STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525625	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakeland Health Care Ctr	1922 Cty Rd Nn Elkhorn, WI 53121

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16584 Based on record review and staff interviews, the facility did ensure 1(R61) out of 18 residents were free from neglect. R61 needed extensive assistance from staff to use the toilet and to transfer on and off the toilet. When R61 would become fatigued, often in the evening, staff would use an EZ stand to transfer R61 on and off the toilet. On 12/24/24, 2nd shift staff member left R61 attached to the sling for the EZ stand, seated on the toilet at approximately 9:30 p.m The 2nd shift CNA left the facility at the end of her shift without providing cares to R61 and transferring R61 back to bed. A night shift nurse found R61,at approximately 12:45 a.m., still seated on the toilet and was visibly upset. R61 is unable to make her needs known and has a diagnosis of dementia. This is evidenced by: Policy Review: Freedom from Abuse, Neglect and Exploitation origination date : 04/2013. Last revision: 02/2024 Definitions: Neglect is defined as the indifference or disregard for resident care, comfort, or safety, result in or could result in physical harm, mental anguish, or emotional distress. Additionally, Wisconsin State Regulation, DHS 13 further defines neglect as an intentional omission or intentional course of conduct by a caregiver or a non-client resident, including but limited to restraint, isolation or confinement that is contrary to the entity's policies and procedures, not a part of the client's treatment plan and , through substantial carelessness or negligence does any of the following: iii.) Causes or could reasonably be expected to cause mental or emotional damage to a client, including harm to the client's psychological or intellectual functioning that is exhibited by anxiety, depression, withdrawal, regression, outward aggressive behavior, agitation, fear of harm or death. R61 was admitted to the facility on [DATE] with diagnosis that included Dementia, major depressive disorder, muscle weakness and anxiety. (continued on next page)

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The most recent annual MDS (Minimum Data Set), dated 8/18/24, documents R61 has unclear speech, is rarely/never understood and rarely/never understands others. R61 has impaired vision and has adequate hearing. R61 was unable to complete the BIMS (brief interview for mental status) and has long and short-term memory impairments. R61 is severely impaired with cognitive skills for daily decision making. R61 uses a wheelchair for mobility and is dependent on staff for toileting needs. R61 is at risk for developing pressure ulcers. R61 has experienced 1 fall at the facility, since admission, without injury. Surveyor conducted a review of R61's plan of care and noted the following: R61 has a self-care deficit. Has Dementia, adjustment disorder with mixed anxiety and depression. Date Initiated: 08/16/2022 .Revision on: 08/16/2022 Interventions include: * TOILET USE: Extensive handheld assist with 1 staff. May use 2nd staff for toilet hygiene, clothing management, If resistive to peri care or unable to complete peri care post bowel movement may lay her down to complete hygiene in bed. I wear a pull up briefs during the day and tan brief at HS (hour of sleep). *Do NOT leave in bathroom unattended. Date Initiated: 08/24/2022 Revision on: 03/28/2024 * TRANSFER: [R61's name] requires extensive handheld assist. May use stand up lift if needed. Date Initiated: 08/16/2022. Revision on: 02/16/2024 Surveyor conducted a further review of R61's medical record and noted the following: On 12/25/2023, at 06:33a.m., Incident Note Text: Unit nurse informed writer that R61 was found in the BR (bathroom) on the toilet with an EZ stand sling in place and the stand in front of her. It was suspected that the resident was taken to the toilet prior to HS cares and HS cares and transfer was not completed. The PM CNA (certified nursing assistant) assigned to her HS care was contacted and it was determined that the resident was left on the toilet attached to the EZ stand and did not have cares completed nor transferred to bed. R61 unable to verbalize except in one-word expressions. Distress was exhibited when resident approached but had no impaired skin integrity and vitals checked and documented. HS completed and resident transferred to bed. Recheck of resident showed resident settled through night. Risk management report completed and on call management contacted. Monitoring and observation continued for seventy-two hours. On 12/25/2023, at 08:19 a.m., Incident Note Text: Writer was rounding at 0045 (12:45 AM), R61's door was closed, and light was on. Upon checking, found R61 still sitting on the toilet with EZ stand in front of res (resident). The time of how long the res has been on the toilet is unknown. R61 was wearing her top regular t-shirt, nothing on the bottom, shoes were on res feet. R61 extremities were cold to touch. Res appears to be upset, saying the word puta numerous times. Skin inspected and skin intact. No redness to gluteus. Recheck of resident at approximately 0400 (4:00 AM) showed resident resting and not disturbed by presence in room. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/25/2023, at 11:03 a.m., Psychosocial Note Text: No apparent emotional distress observed following toileting Incident on 12/25/23. R61 is pleasant this morning talking and laughing to self at breakfast table per resident usual. Resident is unable to recall what happened with toileting Incident on 12/25/23 . R61 quietly in recliner at this time. On 08/27/24 at 12:00 p.m., Surveyor conducted a review of facility's investigation indicating on 12/24/24, R61 was found on the toilet by night shift on 12/25/23 , at approximately 12:45 a.m., still hooked up to the stand-up lift on her and her HS cares were not completed by PM staff. The investigation stated R61 was placed on the toilet at approximately 9:30 p.m., leaving R61 on the toilet for approximately 3 hours and 15 minutes. R61 was transferred to bed and RN (Registered Nurse) completed skin assessment with skin integrity intact. R61 unable to verbalize except in one-word expressions, vitals checked . R61 was rechecked by nurse and showed R61 settled through night. Monitoring and observation of psychosocial well-being continued for seventy-two hours. MD (Medical Doctor) and family made aware in the am shift . R61 is now care planned to not be left alone on toilet. Investigation started. R61 was visibly upset when nurse found her. She was provided with cares and slept throughout the night. R61 was monitored by nursing and social services for changes in mood or behavior with no changes noted. R61 was checked at the time of the incident and skin was intact however on day shift it was noted that there were bruises to calf area bilaterally which are now healing. On 8/29/24 at approximately 10:00 a.m., Surveyor interviewed Administrator - A in regards to R61 being left on the toilet for an extended period of time. Administrator- A stated that the facility was able to substantiate the allegation of neglect and the employee no longer works at the facility. As of the time of exit on 8/29/24, no additional information had been provided as to why staff had left R61 on the toilet for an extended period of time without assistance with cares and transferring.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38829 Based on record review and staff interviews, the facility did not ensure that 2 allegations of abuse involving 5 Residents (R32, R12, R62, R27, and R39) were reported immediately to the Nursing Home Administrator (NHA)-A and the State Survey Agency. *On 2/3/24, and 2/4/24, Registered Nurse (RN)-Q documented R32 was verbally abusing R12, R62, and R27 and did not report this to NHA-A. *On 6/10/24, R39 reported an allegation of mistreatment by a CNA on 6/9/24. The allegation was not reported to NHA-A until 6/17/24. The facility's policy entitled, Freedom From Abuse, Neglect and Exploitation, last revised 2/2024 documents: BACKGROUND . Residents will not be subjected to abuse by anyone, including but not limited to, facility staff, other Residents, consultants or volunteers, staff of other agencies serving the Resident, family members or legal guardians, friends or other individuals. G. Reporting and Response Components Abuse Policy Requirements: It is the policy of the facility that abuse allegations are reported per Federal and State Law. The facility will ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of Resident property, are reported immediately, but not later than 2 hours after the allegation is made if the events that cause the allegation involve abuse or result in serious bodily injury, or no later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and the DQA (Division of Quality Assurance) in accordance with State law through established procedures. In addition, local law enforcement will be notified of any reasonable suspicion of a crime against a Resident in the facility. PROCEDURE: INTERNAL REPORTING: a. Employees, and contracted employees will receive orientation and education on the facility Abuse Policy and reporting requirements. Staff must always report any abuse or suspicion of abuse immediately to the Administrator and Director of Nursing. **Note: Failure to report can make employee just as responsible for the abuse in accordance with State Law. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. The Nursing Home Administrator, Director of Nursing, and Social Services Manager will involve key leadership personnel as necessary to assist with reporting, investigation and follow up. External Reporting: Each covered individual shall report to Division of Quality Assurance and one or more law enforcement entities for the political subdivision in which the facility is located, any reasonable suspicion of a crime against any individual who is a Resident of or is receiving care from, the facility, and each covered individual shall report immediately, but not more than 2 hours after forming the suspicion, if the events that cause suspicion result in serious bodily injury or not later than 24 hours if the events that cause the suspicion do not result in serious bodily injury. Surveyor reviewed the Alleged Nursing Home Resident Mistreatment, Neglect, and Abuse Report submitted to the State Agency on 2/5/24. The report documents R32 verbally abused R12 started on 2/3/24. On 2/4/24, there were two more incidents of verbal abuse from R32 towards R62 and R27. Surveyor notes the Nursing Home Administrator (NHA)-A was not notified of the initial verbal abuse between R32 and R12 occurring on 2/3/24 and 2/4/24. Surveyor notes R32's verbal abuse towards other Residents (R62 and R27) was discovered on 2/5/24 during a review of medical records by the Facility. 1) R32 was admitted to the facility on [DATE] with diagnoses of Alzheimer's Disease, Unspecified Dementia with Agitation, Anxiety Disorder, Major Depressive Disorder, Type 2 Diabetes Mellitus, Heart Failure, Dysphagia, Oropharyngeal Phase, Other Abnormalities of Gait and Mobility, and Repeated Falls. R32 has a legal guardian. R32's Quarterly Minimum Data Set (MDS) completed 8/12/24 documents R32's Brief Interview for Mental Status (BIMS) score to be 6, indicating R32 demonstrates severely impaired skills for daily decision making. R32's MDS documents R32 exhibits verbally abusive behaviors 1-3 days over the last 7 days. R32 has no mood concerns. R32 has range of motion impairment on one side of lower extremities. R32 is dependent for lower body dressing and partial/moderate assistance for upper body dressing. R32's MDS also documents R32 requires partial/moderate assistance for hygiene, and substantial/maximum assistance for mobility and transfers. -R12 was admitted to the facility on [DATE] with diagnoses of Depression, Major Depressive Disorder, Unspecified Dementia, Chronic Obstructive Pulmonary Disease, Chronic Kidney Disease, Stage 4, Heart Failure, and Peripheral Vascular Disease. R12 has an activated Health Care Power of Attorney(HCPOA). R12's Quarterly MDS completed 7/1/24 documents R32's BIMS score to be 12, indicating R12 demonstrates moderately impaired skills for daily decision making. R12 has no mood or behaviors documented. R12 has range of motion impairment on both sides of lower extremities. R12 requires partial/moderate assistance for upper dressing, substantial/maximum assistance for lower dressing, and substantial/maximum assistance for mobility and transfers. -R62 was admitted to the facility on [DATE] with diagnoses of Alzheimer's Disease, Unspecified Dementia with other Behavioral Disturbance, Anxiety Disorder, Depression, and Hyperlipidemia. R62 has a legal guardian. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R62's Quarterly MDS completed 6/3/24 documents R62's short and long term memory is impaired and demonstrates severely impaired skills for daily decision making. R62 has no mood or behavior issues. R62 has no range of motion impairment. R62 requires supervision for upper and lower body dressing and is independent for mobility and transfers. -R27 was admitted to the facility on [DATE] with diagnoses of Depression, Dementia, Psychotic Disturbance, Mood Disturbance and Anxiety, Delusional Disorders, Anxiety Disorder, Alzheimer's Disease, Hypothyroidism, and Hyperlipidemia. R27 has an activated HCPOA. R27's Quarterly MDS completed 6/3/24 documents R27's short and long term memory is impaired and demonstrates severely impaired skills for daily decision making. R27 has no mood or behavior issues. R27 has range of motion impairment on both sides of lower extremities. R27 requires partial/moderate supervision for upper dressing and is dependent for lower dressing. R27 requires partial/moderate assistance for mobility and transfers. On 2/2/2024, at 6:29 PM, Registered Nurse (RN)-Q documented in R32's medical record: Late Entry: Note Text: R32 told R62 that R62 was a stupid idiot and told R62 to go away. R62 just stood and looked at R32. This writer took R62 to TV area to watch a movie. R62 did not appear to be effected by R32's comments. On 2/3/2024, at 6:33 PM, Registered Nurse (RN)-Q documented in R32's medical record: Late Entry: Note Text: R12 was having a conversation with R32 when R32 yelled out, get out of here, to this R12 said I do not have to leave I live here also. R32 replied I will just have to kill you then. Writer took R32 to her room and away from R12. By the time R32 got to her room she did not recall what happened with R12. R32 just asked for TV to be turned on. There is no documentation of R32 verbally abusing R27 in any medical records. The following is documented: On 2/6/2024, at 2:40 PM, Licensed Practical Nurse (LPN)-M Note Text: R27 has no recollection of conversation with peer on 2/4/24. R27 appears calm and content. No signs/symptoms of distress noted. Resting quietly in day area at this time. The summary attached to the Facility's Misconduct Incident Report dated 2/8/24 documents: On 2/3/24, R32 after the evening meal was talking with R12 and suddenly R32 tone changed and told R12 to go away and R12's name replied, I do not have to leave here, I live here, you leave. R32 then stated, I will have to kill you then. On the evening shift of 2/4/24, R32 was agitated after evening meal, R62 was pushing R32's wheelchair. R32 yelled at R62 to stop and then R32 called R62 a stupid idiot and get away. R32 also yelled at R27, get out of here, you do not belong here. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor notes per facility documentation, R32 was de-escalated, put on 30 minute checks, monitored closely for aggression, and new interventions put into place for R32. All Residents were monitored for psychosocial outcome. On 8/28/24, at 11:59 AM, NHA-A confirmed the facility has brought in a dementia specialist from out of state on a regular basis who has actually made several observations of the memory care unit and helped with interventions for specific Residents and recommended environment changes On 8/28/24, at 2:55 PM, Surveyor shared the with NHA-A and Director of Nursing (DON)-B that the first two documented Resident to Resident altercations reports by RN-Q of potential verbal abuse were not reported immediately to NHA-A. NHA-A confirmed the Resident to Resident altercations involving R32, R12, R62, and R27 were not reported immediately per regulatory requirement. On 8/29/24, at 7:58 AM, The Facility provided documentation that the most recent all staff abuse prevention training was held on 11/6/23. 50700 2) R39 was admitted to the facility on [DATE] with diagnosis that included hallucinations, primary open-angle glaucoma, need for assistance with personal cares, major depressive disorder, generalized anxiety disorder, and transient cerebral ischemic attack. R39's Admission Minimum Data Set (MDS) assessment dated [DATE] documented a BIM (Brief Interview for Mental Status) score of 13, indicating R39 is cognitively intact for daily decision-making skills; a PHQ-9 (Patient Health Questionnaire) score of 0, indicating minimal depressive symptoms. R39's Significant Change MDS with an assessment reference date of 7/1/24 documents a BIMS score of 14, indicating R39 is cognitively intact for daily decision making; and a PHQ-9 (Patient Health Questionnaire) score of 1, indicating minimal depressive symptoms R39's care plan, with a target date of 09/24/2024 documents, R39 is independent/dependent on staff etc. (etcetera) for meeting emotional, intellectual, physical, and social needs r/t (related to) current health status. With a goal of: R39 will maintain involvement in cognitive stimulation, social activities as desired through review date. Interventions include: all staff to converse with R39 while providing care. Topics may include her travels with her sister and friend group . her work history. R39 prefers to socialize with: her family and staff friends she has made during her recent stays and those when volunteering. On 6/10/24, at 14:35 (2:35 PM), R39's medical record documents, Resident made remark to PT (Physical Therapist) that she could not do therapy today b/c (because) she is too worked up from the male CNA entering her room and taking her clothes off yesterday. Writer spoke with her she was pleasant, smiling, and felt better and concerned that she is getting all her pills. No further comments made regarding the male CNA or being worked up. Note was written by Licensed Practical Nurse (LPN)- H (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor notes LPN-H didn't report this concern to the supervisor or Facility administration immediately after LPN-H was made aware. On 6/17/24, at 11:40 AM, R39's medical record documents, SW (Social Worker) interviewed [R39's name] about her concerns regarding a CNA, clarified which employee. She (R39) stated she was concerned about her positioning during cares. Resident states she would prefer no male care givers during personal cares. [R39] states that she hallucinates and has nightmares. She is severely visually impaired. She is adjusting after admitting and isolation after illness. She (R39) has an upcoming neurological appt (appointment) to address Parkinson's hallucinations and symptoms. SW to continue to monitor and offer support. Is being followed by psych (Psychiatric) NP (Nurse Practitioner) and had a recent increase in medications. This SW updated sister. Surveyor notes documentation of no male CNA's (certified nursing assistant) is documented in R39's Electronic Medical Record (EMR) under the Profile page but not documented on R39's care plan. On 6/17/24, at 13:33 (1:33 PM), R39's medical record documents, this afternoon writer rcvd (received) a call from resident's sister [name of sister] stating that she had a concern from resident reg [sic] a CNA (Certified Nursing Assistant) named [CNA] . is rough with her, she says he hurts her, and she is petrified of him. Writer re-assured her that she is doing the right thing to voice her concerns and explain the possible steps that will be taken and that she would most likely be receiving a call from social service dept. (department). Writer talked to the unit manager who then talked to SS (Social Service) staff reg [sic] above concern. Note was written by Registered Nurse (RN)-R. On 08/26/2024, at 10:15 AM, Surveyor observed R39 lying in bed. R39 informed Surveyor they have no concern with staff or call light wait times and is happy at the facility. On 08/27/2024, at 08:15 AM, Surveyor observed R39 sleeping, and R39 didn't want to talk this morning. R39 asked Surveyor to come back later. On 08/27/2024, at 10:12 AM, Surveyor interviewed R39 about feeling safe at the facility and how staff treat her. R39 states most of the staff are nice, I feel safe here except for with that one person. R39 states around the time R39 first arrived at facility that there was one CNA that R39 didn't feel safe around. Surveyor asked R39 if there are concerns with having male caregivers assigned, because Surveyor noted a no male caregivers requested documented in R39's EMR on the profile page. R39 stated no, I don't mind males, just the one person, but I don't want to say his name. R39 stated they have been here (at the Facility) for about 4 months, and there was one person that I had a problem with, and I reported it, and they took care of it. R39 states she told a lot of people, including her sister. Surveyor asked if R39 talked with social services about concern and she states she don't remember exactly everyone she talked to and can't confirm social services was one of them. R39 states she is blind in the right eye, and has poor eyesight in the left eye, but can remember this situation. R39 states she was going through a lot with her health at the time with a UTI (urinary tract infection) and pneumonia and going out to the hospital and forgot parts of that but not the situation with the male CNA, this she remember but didn't want to say his name because he doesn't come in here, anymore. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	08/27/24, 12:19 PM, Surveyor observed R39 sitting in her room in a recliner with a blanket on, feet elevated and smiled when greeting this Surveyor. R39 again states she doesn't mind male CNAs but doesn't want the one male that the facility knows about already and doesn't want to mention his name. Surveyor notes R39's medical record documents no male CNAs on the profile page however this information isn't documented in R39's care plan. R39 states she don't recall seeing any male CNAs in her room since telling everyone. Surveyor requested any Facility self-reports or investigations related to R39. The Facility provided Surveyor with an investigation completed related to allegations of potential abuse made by R39. Surveyor notes the Facility conducted an interview with R39 and investigated the allegations on 06/17/24. The Facility documented R39 stated CNA-G twists her bra/breast area. [NAME] asked about feeling safe R39 stated she doesn't want CNA-G as a caregiver. A statement from CNA-G was also included in investigation packet. CNA-G's statement documented he has not worked with R39 since 6/9/24 and denies any misconduct. Surveyor notes the Facility did not report the allegation of abuse to the State Agency. On 08/28/2024, at 03:10 PM, Surveyor interviewed LPN-H, who stated they had been employed at the Facility for [AGE] years. LPN-H stated they spoke to R39 after therapy and R39 made some statements but then R39 seemed fine after talking about the situation. LPN-H stated she looked into it and it was a female CNA that put R39 to bed that night. R39 goes to bed early on 2nd shift and I checked the schedule and the night before a female CNA put her to bed, so I didn't think there was an issue. LPN-H stated she looked into this because you guys have been really on the documenting thing lately. Surveyor asked LPN-H if she would report this situation to a supervisor. LPN-H stated R39 was fine, even happy and smiling and talking fine with me after, so I didn't see an issue/concern that needed to be reported. LPN-H stated this isn't new behavior for her, R39 refuses cares like this. Surveyor asked LPN-H about reporting changes in residents behaviors. LPN-H stated she has 30 residents, is only one person, and can only get so much done. Surveyor reviewed the Facility investigation and noted CNA-G did work with R39 on 6/09/24. LPN-H informed Surveyor she didn't report the alleged abuse related to her own investigation and belief there was no concern. Surveyor notes LPN-H correctly identified the CNA that worked second shift being a female on 6/9/24 per the schedule but the CNA on third shift was a male and in fact was CNA-G, and this was confirmed with the written statement from CNA-G in facility's investigation on 06/17/24. On 08/28/2024, at 01:56 PM, Surveyor informed Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B of the concern R39's allegation of abuse was not reported immediately to the Nursing Home Administrator or to the State Agency.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42037 Based on record review and interview, the facility did not implement fall prevention interventions to prevent falls and did not consult with a physician post fall 2 (R72, R32) of 9 residents reviewed for accidents. *R72 sustained an injury of unknown origin to their scalp that was not properly assessed or reported to physician until 3 days later. * R32 sustained an unwitnessed fall from the toilet due to being unsupervised in the bathroom. R32's comprehensive care plan indicates that they are not to be left alone on the toilet. Findings include: Surveyor reviewed the facility's policy and procedure entitled, Fall Prevention Program, last revised 4/2024 which documents: . Background The facility must ensure that the Resident environment remains free of accident hazards as is possible and each Resident receives adequate supervision and assistive devices to prevent falls and/or accidents. Goal The goal is to create a systems approach by which the facility identifies Residents at risk for falls, evaluates the circumstances causing risk or which may have caused a fall, implements interventions to prevent falls or fall reoccurrence and monitors and/or modifies the plan as needed. Surveyor also reviewed the facility's policy and procedure entitled, Interdisciplinary Plan of Care last revised 11/2023 which documents: Purpose .Provide each Resident with necessary individualized care and services that is Resident centered and Resident driven to improve or maintain highest level of physical, mental, and psychosocial well-being in the, least restrictive environment. Care plan is individualized based on Resident and Resident representative preferences all staff to maintain and follow personalized plan of care. R72 was admitted to the facility on [DATE] with diagnoses of cognitive communication deficit and intracerebral hemorrhage. R72's Quarterly MDS (Minimum Data Set) date of 7/31/24 indicates a BIMS (Brief Interview for Mental Status) Score of 05. This score indicates that R72's mental capacity severely impacts their daily decision making and communication. R72 also requires a wheelchair for mobility and is at risk for falls. R72 requires total assistance with toileting and is unable to toilet self independently due to physical and cognitive limitations. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525625	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakeland Health Care Ctr	1922 Cty Rd Nn Elkhorn, WI 53121

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor conducted a review of a Facility Reported Incident dated 7/10/24 at approximately 7:05 PM. On 7/10/24, R72 was noted with a 3.0 cm x 3.6 cm raised hematoma of unknown origin to the back of their scalp. An investigation was initiated at this time. Investigation lead to the discovery that on 7/7/24, R72 reported to CNA (Certified Nursing Assistant)-K that they had bumped their head on a cabinet in their bathroom. CNA-K reported to LPN-L on 7/7/24 that R72 told CNA-K that they had hit their head earlier in the day. LPN-L did not approach R72 on 7/7/24 to visualize R72's scalp or initiate neurological checks due to R72's allegation of hitting their head on the cabinet. There was no documented monitoring of R72, including an RN assessment or neurological checks from 7/7/24 to 7/9/24 despite R72 reporting hitting their head on 7/7/24. On 8/28/24, CNA-K and LPN-L were not available for interview. On 8/29/24, at 9:20 AM, Surveyor conducted an interview with LPN-M. Surveyor asked LPN-M what the facility's protocol would be for conducted neurological checks for a resident who alleges that they have hit their head. LPN-M responded that neurological checks should be conducted every shift for 3 days for any unwitnessed fall or head injury. Surveyor asked LPN-M if a resident alleges that they have hit their head what the facility's protocol would be for follow up. LPN-M said that they would go to see the resident immediately, alert an RN and initiate neurological checks. On 8/29/24, at 10:30 AM, Surveyor conducted interview with DON (Director of Nursing)-B. Surveyor asked DON-B what the facility's protocol would be for a resident who alleges that they have hit their head. DON-B responded that the facility's protocol would be to initiate neurological checks every shift for 3 days and to monitor the resident until neurological checks are completed and until any injuries that resident sustained are resolved. Surveyor questioned DON-B whether or not it would be appropriate for R72 to be in the bathroom unsupervised and if this had been assessed during the investigation of R72's injury of unknown origin. DON-B told Surveyor that they would need to look into this further. On 8/29/24, at 12:15 PM, DON-B and NHA (Nursing Home Administrator)-A approached Surveyor. NHA-A told Surveyor that they had spoken to CNA-K over the phone. NHA-A reported that on 7/7/24 during evening cares, R72 had reported to CNA-K that they had hit their head on the bathroom cabinet earlier in the day. NHA-A added that R72 does have a history of self propelling their wheelchair as well as a history of self-transfers. Surveyor asked NHA-A and DON-B if the possibility of R72 self-transferring on 7/7/24 had been investigated by facility staff. NHA-A explained that the investigation had been focused on the lack of initial assessment on 7/7/24 and that conducting interviews with staff and residents in addition to education to staff about neurological checks and follow up on injuries of unknown origin. On 8/29/24 at 12:30 PM, Surveyor shared concern related to the failure of LPN-L to conduct a visual examination of R72 on 7/7/24 after CNA-K had reported that R72 had hit their head earlier in the day and sustained a 3.0 cm x 3.6 cm raised hematoma. Surveyor shared concern the facility did not initiate neurological checks for R72 upon reports that R72 had hit their head on 7/7/24. Surveyor shared concern related to R72 not receiving an assessment by an RN on 7/7/24 after reporting that R72 had hit their head earlier in the day sustained a 3.0 cm x 3.6 cm raised hematoma. Surveyor shared concern related to R72's cognitive status and the potential that they had been alone in the bathroom that had not been investigated thoroughly with their investigation of R72's injury of unknown origin. No additional information was provided by the facility at this time. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525625	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/29/2024
NAME OF PROVIDER OR SUPPLIER Lakeland Health Care Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 1922 Cty Rd Nn Elkhorn, WI 53121	

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	38829 2) R32 was admitted to the facility on [DATE] with diagnoses of Alzheimer's Disease, Unspecified Dementia with Agitation, Anxiety Disorder, Major Depressive Disorder, Type 2 Diabetes Mellitus, Heart Failure, Dysphagia, Oropharyngeal Phase, Other Abnormalities of Gait and Mobility, and Repeated Falls. R32 has a legal guardian. R32's Quarterly Minimum Data Set (MDS) completed 8/12/24 documents R32's Brief Interview for Mental Status (BIMS) score to be 6, indicating R32 demonstrates severely impaired skills for daily decision making. R32's MDS documents R32 demonstrates verbally abusive behaviors 1-3 days over a 7 day period. R32 has range of motion impairment on one side of lower extremities. R32 is dependent on staff assistance for lower body dressing and partial/moderate assistance for upper body dressing. R32's MDS also documents R32 requires partial/moderate assistance for hygiene, and substantial/maximum assistance for mobility and transfers. R32 has the following fall assessments completed: -2/9/24, Q (Quarterly) Fall Assessment-Moderate risk identified with a score of 16 -5/10/24, Q Fall Assessment-Moderate risk is identified with a score of 17 -8/7/24, Q Fall Assessment-Moderate risk is identified with a score of 18 R32's Visual/Bedside Kardex Report dated 8/27/24 instructs staff: Safety *Offer and assist to the bathroom if I appear restless. I can not be left unattended while using the bathroom as I may attempt to self transfer. Toileting *1 or 2 assist for toileting. May use stand lift with toilet if needed. L/XL (Large/Extra Large) at all times. Offer to assist to toilet approximately every 2 hours during night time, upon arising, before and after meals, at HS (hour of sleep), and as needed. R32's comprehensive care plan documents: R32 has had an actual fall. R32 has dementia, impaired mobility, and poor safety awareness. Initiated: 8/7/20 and Revised: 8/14/24 Intervention in place related to falls: -Offer and assist to the bathroom if I appear restless. I can not be left unattended while using the bathroom as I may attempt to self transfer. I need my bed in the low position for safety. After the evening meal encourage and offer me to ambulate and use the bathroom. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Initiated: 5/13/21 and Revised: 1/19/24 The following was documented in R32's electronic medical record by Assistant Nurse Manager (ANM)-J on 2/9/24, at 3:05 PM, Note Text: Writer was notified by unit LPN at 1138 (11:38 AM) that R32 had fallen. Upon entering the room unit nurse and CNA (Certified Nursing Assistant) was present. It was noted that R32 had sustained the fall in the bathroom of R32's room. R32 was awake, alert to self and verbalizing that R32 wanted to get up off the floor. R32 was sitting on R32's buttock on the bathroom floor with R32's back against the wall and both knees drawn up towards R32's chest. R32 had R32's tennis shoes on, R32's pants and brief where in a down position by lower calves. Unit nurse obtained vital signs. Unit nurse and CNA assisted R32 up to a standing position with a gait belt. R32 was able to stand without difficulty and denied any pain or discomfort. R32 was assisted to R32's wheelchair. Pupils equal round and reactive to light, hand grasps equal, active and passive range of motion appears at baseline for resident. Bruise remains to top of right hand in varies stages of healing. Small bruise noted to posterior left thigh and reddened linear shaped line approximately 6 cm to left lateral upper thigh noted. Writer was told wheelchair was in a locked position in front of her and call light was within reach to the left side of resident. Unit nurse to update MD (Medical Doctor) and guardian. Writer notified administrator and DON (Director of Nursing). Immediate intervention education given to staff to follow resident plan of care. On 2/11/2024, at 12:07 PM, Licensed Practical Nurse (LPN)-N documents: Note Text: Late entry 2/9/24, R32 found sitting on the floor in her bathroom with back up against the wall. Prior to the fall R32 was sitting on the toilet and appears to have attempted to transfer off the toilet alone to R32's wheelchair. Neuro check negative, bruise noted to left back thigh and red mark to left hip area. Tender to touch back right side of head, no redness or bumps noted. Refused ice pack when offered after fall. 2 assist with gaitbelt to assist off the floor without difficulties. Guardian, nurse manager, MD made aware. Monitor. On 2/12/2024, at 10:4 AM, Director of Nursing (DON)-B documents: Note Text: Interdisciplinary Team (IDT) reviewed fall. Root cause-dementia, poor safety awareness, generalized weakness. Intervention-re-education with staff regarding following residents plan of care. On 8/27/24, at 12:56 PM, Surveyor reviewed R32's fall report. Documented was, R32 was left on the toilet and attempted to self transfer from the toilet to R32's wheelchair. Certified Nursing Assistant (CNA)-P was given a supervisor coaching note which documents: CNA-P did not follow R32's care plan that R32 was not be left alone on toilet. R32 did have a fall due to not following the plan of care. On 8/28/24, at 2:55 PM, Surveyor shared the concern with Nursing Home Administrator (NHA)-A and DON-B that R32 care planned fall prevention interventions were not followed and R2 was left unattended in the bathroom and fell when trying to self transfer. Surveyor shared that on 1/19/24, R32's care plan was revised to include an intervention to not leave R32 unattended on toilet. R32 fell on [DATE]. No further information was provided at this time by the facility.