STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525646	A. Building B. Wing	08/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CCC of Pewaukee	N26 W23977 Watertown Rd Waukesha, WI 53188

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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 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** 49011 Based on interview and record review the facility did not report 1 (R5) of 2 allegations of abuse or neglect to the State Survey Agency during the required timeframe. An allegation of neglect involving R5 was not reported to the State Survey Agency within 24 hours of the allegation being made. Findings include: The Facility Policy titled Abuse Prevention Policy revised 9/28/23, documents (in part) . This will be done by: . -Immediately protecting residents involved in identified reports of possible abuse, neglect, exploitation, mistreatment, and misappropriation of property; -Implementing systems to promptly and aggressively investigate all reports and allegations of abuse, neglect, exploitation, misappropriation of property and mistreatment, and making the necessary changes to prevent future occurrences; . -Filing accurate and timely investigation reports . IV. Internal Reporting Requirements and Identification of Allegations . Any incident that does not involve abuse and does not result in serious bodily injury shall be reported within 24 hours . VII. External Reporting 1. Initial Reporting of Allegations. When an allegation of abuse, exploitation, neglect, mistreatment or misappropriation of resident property has been made, the administrator, or designee, shall complete and submit a DQA form F-62617, notifying DQA that an occurrence of potential abuse, neglect, exploitation, mistreatment or misappropriation of resident property has been reported to the administrator and is being investigated. (continued on next page)

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This report shall be made immediately . R5 was admitted to the facility on [DATE] with diagnoses which include rhabdomyolysis, encounter for surgical aftercare following surgery on the digestive system, acute respiratory failure with hypoxia, anxiety disorder, history of falling, and unspecified abnormalities of gait and mobility. R5 discharged from the Facility and returned to home on 5/15/24. R5's Admission Minimum Data Set (MDS) assessment dated [DATE], documents a Brief Interview for Mental Status score of 13 indicating R5 is cognitively intact for daily decision making. fully intact memory. R5's MDS also documents R5 is not currently on a toiliting program and is occasionally incontinent of urine and frequently incontinent of bowel. A review of R5's plan of care documents a Focus area of: The resident has an ADL (activity of daily living) self-care performance deficit r/t (related to) recent hospitalization and Cholecystectomy and Rhabdomyolysis, initiated on 4/26/24. Interventions (in part): -The resident requires assistance by 2 staff for toileting with use of toilet rails, initiated 4/26/24 -The resident requires assistance by 2 staff to move between surfaces with 2ww, initiated 4/26/24 On 8/19/24, at 9:38 am, Surveyor conducted a review of the Facility's Grievance Log and requested a copy of the 4/29/24 grievance involving R5 labeled customer service/interaction. The Facility provided the Resident Concern Report completed by Therapy on behalf of R5. The concern was Resident reported NOC (night) shift aide told him he can walk to the bathroom vs receiving staff assistance to use the bathroom during the night shift. Surveyor notes R5 requires an assist of two staff for toileting and moving between surfaces with a 2 wheeled walker. Surveyor conducted a further review of the facility's investigation and noted the Department of Health Services Form, F- 62617, was not submitted to the State Survey Agency to inform the State Agency of an allegation of neglect. On 8/20/24, at 9:40 am, Surveyor interviewed Nursing Home Administrator (NHA)-A regarding why the Facility did not report the allegation of neglect to the State Agency. NHA-A stated it was because R5 had been taken care of all night and had been toileted. On 8/20/24, at 11:34 am, Surveyor Spoke with NHA-A and the Director of Nursing-B and informed them of the concern related to the allegation of neglect not being reported to the State Survey Agency. No further information was provided.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49011 Based on interview and record review, the facility did not ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment were thoroughly investigated for 1 (R5) of 2 allegations of abuse or neglect reviewed. R5 made an accusation of neglect on 4/29/2024 that was not thoroughly investigated. Findings include: The Facility Policy titled Abuse Prevention Policy revised 9/28/23, documents (in part) . This will be done by: . -Immediately protecting residents involved in identified reports of possible abuse, neglect, exploitation, mistreatment, and misappropriation of property; -Implementing systems to promptly and aggressively investigate all reports and allegations of abuse, neglect, exploitation, misappropriation of property and mistreatment, and making the necessary changes to prevent future occurrences; . -Filing accurate and timely investigation reports . V. Protection of Residents The facility will take steps to prevent potential abuse while the investigation is underway . -Employees of this facility who have been accused of abuse, neglect, exploitation, mistreatment or misappropriation of resident property will be removed from resident contact immediately. The employee shall not be permitted to return to work until the results of the investigation have been reviewed by the administrator and it is determined that any allegation of abuse, neglect, exploitation, mistreatment or misappropriation of resident property is unsubstantiated. VI. Internal Investigation 1. All incidents will be documented, whether or not abuse, neglect, exploitation, mistreatment or misappropriation of resident property occurred, was alleged or suspected. 2. Any incident or allegation involving abuse, neglect, exploitation, mistreatment or misappropriation of resident property will result in an investigation . 4. Investigation Procedures. The appointed investigator will, at a minimum, attempt to interview the person who reported the incident, anyone likely to have direct knowledge of the incident and the resident, if interviewable. Any written statements that have been submitted will be reviewed, along with any pertinent medical records or other documents. Residents to whom the accused has regularly provided care, and employees with whom the accused has regularly worked, will be interviewed. (continued on next page)

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R5 was admitted to the facility on [DATE]/2021 with diagnoses which include rhabdomyolysis, encounter for surgical aftercare following surgery on the digestive system, acute respiratory failure with hypoxia, anxiety disorder, history of falling, and unspecified abnormalities of gait and mobility. R5 discharged from the Facility and returned to home on 5/15/24. R5's Admission Minimum Data Set (MDS) assessment documented a Brief Interview for Mental Status (BIMS) score of 13 indicating R5 is cognitively intact for daily decision making. On 8/19/24, at 9:38 am, Surveyor conducted a review of the Facility's Grievance Log and requested a copy of the 4/29/24 grievance involving R5 labeled customer service/interaction. The Facility provided the Resident Concern Report completed by Therapy on behalf of R5. The concern was Resident reported NOC (Night) shift aide told him he can walk to the bathroom. The Facility Investigation/Conclusion Report states: Writer called Certified Nursing Assistant (CNA)-L who worked with resident that night. CNA-L stated at no point did she tell the resident he can/should walk alone to the bathroom. CNA-L stated every time he called, he was taken to the bathroom with 2 assist. CNA-L reported she was in the room multiple times helping the resident with positioning, TV, toileting. CNA-L reported he was restless, calling out all night after leaving the room, trying to get up unassisted. Follow-up states resident made cares in pairs. Surveyor notes R5 was already assessed to need two staff to toilet and move between surfaces. On 8/19/2024, at 1:01p.m, Surveyor spoke with Director of Nursing (DON)-B and asked about R5's 4/29/24 grievance. DON-B stated the CNA R5 accused of neglect was interviewed and denied making this statement. DON-B also stated no other residents or staff were interviewed regarding the accusation. On 8/20/2024, at 8:10 am, Surveyor interviewed Nursing Home Administrator (NHA)-A and asked about the lack of interviews completed during the investigation, such as the other CNAs as R5 required assist of 2. NHA-A stated they talked to the nurse and others on the floor that night. Surveyor asked if there was documentation of this, to which NHA-A stated none is available. Surveyor asked if the other residents cared for by CNA-L were interviewed and NHA-A stated none were. Surveyor asked if the bed linen was checked the next day to see if clean and NHA-A stated it would have been reported if R5 has been left in dirty linen. Surveyor asked to see a copy of the CNA-L's performance evaluation. NHA stated it was not available. The Facility switched to a service where they scan in all Human Resource paperwork and are having issues with viewing the tab for annual reviews. Surveyor notes email documentation was provided of correspondence between Facility and [name of HR company] regarding the issue. On 8/20/24, at 11:34 am, Surveyor spoke with NHA-A and the Director of Nursing and informed them of the concern R5's allegation of neglect was not thoroughly investigated. No further information was provided.

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49011 Based on interview and record review the facility did not revise the resident plan of care with person centered interventions for 1 (R4) of 5 residents who's plan of care were reviewed. R4 had three orders on the Medication and Treatment Administration Record that were not carried through to the plan of care and/or Kardex (a summary of patient information used frequently by certified nursing assistants). Findings include: The Facility Policy titled Comprehensive Care Plan Policy revised 8/10/2022, documents (in part) . Purpose: To develop a comprehensive care plan that directs the care team and incorporates the resident's goals, preferences, and services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. Guidelines: . The comprehensive care plan must describe the following: -The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being . A comprehensive care plan must be- . -Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments . The Facility Policy titled Toileting Program Policy effective 4/3/2022, documents: General: To provide guidance for staff on when to toilet residents who are incontinent. Responsible Party: Certified Nursing Assistants, RN (Registered Nurse), LPN (Licensed Practical Nurse) Policy: 1. Residents who are unable to toilet themselves will be toileted. 2. The toileting schedule is as follows: (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. Upon rising b. Before and after meals c. Before going to bed 3. Residents will be toileted more often if necessary or requested by the resident. 4. If a resident refuses, document refusals and update nurse. R4 was admitted to the facility on [DATE] with diagnoses which include encephalopathy, acute and chronic respiratory failure, epilepsy, hemiplegia and hemiparesis following cerebral infarction affecting left dominant side and need for assistance with personal care. R4's Quarterly Minimum Data Set (MDS) with an assessment reference date of 5/30/24 indicated R4 had a Brief Interview for Mental Status score of 4, indicating severe cognitive impairment. R4 has an activated Power of Attorney for Healthcare. R4's MDS documented upper and lower extremities range of motion impairment on both sides; always incontinent of bowel and bladder. On 8/19/2024, at 1:19 pm, Surveyor reviewed R4's Medication and Treatment Administration Record (MAR and TAR) and noted the following orders: -2/22/2024: Ensure resident is being checked and changed every 2 hours. If resident is up in Broda chair when it is time to be changed, resident needs to be transferred into bed and then back to Broda chair when completed if resident wishes. Every shift. -4/24/2024: Ensure staff are providing oral cares to resident twice daily. Resident needs assistance to brush her teeth. Two times a day for hygiene. -7/26/2024: Palm guard to left hand at all times. Monitor for s/s (signs/symptoms) of skin irritation. Every shift. On 8/19/2024, at 11:30 am, Surveyor reviewed R4's plan of care. Surveyor notes there were no focus care plan area or interventions documented related to R4 being incontinent, how frequently to check and change R4 or how often to perform oral care. Surveyor noted R4's care plan documented a focus care plan which stated, The resident has an ADL (Activities of Daily Living) self-care performance deficit, revised on 10/30/23. Interventions (in part): Splint/brace: Palm guard to Left hand at all times, initiated 7/26/2024. Surveyor reviewed R4's Kardex and found no interventions listed related to R4 being incontinent and how often to check and change or how often to perform oral care. On 8/19/2024, at 1:26 pm, Surveyor spoke with Director of Nursing (DON)-B who stated the Facility's policy for toileting is the expectation, but each resident is considered individually. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/20/2024, at 7:24 am, Surveyor was informed by Nursing Home Administrator (NHA)-A that the Facility does not have a specific oral care policy. On 8/20/2024, at 9:35 am, Surveyor interviewed NHA-A about R4's orders for oral care and assessed need for toileting assistance were not documented on either the plan of care or the Kardex. NHA-A stated they would look at issue. On 8/20/2024, at 10:34 am, Surveyor interviewed DON-B and asked who is responsible for updating the plan of care for each resident. DON-B stated the unit manager, social worker or dietary should be each doing their parts. Revisions should be done by the same people. Surveyor asked who should have updated the care plan to include R4's assessed need for toileting assistance and oral care to which DON-B responded the Unit Manager (UM)-E would be responsible. Surveyor asked if it would have been DON-B's expectation that toileting assistance and oral care needs be documented on the care plan, to which the response was, ideally yes. On 8/20/2024, at 10:44 am, Surveyor asked UM-E why R4's toileting and oral care needs were not on the plan of care to which UM-E responded there is no reason, it was an oversight. The orders were put in and there was no follow through. On 8/20/24, at 11:35 am, Surveyor Spoke with NHA-A and Director of Nursing-B and let them know of the concern related to the plan of care not being updated. No further information was provided.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20483 Based on observation, interview, and record review the facility did not ensure 2 (R3 & R4) of 2 residents with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. R3 & R4 were observed not wearing their palm protectors during the survey. Findings include: 1.) R3's diagnoses includes hemiplegia and hemiparesis following cerebral infarction affecting right dominate side and vascular dementia. The physician order with an order date of 7/15/22 documents Palm protector to RUE (right upper extremity) daily, off at night. Monitor skin for breakdown. Every morning and bedtime related to Hemiplegia and Hemiparesis following cerebral infarction affecting right dominate side. The ADL (activities daily living) self-care performance deficit care plan initiated 3/26/22 & revised 4/25/23 includes an intervention dated 7/15/22 of Palm protector to RUE daily, off at night. Monitor skin for breakdown. The quarterly MDS (minimum data set) with an assessment reference date of 7/23/24 assesses R3 as having short & long term memory problems and has severe impairment for cognitive skills for daily decision making. The functional limitation in range of motion for upper extremity (shoulder, elbow, wrist, hand) is assessed as impairments on both sides. The significant change MDS (minimum data set) with an assessment reference date of 8/13/24 assesses R3 as having short & long term memory problems and has severe impairment for cognitive skills for daily decision making. The functional limitation in range of motion for upper extremity (shoulder, elbow, wrist, hand) is assessed as impairments on both sides. The CNA (Certified Nursing Assistant) Kardex as of 8/19/24 under the Dressing/Splint Care section documents * Palm protector to RUE daily, off at night. Monitor skin for breakdown. On 8/19/24, at 8:58 a.m., Surveyor observed R3 in bed on the left side with a pillow under R3's right side and the head of the bed elevated. Surveyor observed R3's right fingers are contracted towards the palm and R3 is not wearing the palm protector. On 8/19/24, at 9:45 a.m., Surveyor observed CNA (Certified Nursing Assistant)-F place a gown, gloves, & face shield on and enter R3's room. Surveyor observed CNA-F remove R3's gown, wash R3's upper body, provide incontinence cares, change R3's incontinence product & gown, reposition R3, and cover R3 with a sheet & blanket. At 10:05 a.m., CNA-F removed her PPE, cleansed her hands, placed gloves on, and removed the soiled linen & garbage from R3's room. Surveyor noted during this observation, CNA-F did not place R3's right palm protector on nor did CNA-F ask R3 about placing the right palm protector on. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/19/24, at 11:16 a.m., Surveyor observed R3 in bed on the right side with a pillow under R3's upper left side & the head of the bed elevated. Surveyor observed R3 is not wearing the right palm protector and the palm protector is on the dresser. On 8/19/24, at 12:28 p.m., Surveyor observed R3 in bed on the left side with the head of the bed elevated. Surveyor observed R3 is still not wearing the right palm protector and the palm protector continues to be on top of the dresser. On 8/19/24, at 1:47 p.m., Surveyor observed R3 in bed on the left side with the head of the bed elevated. Surveyor observed R3 is still not wearing the right palm protector and the palm protector continues to be on top of the dresser. On 8/19/24, at 2:25 p.m., Surveyor reviewed R3's August 2024 TAR (treatment administration record). Surveyor noted for an order for palm protector to RUE daily, off at night. Monitor skin for breakdown every morning and at bedtime related to hemiplegia and hemiparesis following cerebral infarction affecting right dominant side for the 19th at 0800 (8:00 a.m.) documents on and there is a check mark with initials. Surveyor noted R3 is not wearing the right palm protector. On 8/19/24, at 3:34 p.m., Surveyor observed R3 in bed on his back with the head of the bed elevated. R3's arms & hands are under the blanket. Surveyor observed the palm protector on top of the dresser. Surveyor asked R3 if he has anything in his hands. R3 started to cry then shook his head no. On 8/20/24, at 7:18 a.m., Surveyor observed CNA-F & LPN (Licensed Practical Nurse)-C in the process of providing morning cares for R3. Surveyor observed morning cares & repositioning for R3 with CNA-F & LPN-C until 7:29 a.m. Surveyor observed R3's right palm protector was not placed on during this observation nor did staff ask R3 about putting on the right palm protector. Surveyor observed the palm protector continues to be on top of the dresser. On 8/20/24, at 9:37 a.m., Surveyor observed R3 on his left side with his eyes closed. Surveyor observed R3 is now wearing the right palm protector. Surveyor noted this is the first observation with R3 having the right palm protector on. On 8/20/24, at 9:49 a.m., Surveyor asked CNA-F if R3 wears a right hand palm protector. CNA-F informed Surveyor she doesn't know and explained R3 works with therapy. CNA-F stated you have to ask therapy. On 8/20/24, at 9:52 a.m., Surveyor asked OTR (Occupational Therapist Registered)-H who is responsible for applying R3's right palm protector. OTR-H explained if a palm protector is new they will place the palm protector on and then the nursing staff will be educated. Surveyor read R3's physician order for the right palm protector dated 7/15/22 to OTR-H. OTR-H then informed Surveyor nursing would be responsible to place the palm protector on. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/20/24, at 11:12 a.m., Surveyor asked LPN Supervisor-E who is responsible for applying R3's right palm protector. LPN Supervisor-E informed Surveyor the CNA's. Surveyor asked on the TAR if there is a check with initials what does this mean. LPN Supervisor-E informed Surveyor that means the task was done. Surveyor informed LPN Supervisor-E on 8/19/24, R3's TAR documents the right palm protector is on but Surveyor has multiple observations on 8/19/24 of R3 not wearing the palm protector and the palm protector was on top of the dresser. Surveyor informed LPN Supervisor-E Surveyor did not observe R3 wearing the right palm protector until 8/20/24 at 9:37 a.m. On 8/20/24, at 11:35 a.m., Surveyor informed NHA (Nursing Home Administrator)-A and DON (Director of Nursing)-B of R3 not wearing the right palm protector on 8/19/24 according to physician orders even though R3's TAR on 8/19/24 is documented as being on. Surveyor did not observe R3's right palm protector on until 8/20/24 at 9:37 a.m. Surveyor asked for the facility's policy regarding palm guards. On 8/20/24, at 12:53 p.m., NHA-A informed Surveyor they do not have a policy regarding splints, palm guards, etc. 49011 2) R4 was admitted to the facility on [DATE] with diagnoses which include encephalopathy, acute and chronic respiratory failure, epilepsy, hemiplegia and hemiparesis following cerebral infarction affecting left dominant side and need for assistance with personal care. R4's Quarterly Minimum Data Set (MDS) with an assessment reference date of 5/30/24 documented R4 had a Brief Interview for Mental Status score of 04, indicating severe cognitive impairment; upper and lower extremities have range of motion impairment on both sides. On 8/19/2024, at 1:19 pm, Surveyor reviewed Medication and Treatment Administration Record (MAR and TAR) and found the following order: 7/26/2024: Palm guard to left hand at all times. Monitor for s/s of skin irritation. Every shift. R4's care plan documents a focus area of , the resident has an ADL (activities of daily living) self-care performance deficit, revised on 10/30/23. Interventions (in part): Splint/brace: Palm guard to Left hand at all times, initiated 7/26/2024. On 8/19/2024, at 8:55 am, Surveyor observed R4 in bed eating breakfast, R4 would lift her left arm and shake it, no palm guard was on. R4's left hand was contracted in a fist. On 8/19/2024, at 12:28 pm, Surveyor observed R4 feeding self lunch, there was no palm guard on R4 at this time. Left hand was contracted in a fist. On 8/19/2024, at 3:23 pm, Surveyor observed R4 in bed watching TV, no palm guard was on left hand. R4's left hand was contracted in a fist. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/19/2024, at 3:30 pm, Surveyor reviewed the Medication and Treatment Administration Record, for the month of August, nursing staff on each of the three shifts signed off for the palm guard being on R4. No refusals were documented. On 8/20/2024, at 7:19 am, Surveyor observed R4 up in Broda, no palm guard on left hand. Left hand was contracted in a fist. On 8/20/2024, at 9:35 am, Surveyor spoke with NHA-A about palm guard not being on R4 and having been signed out for all three shifts every day so far in August by nursing staff. NHA-A responded that they will look into. On 8/20/2024, at 10:56 am, Surveyor interviewed R4 and asked why the palm guard was not on. R4 responded that staff never put it on, not lately anyway. Surveyor asked where it was and R4 responded it is in here somewhere. Surveyor looked around the room in places that R4 stated it may be and it was not found. On 8/20/24, at 11:35 am, Surveyor informed NHA-A and Director of Nursing-B of the concern related to R4's palm guard not being worn by R4. No further information was provided. On 8/20/2024, at 1:36 pm, NHA-A informed Surveyor the Facility does not have a policy/procedure related to range of motion or contractures.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525646	A. Building B. Wing	08/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CCC of Pewaukee	N26 W23977 Watertown Rd Waukesha, WI 53188

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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 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** 20483 Based on observation, interview, and record review the facility did not ensure 1 (R3) of 1 residents who is fed by enteral means receives the appropriate treatment and services to prevent complication of enteral feeding. During personal care observations on 8/19/24 & 8/20/24, R3's head of the bed lowered flat while the tube feeding continued to be running. R3's Osmolite 1.5 was not running according to physician orders on 8/19/24 & 8/20/24. On 8/19/24, R3's water bag, Osmolite 1.5 container, and syringe were not labeled & dated. There is no assessment or order for R3's GT's (gastrostomy tube) secure device. Findings include: The facility's policy titled, Gastrostomy Tube Feeding and Care and dated 5/17/22 under Purpose documents: To provide nutrients, fluids and medications, as per physician orders, to residents requiring feeding through an artificial opening into the stomach. Under Procedure documents: 1. Licensed nurse will review physician's order for type of formula, concentration, rate of flow, and method of administration. 2. Enteral Formula should be at room temperature. Check expiration date on feeding container. 3. Label container with resident's name, flow rate, date and time. 4. Perform hand hygiene and apply gloves. 5. Position resident on his/her back with head elevated to minimal 30 degrees and preferable 45 degrees. R3's diagnoses includes hemiplegia and hemiparesis following cerebral infarction affecting right dominate side, dysphagia, cognitive communication deficit and vascular dementia. R3 was hospitalized from 7/23/24 to 8/6/24. While in the hospital a G tube was placed. The nutritional progress note dated 8/12/24 documents Sig (significant) change RD (Registered Dietitian) assessment for more details. Res (Resident) has been taken off hospice & feeding tube placed by POA (power of attorney) request. Dx (Diagnoses): AFTT (adult failure to thrive), mod. (moderate) PCM (protein calorie malnutrition), acute metabolic encephaopathy, acute hypernatremia, AKI (acute kidney injury) on CKD3 (chronic kidney disease), dysphagia, PNA (pneumonia), severe erosive esophagitis, duodenal ulcer dz (disease), new PEG tube. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PMH (past medical history) CVA (cerebrovascular accident), dysphagia, PBA (pseudobulbar affect), DM (diabetes mellitus), CKD, HTN (hypertension), vascular dementia, MDD (major depressive disorder), BPH (benign prostatic hyperplasia). Oral Diet order: NPO (nothing by mouth) Current TF (tube feeding order): Osmolite 1.5 @ (at) 50 ml/hr (milliliter per hour) x (times) 24hr (hour), proving 1200 ml product/day, 1800kcal (kilocalorie), 75g (grams) protein, & 941 ml free fld (fluid) via product. Water flush 155 ml x 6/d (day)=930 ml water, totaling 1844 ml free fld via G tube, not including medication flushes. Estimated nutritional needs based on CBW (current body weight) for stable wt (weight): 1575-1900kcal (25-30kcal/kg), 60-80g protein (1.0-1.3g/kg), 1850-1950 ml fld (30ml/kg). Current TF order meets estimated nutritional needs. 8/6 wt: 139# (pounds), no sig wt change at 1,3,6 mo (month), Ht (height): 69 (inches), BMI (body mass index) 20.5 WNL (within normal limits). Skin intact per nursing readmit assessment. Plan: offer alternate timing for TF to allow time off TF for therapy or showers. Alternate TF order: Osmolite 1.5 @ 75 ml/hr x 16 hr, providing same volume of TF as currently ordered. R3's care plan documents, alteration in ability to consume food and/or fluids and requires enteral feeding via (G-Tube, J (jejunostomy) Tube, Peg Tube) to maintain adequate caloric and nutritional status due to: Dysphagia initiated 8/13/24 documents the following interventions: * Administer flushes per physician order and/or medication protocol. Initiated 8/13/24. * Administer tube feeding infusion as ordered via infusion pump. Change tubing daily. Initiated 8/13/24. * Hold feeding when giving care, turning and repositioning. Resume when completed and HOB (head of bed) up. Initiated 8/13/24. * Keep head of bed elevated at least 30 degrees at all times. Initiated 8/13/24. * Monitor and record weight per facility protocol and/or physician order. Initiated 8/13/24. * Perform feeding tube site care/dressing change as ordered and as needed if soiled. Initiated 8/13/24. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	* Resident is NPO (nothing by mouth). May use moistened toothettes, mouth moisturizer with oral care. Initiated 8/13/24. The significant change MDS (minimum data set) with an assessment reference date of 8/13/24 assesses R3 as having short & long term memory problems and has severe impairment for cognitive skills for daily decision making. R3 is assessed as being dependent for eating and is marked yes for feeding tube while a resident. R3 is assessed as not using a trunk restraint. The Feeding tube CAA (care area assessment) dated 8/13/24 under analysis of findings for nature of the problem/condition documents feeding tube in place. The care plan consideration section has not been completed and is blank. The physician orders with an order date of 8/14/24 documents Enteral Feed order two times a day related to Dysphagia following cerebral infarction (I69.391) Continuous Enteral Feeding: Formula: Osmolite 1.5; Rate: 75 ml/hr (milliliters per hour) x (times) 16 hr (hour), Tube Type: G tube; Size of tube: ___. On 8/19/24, at 8:58 a.m., Surveyor observed R3 in bed on the left side with a pillow under R3's right side and the head of the bed elevated. Surveyor observed there is a bottle of Osmolite 1.5 and a water bag hanging from the tube feeding pole. Surveyor observed R3's Osmolite 1.5 & the water bag is not labeled or dated. R3's Osmolite 1.5 feeding has a rate of 50 ml/hr. Surveyor noted R3's tube feeding is not running according to physician orders. Surveyor also observed on top of the dresser there is a feeding syringe in a white Styrofoam cup. There is dried feeding on the bottom of the cup. The white Styrofoam cup has R3's first name written in black marker but there is no date on either the syringe or white Styrofoam cup. On 8/19/24, at 9:45 a.m., Surveyor observed CNA (Certified Nursing Assistant)-F place a gown, gloves, & face shield on and enter R3's room. Surveyor observed R3 is in bed on the left side with the head of the bed elevated. R3's tube feeding is on and running at a rate of 50 ml/hour. CNA-F raised the height of R3's bed and lowered the head of the bed flat. R3's tube feeding was not turned off. CNA-F removed R3's gown, moved the bedding off R3 and unfastened R3's incontinence product. CNA-F went into the bathroom, wet a towel with soap and washed R3's upper body. CNA-F lowered R3's incontinence product, washed R3's frontal perineal area, asked R3 if he was ready and positioned R3 on the right side. Surveyor observed there is a white padded device covering R3's G tube site with a strap that goes around R3's back. CNA-F removed the soiled incontinence product & chux, placed a new incontinence product under R3, and washed & applied barrier cream to R3's buttocks. R3 was positioned on his back and then side to side to straighten out the incontinence product. CNA-F fastened the incontinence product, placed a gown on R3 telling R3 she was almost finished and then placed a pillow under R3's head. CNA-F positioned R3 on the right side with a pillow under R3's upper left side. CNA-F covered R3 with a sheet & blanket, placed the call light in reach and at 10:05 a.m. lowered the bed down and raised the head of the bed up. Surveyor observed R3's Osmolite 1. 3 bottle, water bag, and syringe are still not dated or labeled. On 8/19/24, at 11:16 a.m., Surveyor observed R3 in bed on the right side with a pillow under R3's upper left side & the head of the bed elevated. Surveyor observed R3's Osmolite 1.5 is running at 50 ml/hour not 75 ml/hour according to physician orders. The Osmolite 1.5 bottle, water bag, and syringe are still not labeled or dated. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/19/24, at 12:25 p.m., Surveyor asked CNA-F if the facility has given her any instructions on what to do with a resident who is receiving tube feeding during cares. CNA-F informed Surveyor if it's beeping to let the nurse know otherwise no. On 8/19/24, at 12:28 p.m., Surveyor observed R3 in bed on the left side with the head of the bed elevated. Surveyor observed R3's Osmolite 1.5 is still running at 50 ml/hour not 75 ml/hour according to physician orders. The Osmolite 1.5 bottle, water bag, and syringe are still not labeled or dated. Surveyor reviewed R3's medical record and was unable to locate an order for R3's G tube secure device or an assessment of this device. On 8/19/24, at 1:47 p.m., Surveyor observed R3 in bed on the left side with the head of the bed elevated. Surveyor observed R3's Osmolite 1.5 is still running at 50 ml/hour not 75 ml/hour according to physician orders. The Osmolite 1.5 bottle, water bag, and syringe are still not labeled or dated. On 8/19/24, at 2:40 p.m., during the end of the day meeting with NHA (Nursing Home Administrator)-A and DON (Director of Nursing)-B Surveyor the manufacturer's information regarding R3's G tube secure device. On 8/19/24, at 3:34 p.m., Surveyor observed R3 in bed on his back with the head of the bed elevated. Surveyor observed R3's Osmolite 1.5 is still running at 50 ml/hour not 75 ml/hour according to physician orders. The Osmolite 1.5 bottle, water bag, and syringe are still not labeled or dated. On 8/20/24, at 7:18 a.m., Surveyor observed CNA-F & LPN (Licensed Practical Nurse)-C in the process of providing morning cares for R3. Surveyor observed R3's Osmolite 1.5 is running at a rate of 50 ml/hour and R3's head of the bed is flat. R3 was positioned on his left side and an incontinence product was placed under R3. Surveyor asked LPN-C about the white device covering R3's G tube. LPN-C informed Surveyor its a placement device to keep the tube in place. At 7:21 a.m. R3 started to cough and CNA-F raised the head of R3's bed. LPN-C unfastened the Velcro of the device and showed Surveyor the G-tube is pulled through the back of the pad and then covered with the front portion of the placement device with a strap which goes around R3. On 8/20/24, at 7:31 a.m., Surveyor asked LPN-C why R3's Osmolite 1.5 is running at 50 ml/hour. LPN-C replied I don't know and explained she did not hang it. Surveyor informed LPN-C R3's physician orders document the tube feeding should be running at 75 ml/hour. LPN-C reviewed R3's physician orders and informed Surveyor the orders say 75. LPN-C stated to Surveyor let me check, she will be right back and left. On 8/20/24, at 7:38 a.m., Surveyor observed LPN-C & LPN-D place PPE (personal protective equipment) on and informed Surveyor they were going to change it to 75 and the feeding gets shut off at 8:00 a.m. Surveyor asked LPN-C if R3's tube feeding should have been running at 75 ml/hour. LPN-C replied yes. On 8/20/24, at 7:41 a.m., Surveyor asked LPN-C before a Resident's tube feeding is hung should the physician's orders be checked. LPN-C replied yes. Surveyor asked if the feeding and water bag are labeled when they are hung. LPN-C replied yes with the date, time, & initials. Surveyor asked if the syringe should also be dated. LPN-C replied yes. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/20/24, at 7:44 a.m., Surveyor checked R3's tube feeding. Surveyor observed the rate is now set at 75 ml/hour. The Osmolite 1.5 bottle & water bag are dated 8/19 with the time of 1730 (5:30 p.m.) and the nurses initials. On 8/20/24, at approximately 8:30 a.m., Surveyor reviewed the 2 page manufacturers information for [Name] Enteral Feeding Tube Securement Device. For instructions for use under description documents The [Name] Enteral Feeding Tube Securement Device comfortably and discreetly secures a G-tube, J-tube, or PEG-tube beneath clothing. Its innovative design eliminates the needs for pins and tape, reducing skin irritation and discomfort. Surveyor checked [Name] website and noted there are two additional pages. Surveyor noted page 3 documents It is recommended that a sterile IV split drain dressing be placed against the skin as a buffer (See Figure 1). Wrap strap around the waist and secure it using the hook-and-loop closure, adjusting for comfort Slide tube through slit on pouch and position pouch over tube (See Figure 2). While not in use, the tube can be secured by coiling it and then closing the pouch's bottom flap over the coiled tubing (See Figures 3 and 4). Surveyor noted R3 did not have a split drain dressing on as recommended by the manufacturer. On 8/20/24, at 11:12 a.m., Surveyor met with LPN Supervisor-E to discuss R3. Surveyor asked how do staff ensure the residents tube feeding is running according to physician orders. LPN Supervisor-E informed Surveyor she would look at the order and make sure the rate matches the order. Surveyor informed LPN Supervisor-E R3's tube feeding rate was changed on 8/14/24 to 75 ml/hour but Surveyor had multiple observations on 8/19/24 & 8/20/24 of R3's tube feeding at 50 ml/hour which was the previous order. Surveyor asked when the tube feeding and water bag are hung what is the process. LPN Supervisor-E informed Surveyor you date it. Surveyor asked when providing cares for a resident on tube feeding what should the CNA do. LPN Supervisor-E they should ask for the tube feeding to be stopped. Surveyor informed LPN Supervisor-E of the observations of R3's head of the bed being flat during cares and the tube feeding was not stopped. Surveyor asked LPN Supervisor-E about R3's secure device as Surveyor was unable to locate an order or assessment for this device. LPN Supervisor-E informed Surveyor R3 returned from the hospital with the feeding tube and the device is so R3 doesn't mess with the tube. On 8/20/24, at 11:35 a.m., Surveyor informed Nursing Home Administrator (NHA)-A & DON-B of the observations of R3's head of the bed flat during personal cares on 8/19/24 & 8/20/24, the Osmolite 1.5 bottle, water bag & syringe not labeled or dated on 8/19/24 and no order or assessment for R3's G tube secure device.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38829 Based on record review and staff interview, the facility did not ensure 1 resident (R2) of 5 sampled residents had a medical record that contained complete and accurate information. The facility did not have R2's initial psychiatric consult and R2's talk therapy consult readily accessible for Surveyor to review. Findings Include: The facility's policy Health Information Management-Retention of Medical Records effective [DATE] documents: . Policy Statement: Protection and retention of medical records-The facility is responsible for protecting the Residents' medical records from loss, destruction or unauthorized use. The records must be retained for the period required by applicable state law and/or according to HIPPA guidelines. If there is no state law, then the information must be retained for five years from the date of discharge (or for three years after a minor reaches the state's legal age if the Resident was a minor. Guidelines: Nursing Home Records The administrator is responsible for providing the department of health services with all required information to document the nursing home's compliance with relevant laws and regulations, and to provide the department with means to examine the records and gather information. R2 was admitted to the facility on [DATE] with diagnoses of Metabolic Encephalopathy, Malignant Neoplasm of Glottis, Gout, Wilson's Disease, Degenerative Disease of Nervous System, Unspecified Glaucoma, Essential Hypertension, Retention of Urine, and Cognitive Communication Deficit. R2 was enrolled into hospice care on [DATE] and R2's Health Care Power of Attorney was activated on [DATE]. R2 expired on [DATE]. R2's Significant Change Minimum Data Set (MDS) completed on [DATE] documents R2's Brief Interview for Mental Status (BIMS) score to be 9, indicating R2 demonstrated moderately impaired skills for daily decision making. R2 had no documented behavior concerns and R2's Patient Health Questionnaire (PHQ-9) score is 4, indicating minimal depressive symptoms. R2's MDS also documents R2 required supervision for eating, toileting hygiene, bathing, upper and lower dressing, mobility, and transfers. R2's comprehensive care plan had the following revisions with the documented dates of initiation: (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-[DATE], R2 has an active order for antipsychotic medication(s) use due to psychosis and hallucinations (thinks there are bombs, cartel is out to get [R2's name]). -[DATE], R2 has a mood problem due to psychotic disorder with hallucinations, delusional disorder and anxiety. [DATE], R2 is resistive to care due to anxiety, delusions, hallucinations and thinking people are trying to poison R2 or trying to harm R2 -[DATE], R2 is/has potential to be physically aggressive (throwing items, kicking, scratching and grabbing people's arms) due to psychotic disorder with hallucinations, encephalopathy, anxiety, and delusions. On [DATE], R2 was diagnosed with Delusional Disorders. Delusional Disorder is a documented diagnosis in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR). On [DATE], R2 was diagnosed with Anxiety Disorder. Anxiety Disorder is a documented diagnosis in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR). On [DATE], at 2:58 PM, Surveyor requested from Nursing Home Administrator (NHA)-A R2's psychiatric consults. Surveyor was informed by NHA-A that the talk therapist would be in on [DATE] to discuss R2. On [DATE], at 8:25 AM, Surveyor reviewed R2's electronic medical record (EMR) and noted the initial psychiatric consult and the talk therapydocumentation was not part of R2's EMR. On [DATE], at 9:08 AM, Surveyor interviewed Nursing Home Administrator (NHA)-A in regards to R2's psychiatric information not being accessible in R2's EMR. NHA-A agreed that the psychiatric information for R2 is missing from R2's EMR. NHA-A stated NHA-A is working on it and not too thrilled. NHA-A stated NHA-A is not sure where it went. NHA-A stated its not appropriate that the records are not accessible at this time. NHA-A understands the concern he psychiatric information for R2 is not available at this time. On [DATE], at 9:55 AM, Surveyor interviewed Licensed Clinical Social Worker (LCSW)- K in regards to R2's talk therapy documentation. LCSW-K confirmed LCSW-K provided talk therapy to R2 and LCSW-K concluded that based upon clinical observations and review of R2's record, R2 was not appropriate for psychotherapy. LCSW-K informed Surveyor that since LCSW-K did not do a full assessment and then I don't do a note. LCSW-K stated that LCSW-K informed NHA-A of the conversation with R2 and thought NHA-A would take the information and put it into a progress note and entered it into R2's EMR. On [DATE], at 11:34 AM, Surveyor shared the concern with NHA-A and Director of Nursing (DON)-B that R2's psychiatric information was not readily accessible to Surveyor for review. NHA-A stated, the physician services does not know where the notes are. No further information has been provided by the facility at this time.