

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525578	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/23/2025
NAME OF PROVIDER OR SUPPLIER Cedarburg Health Services		STREET ADDRESS, CITY, STATE, ZIP CODE N27 W5707 Lincoln Blvd Cedarburg, WI 53012	

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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43361</p> <p>Based on staff interview and record review, the facility did not ensure a physician was notified of blood sugar levels that were outside the ordered parameters for 1 resident (R) (R20) of 15 sampled residents.</p> <p>R20 had a diagnosis of diabetes and a physician's order that instructed staff to notify the physician if R20's blood sugar level was over 400 (milligrams/deciliter (mg/dL)). On 12/19/24, 12/23/24, and 1/3/25, R20's blood sugar level was over 400 mg/dL. R20's physician was not notified.</p> <p>Findings include:</p> <p>The facility's Change in Condition of the Resident policy, dated 9/20/22, indicates: Notifications that do not require immediate consultation with a physician may be made via phone, fax, or method preferred by the physician being contacted. The Center shall develop a method to track faxes sent to ensure timely response.</p> <p>On 1/22/25, Surveyor reviewed R20's medical record. R20 was admitted to the facility on [DATE] and had a diagnosis of diabetes. R20's Minimum Data Set (MDS) assessment, dated 11/8/24, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R20 had intact cognition.</p> <p>R20's care plan indicated R20 had insulin-dependent diabetes.</p> <p>R20 had a physician order that indicated: Accucheck two times a day for diabetes. Call (physician) if (blood glucose) less than 60 or greater than 400. Before breakfast and before dinner checks.</p> <p>R20's medical record indicated the following:</p> <ul style="list-style-type: none"> ~ On 12/19/24, R20 had a blood sugar level of 410. ~ On 12/23/24, R20 had a blood sugar level of 422. ~ On 1/3/25, R20 had a blood sugar level of 421. <p>R20's medical record did not indicate the physician was notified in accordance with R20's order.</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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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/22/25 at 2:10 PM, Surveyor interviewed [NAME] President of Success (VPS)-E who indicated the facility could not locate physician notifications for R20's blood sugar levels. VPS-E confirmed staff should have notified R20's physician and documented that R20's physician was notified.		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</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** 50479</p> <p>Based on observation, staff interview, and record review, the facility did not ensure adequate supervision during meals for 2 residents (R) (R24 and R10) of 8 sampled residents observed during mealtime.</p> <p>R24 had a diagnosis of dysphagia (difficulty swallowing). R24's care plan indicated R24 required full assistance with eating and should be cued to take one sip at a time and slow down. On 1/21/25, R24 was observed eating lunch in the dining room without staff assistance. In addition, staff removed R24 from the dining room after R24 coughed, drooled, and appeared to be in distress during the meal.</p> <p>R10's care plan indicated R10 had difficulty swallowing and contained interventions to remind R10 to swallow after each bite and take a drink after every 2-3 bites. On 1/21/25, R10 was observed eating lunch in the dining room without staff assistance.</p> <p>Findings include:</p> <p>During the survey, the facility indicated they do not have a policy related to dining assistance.</p> <p>1. From 1/21/25 to 1/23/25, Surveyor reviewed R24's medical record. R24 was admitted to the facility on [DATE] and had diagnoses including Parkinson's disease, dementia, dysphagia, traumatic subdural hemorrhage, traumatic brain injury, and impaired vision. R24's most recent Minimum Data Set (MDS) assessment, dated 12/29/24, indicated R24 had moderate cognitive impairment.</p> <p>R24 had an activities of daily living (ADL) self-care deficit related to Parkinson's disease, weakness, unsteady gait, and impaired vision care plan. The care plan contained the following interventions: One assist with feeding for all meals; Feed slowly; Double swallow; Drinks in-between bites; Make sure R24 is sitting upright in wheelchair.</p> <p>R24's nutrition care plan indicated R24 was at risk for nutritional status changes related to Parkinson's disease, dementia, diabetes, inconsistent intake, and texture modified diet. The care plan contained the following interventions: Full assist with eating; Have R24 in the dining room and feed R24; Cue to take 1 sip at a time and to slow down; Cut up meats; Use handled cup.</p> <p>R24's medical record indicated R24 was discharged from speech therapy on 9/11/24 because R24 reached the maximum potential with skilled services. Speech therapy discharge recommendations included supervision and assistance at meal time for swallow safety.</p> <p>On 1/21/25 at 12:18 PM, Surveyor observed Licensed Practical Nurse (LPN)-H enter the dining room and sit alone at a table apart from the residents. Surveyor observed LPN-H work on a laptop during lunch service.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 1/21/25 at 12:22 PM, Surveyor observed R24 eat lunch in the dining room and noted there were no staff seated at the table with R24. Surveyor observed R24 feed R24's self and drink liquids without staff at the table to assist. Surveyor observed R24 cough after eating a bite of food and then cough and drool after taking a drink. LPN-H checked on R24 and then sat back down at a table alone and continued to work on R24's laptop.</p> <p>On 1/21/25 at 12:24 PM, Surveyor observed R24 continue to eat and drink without staff assistance. Surveyor observed R24 take a drink and then cough, drool, and lean forward in R24's wheelchair. R24 appeared to be in distress. LPN-H continued to work on LPN-H's laptop and did not react to R24. Nursing Home Administrator (NHA)-A (who was assisting with meal trays in the dining room) checked on R24 and removed R24 from the dining room.</p> <p>On 1/21/25 at 12:27 PM, Surveyor interviewed LPN-H who confirmed LPN-H supervised residents during the lunch meal. LPN-H confirmed R24 was at risk for aspiration and required monitoring during meals. LPN-H indicated it was not required for staff to sit at the table with R24. LPN-H indicated if LPN-H was in the same room as R24 it was considered adequate supervision.</p> <p>2. From 1/21/25 to 1/23/25, Surveyor reviewed R10's medical record. R10 was admitted to the facility on [DATE] and had diagnoses including dementia, dysphagia following unspecified cerebrovascular disease, aphasia following cerebral infarction, and cerebral vascular accident with residual right sided hemiplegia. R10's most recent MDS assessment, dated 12/24/24, indicated R10 had moderate cognitive impairment.</p> <p>R10's care plan (dated 12/16/24) indicated R10 required assistance/potential to restore function for eating related to difficulty swallowing. The care plan contained the following interventions: Cue/remind R10 to swallow after each bite; Take small bites; Take a drink after every 2-3 bites; Tell R10 to cough loud when clearing throat.</p> <p>On 1/21/25 at 12:22 PM, Surveyor observed R10 eat lunch in the dining room and noted there were no staff seated at the table with R10. Surveyor observed R10 feed R10's self and drink liquids without a staff seated at the table to assist.</p> <p>On 1/21/25 at 12:38 PM, Surveyor interviewed Director of Nursing (DON)-B who indicated DON-B expects two staff to circulate in the dining room to monitor residents during meals. DON-B indicated staff are not expected to sit at the table with residents who require assistance during meals.</p> <p>On 1/21/25 at 12:50 PM, Surveyor interviewed Certified Nursing Assistant (CNA)-F who indicated CNA-F is sometimes assigned to monitor residents during meal time in the dining room. CNA-F indicated staff circulate around to assist all residents during meal time. CNA-F confirmed staff do not sit at a table with residents to assist with meals.</p> <p>On 1/21/25 at 1:03 PM, Surveyor interviewed NHA-A who indicated NHA-A expects staff to sit next to residents who require assistance with meals. NHA-A indicated the seated staff should monitor residents for aspiration and provide feeding assistance.</p> <p>On 1/22/25 at 1:43 PM, Surveyor interviewed Speech Therapist (ST)-G who reviewed R24 and R10's care plans. ST-G indicated a staff should be seated next to R24 and R10 during meals to supervise, set up, and cue R24 and R10.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43361</p> <p>Based on observation, staff interview, and record review, the facility did not ensure the accurate administration of medication for 3 residents (R) (R13, R18, and R19) of 15 sampled residents.</p> <p>R13's physician order for fluticasone (a nasal spray) indicated not to keep fluticasone at the bedside. On 1/21/25, fluticasone was observed at R13's bedside.</p> <p>R18's medication administration record (MAR) did not accurately reflect the time polyethylene glycol (an osmotic laxative) was administered on 1/22/25.</p> <p>Staff administered hydralazine (a vasodilator medication used to lower blood pressure) to R19 on 1/22/25 prior to obtaining R19's blood pressure in accordance with the physician's order. In addition, R19's MAR did not accurately reflect the time polyethylene glycol was administered on 1/22/25.</p> <p>Findings include:</p> <p>The facility's Medication Administration Self-Administration by Resident policy, dated 1/2023, indicates: Residents who desire to self-administer medication are permitted to do so with a prescriber's order and if the nursing care center's interdisciplinary team has determined that the practice would be safe and the medications are appropriate and safe for self-administration.</p> <p>The facility's Medication Administration General Guidelines policy, dated 1/23, indicates: The individual who administered the medication records the administration on the resident's medication administration record (MAR) immediately following the medication being given .Obtain and record any vital signs as necessary prior to medication administration .</p> <p>1. From 1/21/25 to 1/23/25, Surveyor reviewed R13's medical record. R13 was admitted to the facility on [DATE] and had a diagnosis of allergic rhinitis. R13's Minimum Data Set (MDS) assessment, 1/21/25, had a Brief Interview for Mental Status (BIMS) score of 14 out of 15 which indicated R13 had intact cognition.</p> <p>On 1/21/25 at 11:01 AM, Surveyor interviewed R13 in R13's room and observed a bottle of fluticasone nasal spray on R13's bedside table.</p> <p>R13's medical record contained the following:</p> <p>~ R13 was prescribed Flonase Allergy Relief Nasal Suspension 50 micrograms/actuation (mcg/act) (Fluticasone Propionate); 1 spray in both nostrils every morning and at bedtime for allergic rhinitis. The order indicated: May not keep at bedside, nursing to store in med cart.</p> <p>~ A self-administration of medication assessment, dated 12/18/23, indicated R13 was aware of the use and administration times for fluticasone but had over-used nasal sprays in the past. The assessment indicated R13 was not safe to self-administer fluticasone and fluticasone should not be kept at the bedside.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>~ A self-administration of medication assessment, dated 12/4/24, indicated R13 preferred that staff administer medications.</p> <p>On 1/22/25 at 10:21 AM, Surveyor interviewed Registered Nurse (RN)-D who worked regularly with R13. When Surveyor informed RN-D that R13 had fluticasone at the bedside, RN-D indicated R13 was able to keep fluticasone at the bedside. When RN-D reviewed R13's order for fluticasone, RN-D confirmed the order indicated fluticasone should not be kept at R13's bedside. RN-D indicated RN-D would remove fluticasone from R13's room.</p> <p>On 1/22/25 at 10:50 AM, Surveyor interviewed Director of Nursing (DON)-B who confirmed if R13's order states not to leave fluticasone at the bedside, staff should not leave fluticasone at R13's bedside. DON-B indicated if staff set medications at R13's bedside, R13 sometimes takes the medications and staff have difficulty getting the medications back.</p> <p>50479</p> <p>2. From 1/21/25 to 1/23/25, Surveyor reviewed R18's medical record. R18 was admitted to the facility on [DATE] and had diagnoses including dementia, cancer, and diabetes mellitus. R18's most recent MDS assessment, dated 1/23/25, indicated R18 had moderate cognitive impairment.</p> <p>On 1/22/25 at 8:54 AM, Surveyor observed RN-D prepare and administer medication to R18. Surveyor did not observe RN-D administer polyethylene glycol.</p> <p>Following the observation, Surveyor reviewed R18's MAR and noted RN-D documented that RN-D administered polyethylene glycol to R18 at 9:24 AM.</p> <p>On 1/22/25 at 11:24 AM, Surveyor interviewed RN-D who confirmed RN-D did not administer polyethylene glycol to R18 at the time it was documented in the MAR. RN-D indicated R18 preferred to take polyethylene glycol early in the day, therefore, RN-D had administered polyethylene glycol earlier.</p> <p>On 1/22/25 at 3:46 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A who indicated staff should document medication administration at the time the medication is administered.</p> <p>3. From 1/21/25 to 1/23/25, Surveyor reviewed R19's medical record. R19 was admitted to the facility on [DATE] and had diagnoses including stroke with hemiplegia and seizure disorder. R19's most recent MDS assessment, dated 12/30/24, indicated R19 had moderate cognitive impairment.</p> <p>On 1/22/25 at 9:02 AM, Surveyor observed RN-D prepare and administer medication to R19, including one hydralazine HCL 10 mg tablet. Surveyor did not observe RN-D obtain R19's blood pressure prior to administering hydralazine. In addition, Surveyor did not observe RN-D administer polyethylene glycol to R19.</p> <p>Following the observation, Surveyor reviewed R19's MAR and noted R19's hydralazine HCL order contained instructions to hold the medication if R19's systolic blood pressure was less than 110. Surveyor also noted R19's MAR indicated RN-D administered polyethylene glycol at the same time R19's other AM medications were administered (9:23 AM).</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 1/22/25 at 11:25 AM, Surveyor interviewed RN-D who verified RN-D did not obtain R19's blood pressure prior to administering hydralazine. RN-D also verified RN-D documented that RN-D administered polyethylene glycol to R19 at 9:23 AM, but had not yet administered the medication. RN-D indicated R19 preferred to take polyethylene glycol later in the day.</p> <p>On 1/22/25 at 3:29 PM, RN-D informed Surveyor that RN-D had just administered R19's polyethylene glycol. Surveyor noted R19's MAR still indicated R19 was administered polyethylene glycol at 9:23 AM.</p> <p>On 1/22/25 at 3:46 PM, Surveyor interviewed NHA-A who indicated staff should document medication administration at the time the medication is administered.</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50479</p> <p>Based on observation, staff interview, and record review, the facility did not ensure it was free a medication error rate of 5% or greater. During medication administration observations, 3 errors occurred during 30 opportunities which resulted in a 10% medication error rate that affected 1 resident (R) (R19) of 5 residents observed during medication administration.</p> <p>During medication administration observations for R19 on 1/22/25, staff did not administer Biofreeze menthol topical analgesic (a pain relieving treatment), cholecalciferol (a vitamin supplement), or levetiracetam (a seizure medication) as ordered.</p> <p>Findings include:</p> <p>1. From 1/21/25 to 1/23/25, Surveyor reviewed R19's medical record. R19 was admitted to the facility on [DATE] and had diagnoses including stroke with hemiplegia, hypertension, and seizure disorder. R19's most recent Minimum Data Set (MDS) assessment, dated 12/30/24, indicated R19 had moderate cognitive impairment.</p> <p>On 1/22/25 at 9:02 AM, Surveyor observed Registered Nurse (RN)-D prepare and administer 13 medications to R19. RN-D stated RN-D was administering Biofreeze but applied Diclofenac 1% topical cream to R19's legs.</p> <p>Surveyor reviewed R19's medication administration record (MAR) and noted R19 did not have an order for Diclofenac 1% topical cream. R19 had an order for Biofreeze 4% menthol external gel to be applied three times a day to the left hip. RN-D documented on R19's MAR that Biofreeze was administered during the medication pass. Surveyor also noted that RN-D documented that cholecalciferol 25 micrograms (mcg) 1 tablet was administered, however, Surveyor did not observe RN-D administer cholecalciferol. In addition, Surveyor noted R19 had an order for levetiracetam twice daily but did not observe RN-D administer levetiracetam during the medication pass.</p> <p>On 1/22/25 at 11:25 AM, Surveyor interviewed RN-D who confirmed RN-D did not administer levetiracetam at the scheduled time of 7:30 AM because the medication was not available. RN-D could not recall if cholecalciferol was administered.</p> <p>On 1/22/25 at 3:46 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A who indicated staff should document a medication as administered when the medication is administered.</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>50479</p> <p>Based on observation, staff interview, and record review, the facility did not ensure all drugs or biologicals were discarded when expired in 1 of 2 medication rooms in the facility.</p> <p>On 1/21/25, expired stock medications were observed in a cabinet and refrigerator in the 400 unit medication room.</p> <p>Findings include:</p> <p>The facility's Disposal of Medications, Syringes and Needles policy, dated 2007, indicates: .5. Dispose of discontinued medications within 90 days of the date the medication was discontinued .7. Outdated medications .shall be destroyed according to the above policy .</p> <p>On 1/21/25 at 11:06 AM, Surveyor and Director of Nursing (DON)-B observed medications stored in the medication room on the 400 unit and noted the following expired medications in the floor stock medication cabinet:</p> <ul style="list-style-type: none"> ~ An unopened bottle of diphenhydramine HCL 25 milligram (mg) tablets with an expiration date of 10/2024 ~ An open bottle of diphenhydramine HCL 25 mg tablets with an expiration date of 6/2024 ~ An unopened bottle of loratadine 10 mg tablets with an expiration date of 10/2024 <p>Surveyor and DON-B observed the following expired medications in the medication refrigerator:</p> <ul style="list-style-type: none"> ~ An open box of acetaminophen 650 mg suppositories with an expiration date of 12/2024 ~ A COVID-19 vaccine with an expiration date of 5/4/24 <p>Following the observations, DON-B confirmed the above medications were expired and should have been discarded.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50988</p> <p>Based on observation, staff interview, and record review, the facility did not maintain an infection prevention and control program designed to prevent the transmission of communicable disease and infection for 2 residents (R) (R9 and R15) of 4 sampled residents.</p> <p>R9 and R15 had symptoms of an upper respiratory infection and were not placed on precautions in a timely manner.</p> <p>Findings include:</p> <p>The facility's Transmission Based (Isolation) Precautions policy, revised 9/24/24, indicates: 1. Facility staff will apply transmission based precautions, in addition to standard precautions, to residents who are known or suspected to be infected or colonized with certain infectious agents requiring additional controls to prevent transmission. 2. The facility will use standard approaches, as defined by the Centers for Disease Control and Prevention (CDC) for transmission based precautions; airborne, contact, and droplet precautions. 9. Initiation of Transmission Based Precautions (Isolation Precautions): a. Nursing staff may place residents with suspected or confirmed infectious diarrhea, influenza, or symptoms consistent with a communicable disease on transmission based precautions/isolation empirically while awaiting confirmation .11. Droplet Precautions: a. Intended to prevent transmission of pathogens spread through close respiratory or mucous membrane contact with respiratory secretions (i.e., respiratory droplets that are generated by a resident who is coughing, sneezing, or talking.)</p> <p>The CDC indicates at https://www.cdc.gov/long-term-care-facilities/hcp/respiratory-virus-toolkit/index.html Viral Respiratory Pathogens Toolkit for Nursing Homes, dated 1/8/25: Healthcare personnel (HCP) who enter the room of a resident with signs or symptoms of an unknown respiratory viral infection that is consistent with SARS-CoV-2 infection should adhere to standard precautions and use a NIOSH-approved(R) particulate respirator with N95(R) filters or higher, gown, gloves, and eye protection (i.e., goggles or a face shield that covers the front and sides of the face). This personal protective equipment (PPE) can be adjusted once the cause of the infection is identified. Test anyone with respiratory illness signs or symptoms. Selection of diagnostic tests will depend on the suspected cause of the infection (e.g., which respiratory viruses are circulating in the community or the facility, recent contact with someone confirmed to have a specific respiratory infection) and if the results will inform clinical management (e.g., treatment, duration of isolation). At a minimum, testing should include SARS-CoV-2 and influenza viruses with consideration for other causes (e.g., RSV).</p> <p>1. From 1/21/25 to 1/23/25, Surveyor reviewed R9's medical record. R9 was admitted to the facility on [DATE] and had diagnoses including multiple sclerosis and depression. R9's Minimum Data Set (MDS) assessment, dated 12/16/24, had a Brief Interview for Mental status (BIMS) score of 15 out of 15 which indicated R9 had intact cognition. R9's medical record indicated R9 had an Activated Power of Attorney for Healthcare (POAHC).</p> <p>A progress note, dated 1/19/25 at 7:09 PM, indicated R9 complained of a headache, nasal congestion, and sore throat. R9's temperature was 99.7 degrees. Tylenol was administered. R9's COVID-19 test was negative.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525578	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/23/2025
NAME OF PROVIDER OR SUPPLIER Cedarburg Health Services		STREET ADDRESS, CITY, STATE, ZIP CODE N27 W5707 Lincoln Blvd Cedarburg, WI 53012	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A progress note, dated 1/20/25 at 11:58 AM, indicated R9 complained of a sore throat and headache over the weekend and tested negative for COVID-19 on 1/18/25. R9 was tested again for COVID-19 on 1/20/25 and was negative. R9 did not have a sore throat, fatigue, or headache. Tylenol was administered for pain.</p> <p>A progress note, dated 1/21/25 at 3:35 AM, indicated R9 was weak, febrile, and congested. Tylenol was administered.</p> <p>On 1/21/25 at 10:28 AM, Surveyor interviewed R9 and noted there was not a contact or droplet precaution sign on R9's door or a personal protective equipment (PPE) cart inside or outside R9's room.</p> <p>A progress note, dated 1/21/25 at 7:23 PM, indicated R9's face was flushed and R9 complained of achy muscles and chills. R9's lungs contained crackles. R9 was sent to the emergency room (ER).</p> <p>A progress note, dated 1/21/25 at 11:17 PM, indicated R9 was diagnosed with influenza A and returned from the ER with a precaution sign and PPE in place.</p> <p>A progress note, dated 1/22/25 at 2:38 AM, indicated R9 had chills, body aches, wheezing, and complained of weakness. R9 returned from the ER and indicated R9 wanted to sleep. Droplet isolation precautions were initiated.</p> <p>A progress note, dated 1/22/25 at 1:21 PM, indicated R9 was tired and slept most of the AM shift. R9 denied a headache, cough, or congestion. Tamiflu was ordered.</p> <p>On 1/23/25 at 9:58 AM. Surveyor interviewed Infection Preventionist (IP)-C who indicated R9 was tested for COVID-19 twice due to complaints of nasal congestion, sore throat, fever, and headache and both tests were negative. IP-C indicated R9 was assessed on 1/20/25 and did not have any respiratory symptoms. IP-C indicated IP-C was notified by nursing staff on 1/21/25 that R9 complained of a sore throat, congestion, fever, and a headache and was placed on droplet precautions. The physician was updated on 1/21/25 at 8:09 AM and ordered R9 be evaluated in the ER where R9 was diagnosed with influenza A. IP-C verified R9 was symptomatic of upper respiratory symptoms starting on 1/19/25 and was not put on droplet precautions until 1/21/25 at 11:37 PM.</p> <p>43361</p> <p>2. From 1/21/25 to 1/23/25, Surveyor reviewed R15's medical record. R15 was admitted to the facility on [DATE], received Hospice services, and had diagnoses including malignant neoplasm of endometrium and encounter for palliative care. R15's MDS assessment, dated 12/20/24, had a BIMS score of 13 out of 15 which indicated R15 had intact cognition.</p> <p>On 1/21/25 at 9:37 AM, Surveyor interviewed Nursing Home Administrator (NHA)-A who indicated one resident was on isolation precautions for COVID-19. NHA-A indicated the resident had just tested negative but would remain on isolation precautions for the full 10 days.</p> <p>On 1/21/25 at 11:20 AM, Surveyor interviewed R15 who was in bed. R15 indicated R15 did not feel well, had a sore throat and cough, and was congested. R15 indicated R15's symptoms started a couple of days prior. Surveyor did not observe a precautions sign or PPE cart near R15's door.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R15's medical record indicated R15 was administered guaifenesin (Robitussen) oral tablet 200 milligrams (mg) for allergies, cough and congestion on 1/17/25 at 2:02 PM and 1/20/25 at 3:05 PM.</p> <p>On 1/22/25 at 10:20 AM, Surveyor interviewed Registered Nurse (RN)-D who confirmed R15 was congested and RN-D placed oxygen on R15 that morning. RN-D indicated RN-D thought Director of Nursing (DON)-B contacted the physician that morning regarding R15. RN-D confirmed R15 was not on precautions.</p> <p>On 1/22/25 at 10:36 AM, Surveyor interviewed IP-C who was not aware that R15 had illness symptoms. IP-C indicated if R15 had illness symptoms, R15 should be on precautions.</p> <p>On 1/22/25 at 10:44 AM, Surveyor interviewed DON-B who confirmed nurses can put a resident on precautions if they have illness symptoms. DON-B indicated DON-B did not contact R15's physician and was not aware that R15 had illness symptoms. DON-B indicated DON-B would expect R15 to be on precautions, however, R15 was on Hospice and Hospice directed R15's care. DON-B confirmed staff should put precautions in place for residents at symptom onset while figuring out what testing should be completed.</p> <p>On 1/23/25, Surveyor noted R9 (in the previous example) had tested positive for Influenza A.</p>		