STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525599	A. Building B. Wing	08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Joseph Residence	107 E Beckert Rd New London, WI 54961

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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 47248 Based on staff interview and record review, the facility did not notify the State Long Term Care Ombudsman of hospital transfers for 2 Residents (R) (R22 and R43) of 4 residents reviewed for hospitalization . R22 was transferred to the hospital on 5/13/24 and 7/13/24. The State Long Term Care Ombudsman was not provided with written notice of the transfers. R43 was transferred to the hospital on 7/10/24. The State Long Term Care Ombudsman was not provided with written notice of the transfer. Findings include: The facility's Transfer or Discharge Documentation document, revised July 26, 2021, indicates: .4. Should it become necessary to make an emergency transfer or discharge to a hospital or other related institution, the facility will implement the following procedures and document in the medical record: .G. Notify the representative or other family member of the transfer and behold .I. Others will be notified as appropriate or necessary . 1. From 8/5/24 to 8/7/24 Surveyor reviewed R22's medical record which indicated R22 was transferred to the hospital on 5/13/24 and 7/13/24 for shortness of breath. R22's medical record did not include a copies of the transfer notices provided to the State Long Term Care Ombudsman. On 8/6/24, Surveyor requested copies of the written transfer notices from Director of Nursing (DON)-B. 2. From 8/5/24 to 8/7/24, Surveyor reviewed R43's medical record which indicated R43 was transferred to the hospital on 7/10/24 to rule out cardiac issues due to perspiration and pain radiating from R43's arm to chest. R43's medical record did not include a copy of the transfer notice provided to the State Long Term Care Ombudsman. On 8/6/24, Surveyor requested a copy of the written transfer notice from DON-B. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/6/24 at 11:34 AM, Surveyor received a Notice of Transfer and Discharge form for R22 and R43 from Social Worker (SW)-H. Surveyor interviewed SW-H who stated the facility did not have documentation of notification to the Ombudsman because the facility only notified the Ombudsman if the discharge was disputed or a 30 day notice was given to the resident. SW-H stated Nursing Home Administrator (NHA)-A completed the transfers and discharges and notified the Ombudsman if necessary. SW-H stated SW-H would speak with NHA-A and provide any documentation to the Ombudsman to Surveyor. On 8/6/24 at 1:52 PM, SW-H approached Surveyor and stated the facility did not have consistent communication with the Ombudsman and only notified the Ombudsman if there was a disputed transfer or a 30 day discharge notice was given. SW-H provided Surveyor with an email from the Ombudsman to NHA-A, dated 7/19/21, that indicated notification of unplanned discharges should to be sent to the Ombudsman. The email indicated most facilities send an end-of-the-month transfer summary to the Ombudsman and provide same day notification when a 30 day notice is issued. The email stated the facility should keep all notifications in case a transfer or discharge is disputed and a resident or family representative requires assistance with an appeal. The email indicated the Ombudsman should also have information regarding the transfers and discharges. On 8/7/24 at 9:12 AM, Surveyor interviewed NHA-A who stated 30 day notices are sent to the Ombudsman but hospital transfer and discharge notifications are only sent to the Ombudsman if they are disputed. NHA-A stated NHA-A believed, despite the email communication from the Ombudsman, that NHA-A was correctly following the requirements.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 47248 Based on observation, staff and resident interview, and record review, the facility did not ensure 1 Resident (R) (R20) of 1 sampled resident received the appropriate care and services to prevent urinary tract infections (UTIs). Staff did not ensure R20 received catheter care in a manner that decreased the risk of infection. Findings include: The facility's Catheter Care, Urinary policy, last reviewed 1/1/24, indicates: The purpose of this procedure is to prevent urinary catheter-associated complications, including urinary tract infections .19. Ensure collection bag is kept below the level of the bladder and that bag and tubing is off the floor . From 8/5/24 to 8/7/24, Surveyor reviewed R20's medical record. R20 had diagnoses including intestinal infectious diseases (gastroenteritis and colitis), neuromuscular dysfunction of bladder with indwelling medical device, calculus in bladder, overactive bladder, and paraplegia. R20's Minimum Data Set (MDS) assessment, dated 6/21/24, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R20 had intact cognition. R20's plan of care contained interventions to report UTI symptoms and care for R20's Foley catheter per facility protocol. On 8/6/24 at 7:59 AM, Surveyor observed Certified Nursing Assistant (CNA)-I enter R20's room to check R20's catheter. Surveyor noted R20 was in bed and R20's catheter tubing and drainage bag was on the floor under R20's bed. CNA-I noted the R20's catheter bag was empty, stated to Surveyor that care did not need to be performed, and began to leave R20's room. Before CNA-I left the room, Surveyor interviewed CNA-I who confirmed R20's catheter bag should be below the level of the bladder and not in direct contact with the floor. CNA-I left R20's room and did not place R20's catheter bag in a basin, hang the catheter bag on the side of R20's bed below the level of R20's bladder, or remove the catheter bag from the floor. Beginning at 8:04 AM on 8/6/24, Surveyor conducted a continuous observation of R20's room. Nursing staff delivered R20's breakfast tray at 8:11 AM and exited R20's room at 8:12 AM. At 8:12 AM, R20's catheter tubing and drainage bag were still on the floor under R20's bed. On 8/6/24 at 9:46 AM, Surveyor interviewed R20 who stated one of the nurses came in just a minute or so ago and moved R20's catheter bag. R20 stated R20 believed the catheter bag was put in a wash tub because R20 observed nursing staff place a wash tub on the floor. On 8/6/24 at 10:31 AM, Surveyor interviewed Director of Nursing (DON)-B who stated staff should hang a resident's catheter bag from the resident's bed or wheelchair or put the bag in a basin on the floor. DON-B confirmed it was not an acceptable practice to have a resident's catheter tubing and drainage bag in direct contact with the floor.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45942 Based on observation, staff interview, and record review, the facility did not ensure the correct amount of Jevity 1.2 (a nutritional meal supplement) was administered for 1 Resident (R) (R7) of 1 sampled resident. On 8/6/24, Surveyor observed Licensed Practical Nurse (LPN)-D administer one 237 mL (milliliter) container of Jevity 1.2 instead of the 250 mL that was ordered by the physician. Finding include: From 8/5/24 through 8/7/24, Surveyor reviewed R7's medical record. R7 was admitted to the facility on [DATE] and had diagnoses including Alzheimer's disease, dementia, adult failure to thrive, dysphagia (difficulty swallowing), and encounter for attention to gastrostomy tube (a medical device used to provide nutrition). R7 had a MIC-KEY tube (an external feeding tube with a button that sits at the level of the skin) through which R7 received nutrition. R7 did not take food or liquid by mouth. R7's medical record contained an order to administer a bolus (single dose given at one time) of 250 mL of Jevity 1.2 around mealtime and evening. On 8/6/24 at 12:07 PM, Surveyor observed LPN-D administer R7 a 237 mL container of Jevity 1.2. On 8/6/24 at 1:45 PM, Surveyor interviewed LPN-D who confirmed R7's order stated to give 250 mL of Jevity 1.2. LPN-D confirmed LPN-D administered 237 mL of Jevity 1.2 which was not in accordance with R7's order. On 8/6/24 at 1:53 PM, Surveyor interviewed Registered Dietician (RD)-E who also confirmed R7 had an order for 250 mL of Jevity 1.2. An Annual Nutrition Assessment for R7, completed by RD-E and dated 12/12/23, indicated R7 received 250 mL of Jevity 1.2 four times daily. RD-E confirmed the container of Jevity 1.2 administered to R7 was 237 mL instead of 250 mL.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51044 Based on observation, staff and resident interview, and record review, the facility did not maintain an infection prevention and control program designed to help prevent the development and transmission of disease and infection as observed during the provision of care for 4 Residents (R) (R42, R31, R20, and R34) of 4 sampled residents. Staff did not wear a protective gown during wound care for R42. Staff did not wear the appropriate personal protective equipment (PPE) during an observation of high-contact care for R31 who was on enhanced barrier precautions (EBP). R20 had a history of methicillin-resistant Staphylococcus aureus (MRSA), a chronic wound, and a catheter. The facility did not place R20 on EBP. R34 had chronic bilateral leg wounds that required wound care by the facility. The facility did not place R34 on EBP. Findings include: The facility's Enhanced Barrier Precautions policy, dated 4/26/24, states: Enhanced Barrier Precautions apply to residents utilizing devices or with wounds but are not limited to urinary catheters .wound care for chronic wounds (i.e., pressure wounds, diabetic foot ulcers, unhealed surgical wounds, venous stasis ulcers, etc.) does not include shorter lasting wounds or wounds that result from an acute injury (i.e., skin breaks or tears covered with an adhesive bandage or similar dressing). Personal protective equipment (PPE) is used during high-contact resident care activities requiring enhanced barrier precautions (EBP) .Handwashing is performed and gloves and gown are applied prior to perform the high-contact resident care activity (as opposed to before entering the room). The facility's Enhanced Barrier Precautions signage indicates High-contact resident care activities include: Dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting, device care or use: central line, urinary catheter, feeding tube, tracheostomy, and wound care. 1. From 8/5/24 to 8/7/24, Surveyor reviewed R42's medical record. R42 was admitted to the facility on [DATE] and had a stage 3 pressure injury on the left buttock. On 8/5/24 at 12:56 PM, Surveyor observed Registered Nurse (RN)-F provide wound care for R42. Surveyor observed an EBP sign on R42's bathroom door and a PPE cart inside R42's room. Surveyor observed RN-F sanitize hands and don gloves prior to wound care. Surveyor did not observe R42 don a gown prior to or during wound care. Immediately following the observation, Surveyor interviewed RN-F who stated staff should wear a gown and gloves during resident cares if a resident is on EBP. RN-F confirmed RN-F should have donned a gown prior to providing wound care for R42. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	43361 2. From 8/5/24 to 8/7/24, Surveyor reviewed R31's medical record. R31 was admitted to the facility on [DATE]. R31's Minimum Data Set (MDS) assessment, dated 6/12/24, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R31 had intact cognition. R31's care plan, dated 8/1/24, indicated R31 had a lymphedemic cluster wound on the right lower extremity. R31 also had a care plan, dated 7/26/24, that indicated R31 had recurrent moisture-associated skin dermatitis (MASD) on the right buttock and an open wound. On 8/5/24 at 10:00 AM, Surveyor interviewed R31 who stated R31 had wounds on R31's bottom and leg. Surveyor did not observe a PPE cart or EBP sign outside R31's room. On 8/6/24 at 10:02 AM, Surveyor observed an EBP sign on R31's door and a PPE cart outside R31's room. Surveyor knocked on R31's door, entered the room, and observed Certified Nursing Assistant (CNA)-G apply lotion on R31's right lower leg. CNA-G was not wearing a gown. On 8/6/24 at 10:07 AM, Surveyor interviewed CNA-G who stated CNA-G was a Restorative Aide and R31 liked to have R31's leg lotioned following R31's walking program. CNA-G stated CNA-G noticed the PPE cart outside R31's door that day and had asked if CNA-G needed to wear a gown. CNA-G stated CNA-G was told CNA-G did not need to wear a gown during ambulation with R31 but needed to wear PPE during high-contact activities like toileting. On 8/6/24 at 10:18 AM, Surveyor interviewed R31 who stated the PPE cart outside R31's room was placed there yesterday (8/5/24) in the late afternoon. R31 was unsure why the PPE cart was there. 47248 3. From 8/5/24 to 8/7/24, Surveyor reviewed R20's medical record. R20 had diagnoses including paraplegia, intestinal infectious diseases (gastroenteritis and colitis), neuromuscular dysfunction of bladder with indwelling medical device, calculus in bladder, overactive bladder, history of methicillin-resistant Staphylococcus aureus (MRSA), stage 4 sacral pressure injury, and osteomyelitis of sacral wound (dated 8/2/24). R20's MDS assessment, dated 6/21/24, had a BIMS score of 15 out of 15 which indicated R20 had intact cognition. R20's care plan contained interventions to report urinary tract infection (UTI) symptoms and care for R20's Foley catheter per facility protocol. On 8/5/24 at 10:07 AM, Surveyor interviewed R20 who stated R20 had a Foley catheter and a pressure injury on R20's bottom. R20 stated staff provided care as needed, wore gloves during cares, and brought in gloves and bandages when they completed cares. Surveyor did not observe an EBP sign or a PPE cart outside R20's room. R20's medical record did not indicate R20 was on EBP for high-contact cares. On 8/5/24 at 12:30 PM, Surveyor did not observe an EBP sign or a PPE cart outside R20's room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/6/24 at 9:46 AM, Surveyor observed an EBP sign inside R20's room and PPE and garbage bins outside R20's room. Surveyor interviewed R20 who stated nursing staff brought the sign and equipment bins the night before and began wearing gowns during cares. R20 stated nursing staff did not wear gowns before and R20 did not understand why they started now. 4. From 8/5/24 to 8/7/24, Surveyor reviewed R34's medical record. R34 had diagnoses including cellulitis of the right lower limb, pressure-induced deep tissue damage of the left and right hips, and type 2 diabetes. R34's MDS assessment, dated 6/6/24, had a BIMS score of 15 out of 15 which indicated R34 had intact cognition. R34's medical record indicated R34 had venous ulcers on the right lower extremity and an order to complete a 15 minute Epsom salt soak, cover wounds with abdominal gauze pads, and wrap with Kerlix twice daily. R34's medical record also indicated R34 was admitted with pressure injuries on the right and left gluteal crease/posterior thighs with orders to monitor and prevent the wounds from re-opening. R34's medical record did not indicate R34 was on EBP for high-contact cares. On 8/5/24 at 9:21 AM, Surveyor interviewed R34 who stated R34 had an open wound on the right leg and previous damage to the right and left hips that previously opened up. R34 stated staff brought in bandages to wrap R34's legs and wore gloves during cares. Surveyor did not observe an EBP sign or a PPE cart outside R34's room. On 8/5/24 at 12:40 PM, Surveyor did not observe an EBP sign or a PPE cart outside R34's room. On 8/6/24 at 7:55 AM, Surveyor observed an EBP sign in R34's room and PPE and garbage bins outside R34's room. On 8/6/24 at 10:31 AM, Surveyor interviewed Director of Nursing (DON)-B who confirmed R20 had an active infection and should have been placed on EBP upon admission due to R20's wounds and Foley catheter. DON-B stated DON-B was not aware R20 had a history of MRSA infection (dated 5/16/24) upon R20's admission to the facility. DON-B stated DON-B conducted an audit of all residents who should be placed on EBP and discovered on 8/5/24 that R20 and R34 should be on EBP but their care plans did not indicate EBP was required. DON-B stated nursing staff were educated on when EBP is required which is during any personal contact such as transfers, personal cares (including washing and lotioning), toileting assistance, brushing teeth, wound care, and catheter care. DON-B stated nursing staff should implement EBP when a resident receives cares or is touched during cares and assistance.