge of the road and documented 83 feet 4 inches.</p> <p>On 08/15/2024 at 08:02 AM, Surveyor observed a camera on R24's dresser across from the bed.</p> <p>On 08/15/2024 at 08:05 AM, Surveyor interviewed NHA-A who informed Surveyor R24 is now a one on one (1:1), assigned staff will monitor R24 on camera only while R24 sleeps. The staff member who is assigned to the 1:1 role with R24 has the monitor with them. The 1:1 staff is a resident assistant who is not certified to do care. While R24 is sleeping, the 1:1 can work on other tasks until R24 is awake, and then when R24 is awake, the assigned 1:1 will be tasked only with being with R24.</p> <p>The facility's failure to provide adequate supervision to a resident identified as being at risk for wandering and elopement led to R24 exiting the facility on 2 separate occasions. This created a reasonable likelihood for serious harm, thus leading to a finding of immediate jeopardy that began on 06/27/2024.</p> <p>The immediate jeopardy was removed on 8/15/24 when the facility completed the following:</p> <ul style="list-style-type: none"> - Elopement assessment completed on the identified resident. All residents had an elopement assessment completed as of 8/14/24. Any residents identified as at risk had their care plan reviewed, and interventions modified as needed to ensure safety. <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>- Resident identified in citation is a high risk for elopement. Care plan reviewed and the following interventions were immediately put in place:</p> <ul style="list-style-type: none"> o Wanderguard was checked for function and for proper placement, checks for placement and function are on the electronic medical record for every shift. o One on one staff supervision for resident implemented. o A comprehensive assessment will be completed using historical data as well as a new interview with residents and their representative to identify any past trauma not already identified and or routines or missed needs. o This resident or any other resident that has exit seeking behaviors or history of elopement will be redirected using individualized interventions for distraction and diversion. Staff will enlist help with other visible staff as needed and maintain a calm presence. The administrator or director of nursing will be notified of any attempts to leave the building. <p>- Elopement policy reviewed, modified and reimplemented by educating all staff to the policy as well as the definition of elopement, interventions to prevent elopement, response to elopement and reporting elopement. Staff have also been educated on the residents currently identified as at risk including the identified resident and interventions developed to prevent elopement and resident safety.</p> <p>- Licensed nurses educated by DON (Director of Nursing) or designee on documentation expectations related to supervision and interventions which is to document on identified resident each shift for effectiveness of interventions.</p> <p>- Medical Director consulted during the development of this corrective action plan.</p> <p>- DON or designee will review progress notes and 24-hour report board daily for 2 weeks and 3 times a week for 4 weeks and then weekly for intervention documentation and effectiveness of same.</p> <p>No additional information was provided as to why the facility did not ensure that R24 was provided adequate supervision and assistance devices to prevent elopement on two separate occasions.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>20025</p> <p>Based on observation, interview and record review the facility did not ensure 1 (R26) of 3 residents observed during medication pass task had medications labeled and dated with an expiration date.</p> <p>* Surveyor observed R26 receive her morning medications. R26 received a multivitamin with minerals, Vitamin D 125 mg and Zinc 22.5 mg (milligrams) from a bottle that was not labeled with R26 name, not dated when the bottle was opened and no expiration date on the bottles.</p> <p>Findings include:</p> <p>The facility's policy regarding medications brought to the facility by the resident/family (not dated) indicates:</p> <ol style="list-style-type: none"> Residents and families must report to the nursing staff any medications that they want to bring or have brought into the facility . Any medications approved by the facility, brought in by the resident/family, must have an open date. <p>1.) On 8/14/24 at 7:30 AM, Surveyor observed LPN (Licensed Practical Nurse)-D prepare R26's morning medications. LPN-D brought out 3 bottles from the medication cart and stated these vitamins were purchased by R26 because she prefers her vitamins from this specific manufacturer.</p> <p>Surveyor observed a bottled labeled multivitamins with mineral, vitamin D 125 mg (milligrams) and zinc 22.5 mg. These bottles were not labeled with R26 name or anything identifying these vitamins were for R26. Surveyor observed all 3 bottles did not have an expiration date but a manufacture date of November 2023. The bottles were not identified as to when they were opened.</p> <p>Surveyor asked LPN-D where the expiration date was on the bottles. LPN-D looked and said she didn't see one. LPN-D stated R26 orders the medication and maybe had a box they come in with an expiration date.</p> <p>While administering R26's medications, LPN-D asked R26 if the vitamin bottles came in a box with an expiration date. R26 stated she receives the bottles without any packaging. R26 stated she has used this manufacturer for her vitamins for a long time and prefers to receive her vitamins from this manufacturer.</p> <p>On 8/14/24 at 10:11 AM, Surveyor interviewed DON (Director of Nursing)-B. Surveyor informed DON-B of the above observations made on medication pass with R26. Surveyor explained the bottles of vitamins R26 purchased are not labeled with her name, there is no expiration date on the bottles and there isn't an open date on any of the bottles. DON-B stated she's not sure why there isn't an expiration date on the bottles and the bottles should be labeled as to when it was open.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>No additional information was provided as to why R26 received medications that were not labeled and dated with an expiration date.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p>20025</p> <p>Based on interview and record review, the facility did not ensure 4 of 4 facility infectious outbreaks were thoroughly investigated.</p> <p>The facility had a Covid 19 outbreak in August 2023 and November 2023, a norovirus outbreak in December 2023 and an influenza outbreak in January 2024. All of the infectious outbreaks were not thoroughly investigated.</p> <p>Findings include:</p> <p>1.) On 8/13/24, Surveyor reviewed the facility's binder of infectious disease outbreaks.</p> <p>The facility had a Covid 19 outbreak that began on 8/24/23. The documents provided were line lists for residents and staff and PPE (personal protective equipment) and handwashing training. No other documentation was included with this outbreak.</p> <p>The facility had another Covid 19 outbreak that began on 11/20/23. The documents provided were line lists for residents and staff and PPE and handwashing training. No other documentation was included with this outbreak.</p> <p>The facility had a norovirus outbreak that began on 12/10/23. The documents provided were line lists for residents and staff and PPE and handwashing training along with norovirus information. No other documentation was included with this outbreak.</p> <p>The facility had an influenza outbreak that began on 1/11/24. The documents provided were line lists for residents and staff and PPE and handwashing training. No other documentation was included with this outbreak.</p> <p>On 8/13/24 at 1:21 p.m., Surveyor interviewed Infection Preventionist (IP)-C. Surveyor explained the infectious outbreaks did not have any documented investigation into the source of the outbreak. Surveyor explained the only documentation was the line list and the type of education provided.</p> <p>IP-C stated she was not aware she needed to complete an investigation and document any and all findings that were completed during the outbreak and the cause of the outbreak. IP-C stated she has emails from those outbreaks of her communication with the county public health department.</p> <p>On 8/13/24 at 3:00 p.m., during the daily exit meeting, Surveyor informed NHA (Nursing Home Administrator)-A and DON (Director of Nursing)-B of the above findings. DON-B understood the concern and had no additional information at that time.</p> <p>On 8/14/24, after the survey team exited the facility, the facility provided Surveyor with copies of email correspondence between IP-C and the county public health nurse. The email contained line list and documentation of interventions that were implemented during the outbreak, such as cleaning and isolation. No other documentation was provided as to the source of the outbreaks.</p> <p>(continued on next page)</p>		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	No additional information was provided as to why 4 of 4 facility infectious outbreaks were thoroughly investigated.		