

| | | | |
|--|--|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525596 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 03/27/2024 |
| NAME OF PROVIDER OR SUPPLIER Hales Corners Care Ctr | | STREET ADDRESS, CITY, STATE, ZIP CODE 9449 W Forest Home Ave Hales Corners, WI 53130 | |

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 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>38253</p> <p>Based on record review and interview, the facility did not thoroughly investigate an allegation of misappropriation affecting 1 (R147) of 1 residents in a Facility Reported Incident that was reviewed.</p> <p>R147 reported a missing wallet. The facility administration did not interview residents in the facility at the time of the report to determine if any other residents were affected by potential theft.</p> <p>Findings include:</p> <p>On 11/15/2023, R147 reported to Social Worker (SW)-C their wallet was missing. The wallet contained money, credit cards, insurance cards and driver's license. SW-C initiated an investigation by interviewing R147's family members who were aware of the missing wallet to determine when the wallet was last seen and to verify no family member had taken the wallet out of the facility. It was determined through those interviews that the wallet was last seen on Friday evening, 11/10/2023. SW-C interviewed all staff members that had worked at the facility 11/10/2023-11/15/2023 with no staff aware of R147's wallet. Surveyor noted no residents were interviewed to determine if there were any other items missing at that time.</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 |
|---|-------|-----------|

| | | | |
|--|---|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525596 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 03/27/2024 |
| NAME OF PROVIDER OR SUPPLIER Hales Corners Care Ctr | | STREET ADDRESS, CITY, STATE, ZIP CODE 9449 W Forest Home Ave Hales Corners, WI 53130 | |
| 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 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>In an interview on 3/26/2024 at 3:28 PM, Surveyor asked SW-C what position SW-C held at the facility. SW-C stated SW-C was a Social Worker, the Grievance Officer, and the Admissions Officer. Surveyor asked SW-C if SW-C could recall the events surrounding R147 reporting a missing wallet on 11/15/2023. SW-C stated R147's family came in to visit R147 on 11/15/2023 and SW-C was in R147's room when the family realized R147's wallet was missing. SW-C stated SW-C knew R147 had their wallet on the day of admission on 11/7/2023 because R147 provided insurance cards at that time. SW-C was not aware of what happened to R147's wallet after getting the insurance cards; SW-C did not know if a family member took the wallet home or if R147 kept the wallet with them in the facility. SW-C stated SW-C interviewed all of R147's family members to determine if any of them had the wallet or knew where the wallet may be and none of the family members had any information. SW-C stated SW-C interviewed all the staff members that worked over the weekend from Friday when the wallet had last been seen until 11/15/2023 when the wallet was reported missing. SW-C stated no staff members had any knowledge of R147's missing wallet. Surveyor asked SW-C if any residents had been interviewed to see if they had any knowledge of the missing wallet regarding seeing anyone with the wallet or if they had any personal items missing at the same time to broaden the scope of the investigation. SW-C stated no, none of the residents were interviewed. SW-C stated no other missing items had been reported so that did not prompt SW-C to ask anyone if they had anything missing. SW-C stated SW-C had overheard R147 telling other residents about the missing wallet, so SW-C knew some residents were aware and no one brought anything forward to SW-C of missing money or items.</p> <p>On 3/27/2024 at 10:33 AM, Surveyor shared with Nursing Home Administrator (NHA)-A the concern when R147's wallet went missing on 11/15/2023, no other residents were interviewed to determine if that was an isolated incident or if any residents had seen activity that would help discover what happened to the wallet. NHA-A did not provide any further information at that time.</p> | | |

| | | | |
|--|---|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525596 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 03/27/2024 |
| NAME OF PROVIDER OR SUPPLIER Hales Corners Care Ctr | | STREET ADDRESS, CITY, STATE, ZIP CODE 9449 W Forest Home Ave Hales Corners, WI 53130 | |
| 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 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> | <p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38253</p> <p>Based on observation, record review, and interview, the facility did not ensure residents at risk for pressure injuries or those admitted with pressure injuries received care consistent with professional standards of practice to prevent pressure ulcers from developing for 2 (R43 and R19) of 3 residents reviewed for pressure injuries.</p> <p>*R43 was admitted to the facility with an Unstageable pressure injury to the right elbow that required antibiotics for a wound infection and developed pressure injuries to the left heel and right Achilles. Wound documentation was not an accurate description of staging, measurements, and characteristics of the wound.</p> <p>*R19 was admitted to the facility with a Stage 3 pressure injury to the right outer ankle. Wound documentation was not an accurate description of staging, measurements, and characteristics of the wound.</p> <p>Findings include:</p> <p>The facility policy and procedure entitled Pressure Ulcer Management dated 11/29/6 states: Procedure: . 2. The licensed nurse further assesses all wounds, including location, type of wound, stage, measurement, exudate, pain, wound bed, periwound, and any other comments. This assessment is recorded on the 'Guide for Wound Assessment and Documentation' form by the nurse performing the assessment, on the date that the wound was identified. Physician's orders for treatment are obtained as appropriate.8. During a skin assessment, if a new wound is identified, the licensed nurse further assesses the wound, including location, type of wound, stage, measurement, exudate, pain, wound bed, periwound, and any other comments. This assessment is recorded on the 'Guide for Wound Assessment and Documentation' form by the nurse performing the assessment, on the date that the wound was identified. Physician's orders for treatment are obtained as appropriate. 11. Current ulcers are assessed by a licensed nurse weekly. Assessment includes type of wound, stage, measurement, exudate, pain, wound bed, periwound, and any other comments. This assessment is scheduled on the TAR and documented on the 'Wound Evaluation Flow Sheet'.</p> <p>1.) R43 was admitted to the facility on [DATE] with diagnoses of right femoral neck fracture, dementia, history of bladder cancer, coronary artery disease, atrial fibrillation, congestive heart failure, and macular degeneration with legal blindness. R43's admission Minimum Data Set (MDS) assessment dated [DATE] indicated R43 had severe cognitive impairment with a Brief Interview for Mental Status (BIMS) score of 5 and needed substantial assistance with bed mobility.</p> <p>On 1/23/2024, on admission, R43 had a Stage 2 pressure injury to the sacrum, a wound to the upper right elbow, a Stage 3 pressure injury to the right scapula, and an Unstageable pressure injury to the left elbow that healed by 2/18/2024. In addition, R43 was admitted with an Unstageable pressure injury to the right elbow.</p> <p>The hospital discharge paperwork dated 1/23/2024 documented R43 had a history of osteomyelitis due to Staphylococcus aureus to the right arm in 2003.</p> <p>(continued on next page)</p> | | |

| | | | |
|--|--|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525596 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 03/27/2024 |
| NAME OF PROVIDER OR SUPPLIER Hales Corners Care Ctr | | STREET ADDRESS, CITY, STATE, ZIP CODE 9449 W Forest Home Ave Hales Corners, WI 53130 | |
| 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 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> | <p>On 1/23/2024 on the Treatment Administration Record (TAR), nursing was instructed to suspend heels with pillows while in bed and was to have a turn schedule while in bed and sign off on the intervention every shift.</p> <p>RIGHT ELBOW</p> <p>On 1/24/2024 on the Wound Evaluation Flow Sheet, Registered Nurse Supervisor (RN Sup)-D charted the right elbow Unstageable pressure injury measured 1.8 cm x 1.4 cm with no depth measurement with 90% scab and 10% slough. The surrounding tissue was red and swollen. A treatment was initiated on 1/24/2024 to cleanse with soap and water, pat dry, apply Santyl to the wound bed followed by foam dressing daily. R43 had an order for Keflex 500 mg three times daily for seven days for cellulitis of right elbow.</p> <p>R43's Alteration in Skin Integrity Care Plan for the right elbow wound was initiated on 1/24/2024 with the following interventions:</p> <ul style="list-style-type: none"> -Refer to interdisciplinary wound care team, if appropriate. -Monitor color, drainage, odor, pain daily or with dressing change and document. -If dressing not due to be changed, monitor surrounding skin, condition of dressing, presence of odor, drainage, and pain. Document findings. -Measure size weekly and record. -Move in bed using breezy pad. -Turn and reposition every two hours using assist of two. -Dietary referral for nutrition assessment. -Therapy referral for positioning, appropriate cushion. -Labs per physician order. -Treatment per physician order. -Culture open area per physician order if indicated. -Wheelchair cushion. -Analgesic for discomfort prior to treatment and as needed. -Assess for pain at least daily and as needed; document and treat as appropriate. <p>(continued on next page)</p> | | |

| | | | |
|--|---|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525596 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 03/27/2024 |
| NAME OF PROVIDER OR SUPPLIER Hales Corners Care Ctr | | STREET ADDRESS, CITY, STATE, ZIP CODE 9449 W Forest Home Ave Hales Corners, WI 53130 | |
| 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 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> | <p>On 1/28/2024 on the Wound Evaluation Flow Sheet, RN Sup-D charted the right elbow Unstageable pressure injury measured 1.2 cm x 1 cm with no depth measurement with 90% yellow slough and 10% black. RN Sup-D charted the dark scab was almost gone and the wound continued with yellow slough. R43 continued with antibiotics for cellulitis with the area less red/swollen. On the Wound Charting progress notes, RN Sup-D charted the wound was 100% slough with two small black areas at 9 o'clock and 3 o'clock. Surveyor did not find any documentation the physician was notified of the change in presentation of the pressure injury.</p> <p>On 2/5/24 the impaired skin integrity care plan was updated to include: treat as ordered, cleanse right elbow with soap and water, pat dry, skin prep to periwound, apply Santyl, f/b (followed by) adhesive dressing qd (each day) and prn (as needed). Revise care plan approaches if wound worsens. Minimize pressure on bony prominences. Instruct on the importance of good skin care and frequent repositioning .there is no indication the facility specifically addressed offloading or decreasing pressure to R43's elbow as the wound continued to worsen.</p> <p>On 2/6/2024 on the Wound Evaluation Flow Sheet, RN Sup-D charted the right elbow Unstageable pressure injury measured 0.5 cm x 0.6 cm with no depth measurement with 100% dark slough. RN Sup-D charted the surrounding tissue was erythematous and swollen.</p> <p>On 2/12/2024 the right elbow Unstageable pressure injury was measured by a Licensed Practical Nurse (LPN) and reviewed by RN Sup-D. The pressure injury measured 0.5 cm x 0.7 cm x 0 cm with yellow thick exudate with 10% slough and 90% eschar.</p> <p>On 2/18/2024 the right elbow pressure injury was measured by an LPN and reviewed by RN Sup-D. The LPN charted in the Wound Charting progress notes the wound was a worsening Stage 3 pressure injury that measured 0.7 cm x 0.6 cm x 0 cm with 100% slough and purulent yellow thick exudate. Surveyor noted the pressure injury was staged as a Stage 3 even though the wound base was covered with slough and not visible.</p> <p>On 2/25/2024 on the Wound Evaluation Flow Sheet, RN Sup-D charted the right elbow Unstageable pressure injury measured 0.7 cm x 0.5 cm x 0.4 cm with 100% thick yellow slough. A wound culture was done and came back positive for Staphylococcus and Doxycycline 100 mg twice daily for seven days was started. A consult for the wound clinic to assess R43's elbow was completed.</p> <p>On 2/28/2024, R43 went to the wound clinic for a consultation for the non-healing right elbow wound. The consult note contained the following information:</p> <p>Findings: Right elbow shallow ulcer with deep circumferential undermining with serous drainage. R43 was on doxycycline for staph infection. Recommendations: ortho consult to debride and close elbow joint ulcer, daily packing with vashe moistened gauze. Treatment: wash with soap and water, pat dry. Vashe moistened quarter inch Nugauze packing daily. Offload and avoid direct pressure on elbow. Complete prescribed antibiotic. Return to clinic in one month or as needed.</p> <p>Review of R43's care plan indicates the recommendation to avoid direct pressure to R43's elbow was not added to R43's plan of care.</p> <p>(continued on next page)</p> | | |

| | | | |
|--|--|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525596 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 03/27/2024 |
| NAME OF PROVIDER OR SUPPLIER Hales Corners Care Ctr | | STREET ADDRESS, CITY, STATE, ZIP CODE 9449 W Forest Home Ave Hales Corners, WI 53130 | |
| 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 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> | <p>On return from the wound clinic appointment on 2/28/2024, an order was obtained for a consult to the ortho clinic for debridement and closure of the right elbow joint ulcer. An appointment was made for 3/6/2024.</p> <p>On 3/3/2024 on the Wound Charting progress notes, RN Sup-D charted the Unstageable pressure injury measured 0.7 cm x 0.6 cm x 0.4 cm with 100% granulation tissue with less than 2 cm undermining in any area. The wound had non-pitting edema that extended less than 4 cm around the wound and had thick yellow purulent drainage. R43 completed the antibiotic for the wound infection and the area was less red and swollen. R43 was taking multivitamins, high calorie boost, magic cup and milk with protein powder. RN Sup-D charted the area had a punched out look with undermining around entire circular area of wound and continued with yellow purulent drainage. The wound bed was 100% pink, the margins slightly macerated and was being followed by the wound clinic. Surveyor noted the pressure injury was not staged when the base of the wound was visible and not covered with slough.</p> <p>On 3/4/2024, R43 had an order for doxycycline 100 mg twice daily for seven days for the wound infection.</p> <p>On 3/5/2024, R43 had an order to start Megestrol Acetate 40 mg/ml (10 ml or 400 mg) daily for cachexia, or muscle and adipose tissue wasting.</p> <p>On 3/6/2024, R43 went to the ortho clinic for the right elbow wound. Recommendations were to continue packing the wound and must correct protein deficiency for wound healing.</p> <p>On 3/10/2024 on the Wound Evaluation Flow Sheet and the Wound Charting progress notes, RN Sup-D charted the right elbow Unstageable pressure injury measured 0.5 cm x 0.5 cm x 0.4 cm with 100% granulation and undermining 2 cm circumference with purulent drainage and was receiving doxycycline for the wound infection. Surveyor noted the pressure injury was not staged with 100% granulation tissue. The treatment was changed to include irrigating the wound with vashe.</p> <p>On 3/18/2024 on the Wound Charting progress notes, RN Sup-D charted the right elbow Unstageable pressure injury measured 0.5 cm x 0.5 cm x 0 cm and noted the wound was covered by a scab with the surrounding area red and soft. RN Sup-D called and spoke with the wound clinic and an appointment was made for 3/20/2024. A treatment of betadine swab to the wound bed and cover with dry dressing was ordered daily.</p> <p>On 3/20/2024, R43 went to the wound clinic and the wound clinic evaluated the wound stating the right elbow wound had undermining approximately 1.7 cm circumferentially. The wound clinic ordered the same treatment with the packing of the wound daily with quarter inch vashe soaked Nugauze.</p> <p>On 3/20/2024 on the Wound Charting progress notes, RN Sup-D charted the right elbow Unstageable pressure injury measured 0.5 cm x 0.5 cm x 0.4 cm with 90% granulation and 10% slough with undermining at 9 o'clock 2 cm, 12 o'clock 1 cm, 3 o'clock 1 cm, and 6 o'clock 1 cm. The surrounding tissue was non-pitting edema that extended less than 4 cm around the wound with purulent yellow thick exudate. RN Sup-D noted the depth of the wound was unchanged, but the undermining was deeper since R43 was at the wound clinic on 3/20/2024. Surveyor noted the pressure injury was not staged.</p> <p>LEFT HEEL</p> <p>(continued on next page)</p> | | |

| | | | |
|--|--|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525596 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 03/27/2024 |
| NAME OF PROVIDER OR SUPPLIER Hales Corners Care Ctr | | STREET ADDRESS, CITY, STATE, ZIP CODE 9449 W Forest Home Ave Hales Corners, WI 53130 | |
| 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 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> | <p>On 1/23/2024 on the Treatment Administration Record (TAR), nursing was instructed to suspend heels with pillows while in bed and was to have a turn schedule while in bed and sign off on the intervention every shift.</p> <p>On 2/8/2024 on the Wound Evaluation Flow Sheet, R43 developed a Stage 2 pressure injury that measured 1.5 cm x 0.8 cm.</p> <p>On 2/10/2024 on the TAR, wound care was ordered to apply skin prep to bilateral heels twice daily.</p> <p>On 2/14/2024 on the Wound Evaluation Flow Sheet, RN Sup-D charted the Stage 2 pressure injury measured 2.0 cm x 2.5 cm that was 50% red non-blanchable and 50% dark red in the center. RN Sup-D charted the area was previously a blister.</p> <p>On 2/18/2024 the left heel pressure injury was measured by an LPN and reviewed by RN Sup-D. The LPN charted in the Wound Charting progress notes the Deep Tissue Injury (DTI) measured 0.3 cm x 1.0 cm x 0 cm with 100% yellow scab. Surveyor noted a DTI does not have the characteristic of a scab and would be considered an Unstageable pressure injury and the wound had previously been staged as a Stage 2 pressure injury.</p> <p>The left heel was assessed weekly with the following measurements and characteristics:</p> <p>2/25/2024 - DTI that measured 0.3 cm x 1.0 cm with 100% yellow scab.</p> <p>3/3/2024 - Unstageable pressure injury that measured 0.4 cm x 1.0 cm with 80% yellow and 20% dark purple tissue.</p> <p>3/10/2024 - Unstageable pressure injury that measured 1.0 cm x 0.5 cm with yellow and purple scab.</p> <p>3/18/2024 - DTI that measured 1.0 cm x 0 cm with a yellow scab on the Wound Charting progress notes and measured 0.8 cm x 0.6 cm on the Wound Evaluation Form. No tissue type was written on the Wound Evaluation Form. Surveyor noted the inconsistencies of the documentation of the measurements and the tissue type.</p> <p>3/25/2024 - DTI that measured 1 cm x 0.5 cm with deep purple tissue on the Wound Charting progress notes and measured 0.5 cm x 0.5 cm with a yellow scab on the Wound Evaluation Flow Sheet. Surveyor noted the inconsistencies of the documentation of the measurements and the tissue type.</p> <p>On 3/19/2024 on the TAR, R43 had an order of no shoes, only grippy socks for the bilateral DTIs to the heels.</p> <p>RIGHT ACHILLES</p> <p>On 1/23/2024 on the Treatment Administration Record (TAR), nursing was instructed to suspend heels with pillows while in bed and was to have a turn schedule while in bed and sign off on the intervention every shift.</p> <p>On 2/10/2024 on the TAR, wound care was ordered to apply skin prep to bilateral heels twice daily.</p> <p>(continued on next page)</p> | | |

| | | | |
|--|---|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525596 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 03/27/2024 |
| NAME OF PROVIDER OR SUPPLIER Hales Corners Care Ctr | | STREET ADDRESS, CITY, STATE, ZIP CODE 9449 W Forest Home Ave Hales Corners, WI 53130 | |
| For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency. | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) | | |
| F 0686 Level of Harm - Actual harm Residents Affected - Few | <p>On 2/14/2024 on the Wound Evaluation Flow Sheet, RN Sup-D charted R43 developed a DTI to the right Achilles that measured 0.2 cm x 0.3 cm that was deep maroon in color.</p> <p>The right Achilles was assessed weekly with the following measurements and characteristics:</p> <p>2/18/2024 - DTI that measured 2.5 cm x 2.0 cm that was deep maroon and not blanchable.</p> <p>2/25/2024 - DTI that measured 2.5 cm x 2.0 cm that was deep maroon and not blanchable.</p> <p>3/3/2024 - DTI that measured 1.0 cm x 0.8 cm that was deep maroon and not blanchable.</p> <p>3/10/2024 - DTI that measured 0.5 cm x 0.5 cm that was 100% purple.</p> <p>3/18/2024 - DTI that measured 0.8 cm x 0.6 cm with no characteristics of the wound.</p> <p>3/25/2024 - DTI that measured 0.5 cm x 0.5 cm with a yellow scab. Surveyor noted the yellow scab was not consistent with a DTI.</p> <p>On 3/25/2024 at 11:06 AM, Surveyor observed R43 in the doorway of R43's room. R43 stated R43 had a sore on the elbow and indicated by pointing it was on the right elbow. R43 denied any other wounds. R43 was difficult to direct in conversation and verbalized confusion as to where R43 should be at that time. R43 was observed to be wearing gripper socks and no shoes. RN Sup-D came to assist R43 to the bathroom. RN Sup-D stated R43 had fallen at home and was on the ground for about seven hours before help came and R43 sustained the pressure injury to the right elbow at that time. RN Sup-D stated they are packing the wound as a treatment.</p> <p>In the evening of 3/25/2024, R43 was transferred to the hospital for cardiac concerns and did not return to the facility during the remainder of the survey.</p> <p>(continued on next page)</p> | | |

| | | | |
|--|---|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525596 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 03/27/2024 |
| NAME OF PROVIDER OR SUPPLIER Hales Corners Care Ctr | | STREET ADDRESS, CITY, STATE, ZIP CODE 9449 W Forest Home Ave Hales Corners, WI 53130 | |
| 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 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> | <p>In an interview on 3/27/2024 at 10:00 AM, Surveyor asked Director of Nursing (DON)-B to discuss R43's pressure injuries. DON-B stated R43 had been living at home alone and had not been taking showers and the home was not clean. DON-B stated R43 had a lot of wounds when first admitted, which most have healed since admission. DON-B stated they were concerned about R43's right elbow wound because it looked infected, and they had the physician look at the wound and got a consult for the wound clinic. Surveyor asked why the right elbow wound did not have depth measurements from admission until 2/12/2024. DON-B stated they thought R43 had cellulitis and was not making progress and now has undermining because the wound clinic removed a lot of junk from the wound so now, they are irrigating and packing the wound. DON-B did not answer why there were no depth measurements for the right elbow wound. DON-B stated the wound did not look good, so they called the wound clinic. DON-B stated they call the wound clinic if a wound is not improving. DON-B stated they measure all the wounds every Sunday or Monday, depending on staffing, and then they have a wound meeting every Monday with the dietician, therapists, and Nursing Home Administrator (NHA)-A. Surveyor asked DON-B again why the right elbow wound did not have any depth measurements from admission until 2/12/2024. DON-B stated there was not depth in the beginning because of the cellulitis. DON-B stated RN Sup-D is aggressive with wounds and a lot of progress has made with wounds; the residents with wounds were admitted with them from the community. Surveyor asked DON-B who does the weekly measurements and assessments. DON-B stated DON-B and RN Sup-D will do the measurements; the LPNs will measure the wounds and then RN Sup-D will follow up. Surveyor shared with DON-B the concern depths were not documented and then the wound measured 0.4 cm depth on 2/25/2024 and needed antibiotics for a staphylococcus infection. Surveyor asked DON-B what prompted them to do a wound culture. DON-B stated there must have been something that would have made them do a culture or no progress was being made. DON-B stated they would have to look at R43's notes. Surveyor shared there was not documentation prior to the wound culture and the start of the antibiotic that showed an infective process. RN Sup-D joined the interview. RN Sup-D stated measurements are done every week. RN Sup-D stated the wound was opened to begin with. Surveyor asked RN Sup-D why there were no depth measurements of the right elbow wound for the first few weeks. RN Sup-D did not have an answer. Surveyor asked RN Sup-D what caused them to culture the right elbow wound. RN Sup-D stated there was greenish drainage and an odor, so they cultured it, and it was positive for staphylococcus and then the ortho clinic extended the antibiotic for an additional week. Surveyor asked RN Sup-D why the right elbow wound was not staged when it had 100% granulation tissue. RN Sup-D stated the staging cannot be changed. Surveyor shared with RN Sup-D that an Unstageable wound can be staged once the necrotic tissue is no longer covering the wound bed and the underlying tissue can be observed. RN Sup-D stated RN Sup-D did not know that. Surveyor asked RN Sup-D how R43 developed the DTIs to the left heel and right Achilles. RN Sup-D stated R43 kicks off the boots and constantly moves the legs. Surveyor asked RN Sup-D why the left heel was determined to be a DTI when it started as a Stage 2 blister. RN Sup-D stated it should have been documented as a healing DTI.</p> <p>On 3/27/2024 at 10:33 AM, Surveyor shared with NHA-A the concern R43's pressure injuries did not have accurate documentation of staging or measurements. No further information was provided at that time.</p> <p>2.) R19 was admitted to the facility on [DATE] with diagnoses of prostate cancer with metastases to the bone, Stage 3 pressure injury to the right lateral ankle, and cardiomyopathy. R19's significant change Minimum Data Set (MDS) assessment dated [DATE] indicated R19 had moderate cognitive impairment with a Brief Interview for Mental Status (BIMS) score of 11 and required substantial assistance with bed mobility. R19 was admitted to hospice services on 12/1/2023, shortly after admission to the facility.</p> <p>(continued on next page)</p> | | |

| | | | |
|--|---|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525596 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 03/27/2024 |
| NAME OF PROVIDER OR SUPPLIER Hales Corners Care Ctr | | STREET ADDRESS, CITY, STATE, ZIP CODE 9449 W Forest Home Ave Hales Corners, WI 53130 | |
| 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 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> | <p>R19's hospital discharge summary dated 11/16/2023 indicated R19 had a chronic right ankle ulcer that was stable.</p> <p>On 11/20/2023 on the Wound Evaluation Flow Sheet, nursing charted R19 had a Stage 3 pressure injury that measured 1.0 cm x 0.7 cm x 0.3 cm with 50% granulation and 50% slough and a dark dot in the center with thick tan exudate. The narrative on the Wound Charting progress notes stated R19 goes to the wound clinic every three weeks. Surveyor noted R19 did not go to the wound clinic at any time since admission.</p> <p>On 11/20/2023 on the Treatment Administration Record (TAR), R19 had a treatment order for the right outer ankle: cleanse with soap and water, iodisorb paste to the wound bed and cover three times a week.</p> <p>R19's right outer ankle Stage 3 pressure injury was comprehensively assessed weekly:</p> <p>11/28/2023 - Stage 3 that measured 1.0 cm x 1.2 cm x 0.4 cm with 50% granulation and 50% slough.</p> <p>12/4/2023 - Stage 3 that measured 1.0 cm x 0.7 cm x 0.2 cm with 100% granulation.</p> <p>12/12/2023 - Stage 3 that measured 1.1 cm x 0.6 cm x 0.2 cm with 100% granulation.</p> <p>12/17/2023 - Stage 3 that measured 1.3 cm x 1.3 cm x 0.2 cm with 100% granulation. A notation was made that the wound was larger, the margins indurated, and a small circular area at 9 o'clock measured 0.1 cm x 0.1 cm x 0.2 cm. Surveyor noted the smaller area did not have any characteristics other than a measurement.</p> <p>12/25/2023 - Stage 3 that measured 1.6 cm x 1.5 cm x 0.3 cm with bone visible in the center and white tissue possibly cartilage. Surveyor noted a Stage 3 pressure injury does not have bone visible; a Stage 4 pressure injury involves bone. No documentation was found the physician was notified with the deterioration of the wound.</p> <p>1/2/2024 - Stage 3 that measured 1.7 cm x 1.6 cm x 0.2 cm with 50% granulation and 50% slough.</p> <p>1/7/2024 - Stage 3 that measured 1.5 cm x 2.0 cm x 0.2 cm with 10% granulation and 90% slough.</p> <p>1/14/2024 - Stage 3 that measured 1.9 cm x 2.0 cm x 0.2 cm with 10% granulation and 90% slough.</p> <p>1/22/2024 - Stage 3 that measured 1.6 cm x 1.6 cm x 0.2 cm with 100% necrotic white tissue and macerated wound edges rolled in and purulent cream opaque exudate.</p> <p>1/28/2024 - Stage 3 that measured 1.2 cm x 1.4 cm x 0.2 cm with 100% cream colored slough and cream colored purulent drainage.</p> <p>2/6/2024 - Stage 3 that measured 1.5 cm x 1.1 cm x 0.1 cm with 40% granulation and 60% slough with cream colored purulent drainage.</p> <p>2/11/2024 - Stage 3 that measured 1.5 cm x 1.1 cm x 0.1 cm with 40% granulation and 60% slough.</p> <p>(continued on next page)</p> | | |

| | | | |
|--|--|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525596 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 03/27/2024 |
| NAME OF PROVIDER OR SUPPLIER Hales Corners Care Ctr | | STREET ADDRESS, CITY, STATE, ZIP CODE 9449 W Forest Home Ave Hales Corners, WI 53130 | |
| 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 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> | <p>2/18/2024 - Stage 3 that measured 2.0 cm x 1.2 cm x 0.1 cm with 100% granulation.</p> <p>2/25/2024 - Stage 3 that measured 2.0 cm x 1.3 cm x 0.1 cm with 10% granulation and 90% slough with purulent thick yellow exudate.</p> <p>3/3/2024 - Stage 3 that measured 2.0 cm x 1.5 cm x 0.2 cm with 60% granulation and 40% slough with purulent thick yellow exudate.</p> <p>3/10/2024 - Stage 3 that measured 1.5 cm x 1.0 cm x 0.4 cm with 90% granulation and 10% slough.</p> <p>3/18/2024 - Stage 3 that measured 1.5 cm x 1.0 cm x 0.4 cm with 100% granulation.</p> <p>3/25/2024 - Stage 3 that measured 1.5 cm x 1.0 cm x 0.4 cm with 80% granulation and 20% slough.</p> <p>Surveyor reviewed the treatment orders for R19's right outer ankle Stage 3 pressure injury.</p> <p>-On 11/20/2023, cleanse with soap and water, iodisorb paste to the wound bed and cover three times a week.</p> <p>-On 12/3/2023, metronidazole 250 mg tablet crushed and place in wound bed, cover with calcium alginate and a dry dressing. This treatment was applied one time and then the original order was reinstated.</p> <p>-1/5/2024, apply lidocaine ointment 5% for 10 minutes prior to completing right lateral ankle treatment of cleanse with soap and water, iodisorb paste to the wound bed and cover three times a week. The lidocaine ointment prior to the treatment was initiated by the hospice Nurse Practitioner on 12/21/2023 and after clarification with physicians, hospice, and pharmacy, the final 5% ointment was implemented. Surveyor noted the treatment to the wound had not changed since admission on 11/20/2023 even with a change in the appearance of the wound.</p> <p>On 3/27/2024 at 8:24 AM, Surveyor observed Registered Nurse Supervisor (RN Sup)-D complete the treatment to R19's Stage 3 right outer ankle pressure injury. R19 was in bed with heel boots on, grippy socks on, and a pillow under the calves. RN Sup-D stated R19 had gotten the scheduled morphine about 15 minutes prior so that would help with pain control during the treatment. R19 had pain to touch during the treatment. The wound measured approximately 1.0 cm x 1.0 cm x 0.3 cm with 100% granulation.</p> <p>(continued on next page)</p> | | |

| | | | |
|--|---|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525596 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 03/27/2024 |
| NAME OF PROVIDER OR SUPPLIER Hales Corners Care Ctr | | STREET ADDRESS, CITY, STATE, ZIP CODE 9449 W Forest Home Ave Hales Corners, WI 53130 | |
| 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 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> | <p>On 3/27/2024 at 10:00 AM, Surveyor interviewed Director of Nursing (DON)-B and RN Sup-D about R19's Stage 3 pressure injury to the right outer ankle. DON-B stated R19 has prostate cancer with bone metastases so is compromised. RN Sup-D stated R19 has not had any change in measurements to the wound and sometimes the slough comes and goes. RN Sup-D stated R19 is always premedicated and then lidocaine is applied to control pain. Surveyor asked RN Sup-D if R19 goes to the wound clinic because it was stated in the first assessment of the wound that R19 goes to the wound clinic every three weeks. RN Sup-D stated that may have been the case when R19 was at home, but now R19 is on hospice and with the overall decline and prognoses, we are just keeping R19 comfortable. RN Sup-D stated the iodorsorb is keeping the wound clean and dry. Surveyor shared with RN Sup-D the documentation that R19 had purulent drainage and asked if the wound had ever been infected. RN Sup-D stated the wound has never been infected and purulent was the wrong adjective; the slough was thick and stringy but has never had an infection. Surveyor asked RN Sup-D why the treatment has never changed since the wound has not progressed at all. RN Sup-D stated the wound has never been infected so they do not feel like a different treatment would help it or close it. DON-B stated R19's spouse does not want any aggressive treatments. RN Sup-D stated R19 had morphine as needed and now it is scheduled as well as needed. Surveyor asked RN Sup-D why the wound was not staged at a Stage 4 when bone was exposed. RN Sup-D stated it was not bone, it could have been white slough. DON-B showed RN Sup-D the charting where RN Sup-D documented bone or cartilage. RN Sup-D stated that RN Sup-D did not know why RN Sup-D charted that, but did not think at this time it was bone. Surveyor shared with DON-B and RN Sup-D the concern there was no documentation showing the physician was notified when there was a change in the presentation of the pressure injury. RN Sup-D stated RN Sup-D calls the physician's office every day about something and is updated when they are on the phone and the physician comes in every week and sees R19 and R19's wound.</p> <p>Surveyor reviewed R19's physician visit notes. R19 was seen by the physician on 11/23/2023, 12/18/2023, 1/21/2024, 3/3/2024, and 3/24/2024. Each visit note had the same documentation of PHYSICAL EXAM: . EXTREMITIES: no deformity, no ulceration. There was no documentation that was found indicating the physician was monitoring R19's Stage 3 pressure injury.</p> <p>In an interview on 3/27/2024 at 11:08 AM, Surveyor asked RN Sup-D if hospice was involved in the management of R19's pressure injury. RN Sup-D stated no, hospice was not involved. RN Sup-D stated the RN from hospice gets wound measurements from RN Sup-D.</p> <p>In a phone interview on 3/27/2024 at 11:46 AM, Surveyor asked hospice RN-E what involvement hospice had in the care of R19's pressure injury. RN-E stated the wound is monitored and RN-E will peel back the dressing to visualize the area but does not take measurements since the facility is already doing that. RN-E stated RN-E is the one that suggested the use of lidocaine with the wound treatments because R19 was in a lot of pain during the procedure. RN-E stated pharmacy did not have the dosage prescribed so between hospice, the facility, and the pharmacy, an appropriate lidocaine was obtained. Surveyor asked RN-E what the expectation was regarding the wound. RN-E stated they are palliative and do not expect the wound to heal because R19 has had it for a long time.</p> <p>On 3/27/2024 at 10:33 AM, Surveyor shared with NHA-A the concern R19's pressure injury documentation was difficult to follow and, after the interview with RN Sup-D, inaccurate. Surveyor shared RN Sup-D stated when bone and purulent drainage was documented, those were not accurate in describing the wound. No further information was provided at that time.</p> | | |