

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525609	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/30/2025
NAME OF PROVIDER OR SUPPLIER St Marys Home for the Aged		STREET ADDRESS, CITY, STATE, ZIP CODE 1635 S 21st Street Manitowoc, WI 54220	

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 0637</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Assess the resident when there is a significant change in condition</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51044</p> <p>Based on staff interview and record review, the facility did not ensure a Significant Change in Status (SCIS) Minimum Data Set (MDS) assessment was completed timely for 1 resident (R) (R1) of 3 sampled residents.</p> <p>R1 met the criteria for a Significant Change in Status MDS assessment on 3/15/25. A SCIS assessment was not completed.</p> <p>Findings include:</p> <p>The Centers for Medicare and Medicaid Services (CMS) Resident Assessment Instrument (RAI) manual 3.0 states a Significant Change in Status MDS must be completed when the Interdisciplinary Team determines a resident meets the significant change guidelines for either a major decline or a major improvement. A significant change is a major decline or improvement in a resident's status that: 1. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions; the decline is not considered self-limiting; 2. Impacts more than one area of the resident's health status; and 3. Requires interdisciplinary review and/or revision of the care plan.</p> <p>The facility's Significant Change of Resident's Condition or Status policy, revised 2/21/19, indicates: .2. Significant change of condition related to MDS criteria. a. A significant change (based on MDS guidelines) of condition is a decline or improvement in the resident's status that: .ii. Impacts more than one area of the resident's health status; .7. Significant change assessments: a. If a significant change in the resident's physical or mental condition occurs, a comprehensive assessment of the resident's condition will be conducted as required by current Omnibus Budget Reconciliation Act (OBRA) regulations governing resident assessments and as outlined in the MDS RAI instruction manual.</p> <p>On 4/30/25, Surveyor reviewed R1's medical record. R1 was admitted to the facility on [DATE] and had diagnoses including traumatic subdural hemorrhage, flaccid hemiplegia affecting right dominant side, left subdural hematoma, and history of falls. R1's MDS assessment, dated 2/17/25, had a Brief Interview for Mental Status (BIMS) score of 8 out of 15 which indicated R1 had moderate cognitive impairment. R1 had an activated Power of Attorney for Healthcare ((POAHC)-E).</p> <p>R1's MDS assessment, dated 2/17/25, indicated the following:</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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0637</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>~ No impairment in extremities</p> <p>~ Eating assist - set up</p> <p>~ Brushing teeth - no assistance</p> <p>~ Mobility - partial/moderate assist, helper does half the effort</p> <p>~ Chair to bed transfer - partial/moderate assist, helper does half the effort</p> <p>~ Walking - walk 10 feet with supervision and touching assistance; walk 50 feet with supervision, touching assistance, and verbal cues</p> <p>~ Wheelchair - wheel 50 feet with 2 turns - requires verbal cues or touching/steadying assistance</p> <p>~ Swallowing - no loss of liquids, coughing, or chewing difficulties</p> <p>On 4/30/25, Surveyor reviewed a Certified Nursing Assistant (CNA) care plan, dated 4/9/25, that was posted on the wall in R1's room. The care plan indicated R1 required a medical stand with the assistance of 2 staff for all transfers. The care plan also indicated R1 needed assistance with activities of daily living (ADLs), including eating and thorough hygiene, due to right-sided weakness. R1 had an order for an easy chew diet with soft, bite-sized meat (pureed soup) and mildly thick liquids.</p> <p>On 4/30/25 at 12:37 PM, Surveyor interviewed Registered Nurse (RN)-F who indicated the last MDS assessment RN-F completed was dated 2/17/25. RN-F indicated R1 was discharged from Hospice services in early February. RN-F did not complete a SCIS MDS assessment because RN-F was not sure if R1 met the requirements of a significant change in status.</p> <p>On 4/30/25 at 1:15 PM, Surveyor interviewed Director of Rehab (DOR)-C who reviewed R1's therapy notes and indicated R1 required a sit-to-stand lift with the assistance of 2 staff for transfers. DOR-C indicated R1 was unable to stand at a walker with moderate assistance of 2 staff. DOR-C stated R1 had decreased range of motion (ROM) and strength in the right extremities and indicated R1 required the assistance of 1 staff for eating due to decreased strength and ROM in the right arm. DOR-C indicated R1 coughed with liquids and was changed to mildly thick liquids. R1 was prescribed an easy chew, soft, bite-sized diet. DOR-C indicated R1 had a significant decline in ADL function since 3/15/25.</p> <p>On 4/30/25 at 3:29 PM, Surveyor interviewed CNA-D who indicated R1 required a sit-to-stand lift with the assistance of 2 staff for transfers and was unable to stand at a walker with assistance. CNA-D stated R1 was able to self-propel a wheelchair a few feet, however, staff pushed R1 in wheelchair because propelling a wheelchair was difficult for R1. CNA-D indicated R1 required the assistance of 1 staff for dressing and brushing R1's teeth. CNA-D verified R1 required assistance with eating and was on thickened liquids.</p> <p>On 4/30/25 at 2:26 PM, Surveyor interviewed POAHC-E via telephone who stated R1 had a SCIS on 3/15/25. POAHC -E indicated R1's ADL functional abilities had declined since 3/15/25.</p> <p>On 4/30/25 at 3:14 PM, Surveyor interviewed NHA (Nursing Home Administrator)-A who indicated the facility was aware of R1's change in condition and verified a SCIS MDS assessment was not completed.</p>		