

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525654	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/23/2024
NAME OF PROVIDER OR SUPPLIER  Heritage Lakeside		STREET ADDRESS, CITY, STATE, ZIP CODE  1016 Lakeshore Dr Rice Lake, WI 54868	

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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>30570</p> <p>Based on interview and record review, the facility did not report an incident of potential misconduct to the state agency immediately upon learning of the incident and did not submit the 5 day investigation within 5 days as required. The facility practice had the potential to affect 1 of 12 residents reviewed for abuse (R7).</p> <p>The facility administration learned of the incident when Certified Nursing Assistant (CNA) E flushed R7's feeding tube on 06/28/24. The facility did not report the incident to the state agency until 07/10/24 via a Misconduct Incident Report (5-day Investigation). No immediate initial reporting was submitted.</p> <p>Findings include:</p> <p>Surveyor requested and reviewed the facility policy titled Resident Safety Abuse Policy dated as last reviewed 10/23. The policy in part read:</p> <p>Purpose: It is the policy of our facility to maintain a work and living environment that is professional and free from neglect .</p> <p>Federal Definitions:</p> <p>Neglect means the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress.</p> <p>All facility staff member shall ensure that all alleged violation involving neglect are reported immediately, but not later than 2 hours after the allegation is made or not later than 24 hours to the administrator and the administrator will ensure reporting to other officials (including state survey agency</p> <p>The administrator shall also report the results of the investigation to other officials in accordance with state law, including to the state survey agency within 5 working days of the incident.</p> <p>Surveyor reviewed the misconduct incident report (5-day investigation) submitted to the state agency. The facility did not submit an initial report of the 06/28/24 incident until 07/10/24.</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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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The incident report submitted on 07/10/24 notes:</p> <p>Date discovered: 06/28/24. Time occurred: 11:15 AM.</p> <p>Briefly describe the incident: TMA (Therapeutic Medication Aide) came to DON (Director of Nursing) and stated CNA (Certified Nursing Assistant) E told her she found PEG/G-tube feeding not attached to resident. CNA E then stated she flushed the PEG tube with warm water to make sure it was patent. TMA told CNA E this was not in the scope of her practice. CNA E stated, I've seen you do it and it doesn't look hard. The resident then went to the TMA and asked when that CNA became a nurse.</p> <p>The resident was not identified in the reporting.</p> <p>Person preparing this report: DON B.</p> <p>On 07/23/24 at 2:41 PM, Surveyor interviewed DON B who was noted as preparing the misconduct incident report about the initial reporting and late submission of the facility investigation. DON B expressed the facility believed the incident to be potential abuse/neglect/mistreatment to R7. The Certified Nursing Assistant was working outside the scope of her practice which was deemed as potential abuse/neglect/mistreatment by the facility. DON B expressed she is somewhat new to her position and was directed by the facility corporate nurse in the investigation process and submission to the state of Wisconsin. Most of the investigation was completed by her and the submission was done by her. Due to being somewhat new she was not familiar with the state required timeline and submission process.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>30570</p> <p>Based on interview and record review, the facility did not conduct a thorough investigation and complete appropriate actions to correct an alleged violation affecting 1 of 12 residents (R) reviewed for potential abuse (R7).</p> <p>Certified Nursing Assistant (CNA) E flushed R7's feeding tube with warm water to make sure it was patent when she found R7's feeding tube not attached. The facility investigation included limited staff interviews, no resident interviews, and no post incident education to staff as a corrective action in attempts to prevent further incidents.</p> <p>Findings include:</p> <p>Surveyor requested and reviewed the facility policy titled Resident Safety Abuse Policy dated as last reviewed 10/23. The policy in part read:</p> <p>Purpose: It is the policy of our facility to maintain a work and living environment that is professional and free from neglect .</p> <p>Federal Definitions:</p> <p>Neglect means the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress.</p> <p>Procedure for Investigation:</p> <p>All alleged violations will be thoroughly investigated, and all investigations are conducted by or coordinated through facility administration.</p> <p>The facility must have evidence that all alleged violations thoroughly investigated.</p> <p>Other Administrative Duties:</p> <p>If an alleged violation is verified, the administrator will ensure appropriate corrective action is taken.</p> <p>Surveyor reviewed the misconduct incident report (5-day investigation) submitted to the state agency. The incident report noted as submitted 07/10/24 notes:</p> <p>Date discovered: 6/28/24. Time occurred: 11:15 AM.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Briefly Describe the Incident: TMA (Therapeutic Medication Aide) came to DON (Director of Nursing) and stated CNA E told her she found PEG/G-tube feeding not attached to resident. CNA E then stated she flushed the PEG tube with warm water to make sure it was patent. TMA told CNA E this was not in the scope of her practice. CNA E stated, I've seen you do it and it doesn't look hard. The resident then went to the TMA and asked when that CNA became a nurse.</p> <p>Describe the effect the incident had on the affected person: No ill effects to the resident although he knew the CNA flushed his tube and she should not have. TMA was upset CNA E was working outside the scope of her practice.</p> <p>Explain what steps the entity took upon learning of the incident .When the DON learned of the incident CNA E was gone for the day (her shift had ended). DON tried to call her on her cell phone but no answer and no return call. The next scheduled shift she worked, DON went to CNA E and asked what occurred. CNA E stated RN (Registered Nurse) working that day instructed her to flush the PEG tube with warm water. CNA E also stated many nurses have asked her to do this although she couldn't recall the names of who asked her. CNA E did not work while the investigation occurred. RN was questioned and stated she never instructed the CNA to flush the tube. Five other nurses were called and asked if they have ever asked a CNA to flush a PEG tube or work out of their scope of services, they all denied doing so. Five CNAs were also questioned and asked if any nurse had ever asked them to flush a PEG tube or work out of their scope of service and they all denied doing so.</p> <p>Person preparing this report: DON B.</p> <p>There is no evidence all nursing staff were interviewed. There is no evidence any residents were interviewed to ensure no reporting of CNAs working outside the scope of their practice. There is no evidence the facility completed post incident education to nursing staff regarding certified nursing assistant scope of practice.</p> <p>On 7/23/24 at 2:41 PM, Surveyor interviewed DON B, who was noted as preparing and investigating the misconduct incident report. DON B expressed the facility believed the incident to be potential abuse/neglect/mistreatment. DON B stated she is somewhat new to her position and was directed by the facility's corporate nurse of the investigation process, indicating most of the investigation was completed by her with some assistance gathering witness statements. DON B expressed she did not speak with all nursing staff and did not speak with other residents to ensure certified nursing assistance were not working outside their scope of services as part of her investigation. Surveyor asked DON B if post incident education was provided to nursing staff regarding scope of practice. DON B stated she had told some staff they should not work outside the scope of their practice but could not recall who she had spoken to. Surveyor requested evidence of the education and who had received the education. DON B responded she did not have any evidence of the education or which staff had received the information.</p>		

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<p>F 0659</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care by qualified persons according to each resident's written plan of care.</p> <p>30570</p> <p>Based on interview and record review, the facility did not ensure services were provided by a qualified person in accordance with resident's written plan of care. The facility practice had the potential to affect 1 of 12 sampled residents (R7).</p> <p>Certified Nursing Assistant (CNA) E flushed R7's feeding tube with warm water to make sure it was patent when she found R7's feeding tube not attached to R7.</p> <p>Findings include:</p> <p>Surveyor reviewed R7's care plan and noted:</p> <p>Focus: Resident requires tube feeding r/t (related to) swallowing problem.</p> <p>Date Initiated: 11/30/24.</p> <p>Goal: Resident will be free of side effects or complications related to feeding through review date: 10/08/24.</p> <p>Interventions:</p> <p>Resident is dependent with tube feeding and water flushes. See MD orders for orders.</p> <p>R7's orders were reviewed with the following noted:</p> <p>12/28/23: four times a day Flush PEG tube with 250 ml four times daily</p> <p>Surveyor reviewed the misconduct incident report (5-day investigation) submitted to OCQ. The incident report noted as submitted 7/10/24 notes:</p> <p>Date discovered: 6/28/24. Time occurred: 11:15 AM.</p> <p>Briefly Describe the Incident: TMA (Therapeutic Medication Aide) came to DON (Director of Nursing) and stated CNA E (Certified Nursing Assistant) told her she found PEG/G-tube feeding not attached to resident. CNA E then stated she flushed the PEG tube with warm water to make sure it was patent. TMA told CNA E this was not in the scope of her practice. CNA E stated, I've seen you do it and it doesn't look hard. DON went to CNA E and asked what occurred. CNA E stated the RN (Registered Nurse) working that day instructed her to flush the PEG tube with warm water. CNA E also stated many nurses have asked her to do this although she couldn't recall the names of who asked her to anything outside the scope of services. CNA E did not work while the investigation occurred. The RN was questioned and stated she never instructed CNA E to flush the tube.</p> <p>Surveyor did not find evidence the facility completed post incident education to nursing staff regarding certified nursing assistant scope of practice.</p> <p>(continued on next page)</p>		

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<p>F 0659</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 07/23/24 at 2:41 PM, Surveyor interviewed DON B, who was noted as preparing and investigating the misconduct incident report into CNA E flushing R7's feeding tube. DON B expressed the investigation determined CNA E had flushed R7's feeding tube which was not within her scope of practice as she is not qualified to do so. Surveyor requested evidence of any education provided and the staff who had received the education. DON B responded she did not have any evidence of education.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44863</b></p> <p>Based on observation, interview and record review, the facility did not ensure residents received the necessary treatment and services consistent with professional standards of practice for 2 of 2 residents (R2 and R4) reviewed with non-pressure injuries.</p> <p>-On 07/07/24, R4 developed a facility acquired non-pressure injury to his left heel. Documentation indicated staff was checking R4's heels and feet twice daily for skin issues. Weekly wound assessment on 07/08/24 is not accurate and indicated R4 had no skin concerns. On 07/16/24, R4 had developed two additional facility acquired non-pressure injuries to left and right foot and his previous non-pressure injury had worsened, this was not documented in a weekly wound assessment.</p> <p>Findings:</p> <p>Example 1</p> <p>R4 was admitted to the facility on [DATE]. Diagnoses included diabetes mellitus, end stage renal disease, renal dialysis, failure to thrive, weakness, and difficulty walking.</p> <p>Minimum data set (MDS) assessment, completed on 06/16/24, confirmed R4 scored 15/15 during Brief Interview for Mental Status (BIMS), indicating intact cognition. MDS assessment confirmed R4 had no skin concerns and was at risk for pressure injuries.</p> <p>R4's care plan included the following:</p> <p>SKIN: at risk for skin breakdown/pressure ulcers related to renal failure, dialysis, diabetes, malnutrition, muscle weakness, sleeps in recliner, sits in wheelchair most of the day, history of amputation of toes, and non-compliant with diet.</p> <p>07/07/24, has area to left heel.</p> <p>07/16/24, fluid filled blister to left foot, facility acquired. Possibly from diabetic shoes.</p> <p>07/16/24, fluid filled blister to bottom of right foot, facility acquired.</p> <p>SKIN interventions:</p> <p>07/09/24, Check coccyx and both heels twice daily.</p> <p>07/16/24, diabetic shoes may be causing issues, only shoes R4 has.</p> <p>Physician orders included:</p> <p>06/17/24, weekly skin assessments on Mondays.</p> <p>07/03/24, check feet and heels every morning and at bedtime for skin breakdown prevention.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>07/08/24, left heel treatment orders daily.</p> <p>07/22/24, stat referral for wound care to left heel/posterior upper foot, right posterior foot, and coccyx.</p> <p>R4's treatment administration record:</p> <p>06/17/24, weekly skin assessment on Mondays. Documentation not completed on 07/01/24 and 07/15/24.</p> <p>07/03/24, check feet and heels twice daily. Documentation not completed on 07/07/24, 07/11/24, and 07/15/24.</p> <p>07/07/24, check left heel each shift to ensure dressing is intact. Documentation not completed on 07/08/24, 07/11/24, and 07/15/24.</p> <p>07/08/24, left heel treatment daily. Documentation not completed 07/11/24 and 07/15/24.</p> <p>R4's skin assessments:</p> <p>07/08/24, no new skin issues this week. Skin clear and intact. Complete skin assessment not completed. This assessment was not accurate as an open area to the left heel was documented on 07/07/24.</p> <p>07/12/24, new wounds, two. No other information was included in the assessment.</p> <p>R4's progress notes:</p> <p>07/07/24, noted open area on bottom of left heel measuring approximately 3 x 3 cm. Cleansed with wound wash and covered with bordered foam dressing.</p> <p>07/16/24, new intact fluid filled blister to right under foot that measures approximately 3 cm in length by 2 cm in width. Resident also has a new fluid filled blister to under left foot. New onset. that measures 8 cm in length by 3.5 width. Both areas were assessed, areas around wound are reddened, no pain, states I can feel a little bit of when dressing is being changed. Left bottom of heel changed per orders, area is approximately 3 cm in length by 3.5 in width. Area is white around edges.</p> <p>Surveyor noted wound assessment was not completed weekly and R4's left heel wound had increased in size from last assessment.</p> <p>On 07/22/24 at 11:12 AM, Surveyor interviewed R4. R4 was in his wheelchair and stated he was leaving soon to go to dialysis. Surveyor observed R4's bilateral lower legs were wrapped with ace bandages.</p> <p>On 07/23/24 at 1:02 PM, Surveyor interviewed R4. R4 was in his room, in his wheelchair. R4 was covered with a blanket and reported he was tired. R4 agreed to be interviewed but did not agree to Surveyor observing his feet. R4 stated he did not think the injuries to his feet were from his shoes. R4 reported he does accumulate fluid in his lower legs and feet due to dialysis. R4 reported prior to treatment orders for his wounds, staff did not check his feet and heels as ordered.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 07/23/24 at 1:13 PM, Surveyor interviewed Director of Nursing (DON) B. DON B reported she felt R4 was accurate in his statement that staff were not checking his feet and heels as ordered to identify the skin concern so interventions could be implemented to prevent further breakdown. DON B stated, How could they have been checking his feet twice daily?</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44863</b></p> <p>Based on observation, interviews, and record review, the facility did not ensure 1 of 1 resident (R3) at high risk for pressure ulcer development received the necessary treatment and services needed to prevent the development of a pressure injury (PI) or to prevent worsening of an existing PI.</p> <p>-R3 developed a facility acquired unstageable PI to right foot on 07/10/24 which became larger with a macerated center on 07/16/24 resulting in actual harm. The facility did not complete weekly comprehensive assessments of R3's PI. The facility did not ensure preventative pressure relieving measures were implemented. The PI of the right foot is cited at actual harm.</p> <p>-R3 acquired a PI to right buttock stage II, due to shearing on 06/12/24. Interventions to prevent friction and shearing were not put into place. The facility did not complete weekly comprehensive assessments of R3's PI.</p> <p>Findings include:</p> <p>The facility policy titled Prevention of Pressure Injuries, reads in part .</p> <p>Assess the resident on admission (within twenty-four hours) for existing pressure injury risk factors. Repeat the risk assessment weekly and upon any changes in condition.</p> <p>Conduct a comprehensive skin assessment upon (or soon after) admission, with each risk assessment, as indicated according to the resident's risk factors.</p> <p>During the assessment, inspect: a. Presence of erythema. b. Temperature of skin. c. Edema.</p> <p>Inspect the skin on a daily basis when performing or assisting with personal cares or ADLs. a. Identify any signs of developing pressure injuries (i.e. non-blanchable, erythema). b. Inspect pressure points.</p> <p>Evaluate, report, and document potential changes in the skin.</p> <p>Review the interventions and strategies for effectiveness on an ongoing basis.</p> <p>According to the National Pressure Injury Advisory Panel/European Pressure Ulcer Advisory Panel (NPIAP/EPUAP), Weekly assessments provide an opportunity for the health care professional to detect early complications and the need for changes in the treatment plan.</p> <p>The NPIAP directs that the professional should reevaluate the pressure injury assessment plan if the pressure injury does not show signs of healing within two weeks and adjust the treatment accordingly.</p> <p>The NPIAP states a comprehensive wound assessment should be completed weekly and should consist of the following information:</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<ul style="list-style-type: none"> <li>-location of the wound;</li> <li>-category/stage of the wound;</li> <li>-size of the wound;</li> <li>-tissue type(s);</li> <li>-description of the wound bed and periwound;</li> <li>-description of the wound edges;</li> <li>-presence of any sinus tracts, undermining, or tunneling;</li> <li>-presence of exudate or drainage;</li> <li>-presence of necrotic tissue or slough;</li> <li>-presence of odor;</li> <li>-presence/absence of granulation tissue and/or epithelialization; and</li> <li>-the current treatment being utilized.</li> </ul> <p>R3 was admitted to the facility on [DATE]. Diagnoses (dx) included osteomyelitis of ankle and foot, type 2 diabetes mellitus, venous insufficiency, and heel fracture. R3's Minimum Data Set (MDS) assessment, completed on 06/18/24, indicated R3 had no skin concerns or PIs and was at risk for PIs.</p> <p>R3's skin care plan:</p> <ul style="list-style-type: none"> <li>-06/12/24, has right buttock open areas possibly due to shearing. (Surveyor noted no interventions related to right buttock wound).</li> <li>-06/14/24, The resident is at risk for skin breakdown/pressure areas related to dx of diabetes, does not like to get out of bed at times, incontinent of bowel and bladder at times. (Surveyor noted no interventions related to risk for skin breakdown).</li> <li>-07/11/24, unstageable pressure area to bottom of right foot.</li> <li>-07/16/24, resident has pressure area to left coccyx-new-facility acquired.</li> </ul> <p>R3's skin interventions:</p> <ul style="list-style-type: none"> <li>-06/14/24, Diabetes medication as ordered.</li> <li>-06/14/24, Fasting serum blood sugar.</li> <li>-06/14/24, Monitor and document blood sugars.</li> </ul> <p>(continued on next page)</p>

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>-06/14/24, Monitor and document signs of hypoglycemia.</p> <p>-06/14/24, Dietary consult.</p> <p>-06/14/24, Monitor and report compliance with diet.</p> <p>(Note, interventions listed above do not address R3's right buttock PI, shearing, and potential for skin breakdown).</p> <p>-07/03/24, Check heels and feet twice daily for any skin issues.</p> <p>-07/05/24, Check air mattress and let maintenance know of any concerns.</p> <p>-07/11/24, Heel riser to be used when resident is in bed. (Note, Surveyor did not observe this intervention during the survey period.)</p> <p>-07/16/24, Resident has pool noodle at end of bed to help prevent foot from touching footboard. Place pillow under heels to be sure heels/feet are not touching bed/footboard (Note, Surveyor observed pool noodle on R3's floor during the survey period. R3's heels/feet were not elevated on pillows. Surveyor observed R3's right foot and heel to be resting against the footboard).</p> <p>R3's physician orders included:</p> <p>-07/10/24, right foot, cleanse area with ns, pat dry, cover with mepilex, two times a day for wound care.</p> <p>-07/18/24, weekly skin assessments.</p> <p>(Surveyor noted orders on 07/22/24, were obtained after Surveyor interviewed staff related to R3's PIs.)</p> <p>-07/22/24, 4.2 cm x 6.0 cm unstageable pressure wound to bottom of right foot. Cleanse with normal saline, pat dry, apply telfa, followed by gauze, two times daily. (Note, order for 4.2 cm x 6.0 cm is not accurate based on measurements from 07/16/24 of 8.0 cm x 6.2 cm).</p> <p>-07/22/24, Stat referral to wound care to right posterior foot.</p> <p>(Note, no physician orders related to right buttock wound).</p> <p>R3's skin assessments:</p> <p>-06/12/24, admission progress note, right buttock has an open area. (Note, a comprehensive skin assessment was not completed.)</p> <p>-06/20/24, a comprehensive weekly skin assessment was not completed.</p> <p>-06/27/24, RIGHT BUTTOCK, pressure: 4 x 4 x 0, suspected deep tissue injury, (Note, a comprehensive skin assessment was not completed.)</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Heritage Lakeside		STREET ADDRESS, CITY, STATE, ZIP CODE  1016 Lakeshore Dr Rice Lake, WI 54868	
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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>-07/04/24, RIGHT BUTTOCK, pressure: 4 x 4 x 0, suspected deep tissue injury, (Note, a comprehensive skin assessment was not completed.)</p> <p>-07/10/24, progress note reads: unstageable pressure area on bottom of RIGHT FOOT. Measures approx. 4.2 x 6.0 cm. (Note, a comprehensive skin assessment was not completed.)</p> <p>-07/16/24, RIGHT BUTTOCK, stage 2 pressure area, facility acquired on 06/12/24, possibly from friction and shearing. 1.0 x 0.8 cm. (Note, 07/16/24 is the first comprehensive skin assessment, 34 days after acquiring PI.)</p> <p>RIGHT GREAT TOE/RIGHT FOOT, 8 cm x 6.2 cm. Scant drainage. Area is red and rolled edges with macerated center. No redness/swelling around site, no greenish drainage, (Note, 07/16/24, is the first comprehensive skin assessment, 6 days after acquiring PI.)</p> <p>LEFT GLUTEAL FOLD, 2.5 cm x 0.8 cm, stage 2 pressure area, facility acquired, new.</p> <p>During interview with Director of Nursing (DON) B, it was noted Quality Nurse M completed skin assessment of R3's buttocks on 07/16/24; she noted the dressing was dated 12 days prior on 07/04/24. Surveyor noted there are no physician orders for buttock treatment.</p> <p>On 07/22/24 at 10:15 AM, Surveyor interviewed R3. R3 was lying in bed. Surveyor observed R3's right foot was wrapped with clean, dry gauze dressing. Surveyor observed R3's right foot was resting on the surface of the bed, and on the footboard of the bed. R3 stated, My right foot was okay when I admitted, now I have a sore on it, maybe from rubbing on the footboard. R3 reports receiving showers twice weekly. R3 confirmed he does not like to reposition often, and he is most comfortable on his back.</p> <p>On 07/22/24 at 10:36 AM, Surveyor interviewed Registered Nurse (RN) K. RN K reported she requested a stat order wound consult today, as R3's right foot is odorous. RN K confirmed R3 has a follow-up appointment scheduled with orthopedics on 07/31/24.</p> <p>On 07/22/24 at 10:45 AM, Surveyor interviewed Licensed Practical Nurse (LPN) G. LPN G reported weekly wound progress was completed by an employee who no longer works at the facility. LPN G was not aware of the staff person responsible for completing weekly wound assessments now.</p> <p>On 07/22/24 at 2:29 PM, Surveyor observed R3's feet were resting on the surface of the bed. Surveyor did not observe heel risers or a pool noodle per R3's care plan.</p> <p>On 07/23/24 at 6:37 AM, Surveyor observed R3 in bed, blue pool noodle was lying on the floor. R3's feet were resting on the surface of the bed and against the footboard of the bed.</p> <p>On 07/23/24 at 9:08 AM, Surveyor observed R3 in bed, blue pool noodle was lying on the floor. R3's feet were resting on the surface of the bed and against the footboard of the bed.</p> <p>On 07/23/24 at 9:16 AM, Surveyor interviewed Certified Nursing Assistant (CNA) D. CNA D stated staff are to keep R3's feet off the footboard of the bed and to elevate his feet on pillows.</p> <p>(continued on next page)</p>		

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F 0686  Level of Harm - Actual harm  Residents Affected - Few	<p>On 07/23/24 at 9:18 AM, Surveyor observed LPN L complete wound treatment to R3's right foot. Surveyor observed R3's bottom great right toe and pad of bottom right foot were black covered eschar and unstageable. R3 denied pain in the foot during treatment. There were no concerns related to wound treatment completed by LPN L. R3 declined to allow Surveyor to observe wounds to his buttocks.</p> <p>On 07/23/24 at 9:48 AM, Surveyor interviewed DON B. DON B reported the employee who was completing weekly wound care assessments no longer works at the facility. DON B stated she was aware weekly wound assessments and documentation were not completed for a week after the employee left, but stated assessments had been completed by Quality Nurse M last week on 07/16/24. Surveyor noted staff education had not been completed with all staff on PI prevention prior to start of this survey. Current noncompliance was observed during the survey.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>30570</p> <p>Based on observation, interview and record review, the facility did not provide the needed supervision to prevent accidents for 2 of 3 residents reviewed for accidents (R6 and R11).</p> <p>Facility staff did not provide supervision while R6 was eating breakfast. Speech Therapy caregiver instructions and care plan indicated R6 requires supervision to eat.</p> <p>Facility staff did not provide supervision while R11 was eating breakfast. R11's caregiver instructions and care plan indicated she requires supervision to eat.</p> <p>This is evidenced by:</p> <p>Example 1</p> <p>R6's most recent Minimum Data Set (MDS) completed 06/30/24 notes R6 eats independently.</p> <p>Follow-Up Caregiver Instructions: Referred by: Speech therapy (ST) dated 09/09/23 indicated:</p> <p>Issue: Swallowing Strategies: .Soft bite sized foods, thin liquids</p> <p>Activities to be performed with Resident:</p> <ol style="list-style-type: none"> <li>1. Patient needs to be upright and alert for all meals, snacks, and meds.</li> <li>2. Small bites-chew food well.</li> <li>3. Small sips.</li> <li>4. Alternate food and drink.</li> </ol> <p>Add butter or gravy, sauces etc. to foods that are dry.</p> <ol style="list-style-type: none"> <li>5. Remain upright for 30 minutes after meal.</li> </ol> <p>Supervision at meals.</p> <p>R6's care plan included:</p> <p>Focus: The resident has an ADL (Activities of Daily Living) self-care performance deficit r/t (related to) anxiety.</p> <p>Goal: Resident will maintain current level of function in ADLs through review date: 10/14/2024.</p> <p>Interventions:</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Swallowing Strategies .soft and bite sized foods.</p> <p>Patient needs to be upright and alert for all meals snacks and med's.</p> <p>Small bites - chew food well.</p> <p>Small sips.</p> <p>Alternate food and drink.</p> <p>Add butter or gravy, sauces, etc. to foods that are dry.</p> <p>Remain upright for 30 min after a meal.</p> <p>Requires supervision at meals.</p> <p>Initiated 9/09/23.</p> <p>On 07/23/24 at 8:11 AM, Surveyor observed R6 sitting at a table in the small lounge/dining area on the rehabilitation wing. R6 was eating breakfast with no staff providing supervision while she ate. R6 was served bite sized french toast with syrup, ground meat with gravy, cheerios cereal with milk and her beverages. R6 was observed eating her french toast, ground meat without alternating food and drink. R6 continued eating without supervision until 8:26 AM when Certified Nursing Assistant (CNA) D joined R6 at the table.</p> <p>Example 2</p> <p>Surveyor reviewed R11's record and noted:</p> <p>R11's most recent Minimum Data Set (MDS) completed 06/30/24 notes R11 eats independently.</p> <p>Follow-Up Caregiver Instructions: Referred by: Speech therapy (ST) dated 05//05/2024 Indicated:</p> <p>Issue: Diet Upgrade: .Soft and bite sized foods, break ok-crust off.</p> <p>Activities to be performed with Resident:</p> <ol style="list-style-type: none"> <li>1. Upright position for all meals, snacks.</li> <li>2. Small bites-chew food well.</li> <li>3. Sit up for 30 minutes.</li> </ol> <p>Supervision at meals.</p> <p>Precautions: Patient was admitted at SNF (Skilled Nursing Facility) without bottom dentures.</p> <p>R11's care plan included:</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Focus: The resident has an ADL (Activities of Daily Living) self-care performance deficit r/t (related to) decline in function.</p> <p>Goal: Resident will maintain current level of function in ADLs through review date: 09/30/24.</p> <p>Interventions:</p> <p>Eating: Independent after set-up .</p> <p>Swallowing Strategies .soft and bite sized foods</p> <ol style="list-style-type: none"> <li>1. Upright position for all meals, snacks.</li> <li>2. Small bites-chew food well.</li> <li>3. Remain upright for 30 minutes after eating .</li> </ol> <p>**Supervised Setting**</p> <p>Date Initiated: 3/20/24.</p> <p>On 07/23/24 at 8:11 AM, Surveyor observed R11 sitting at a table in the small lounge/dining area on the rehabilitation wing. R11 was eating breakfast with no staff providing supervision while she ate. R11 was served french toast with syrup that was cut up, cereal with milk, and her beverages. R11 was observed eating without supervision until 8:26 AM when CNA D joined R11 at the table.</p> <p>On 7/23/24 at 8:34 AM, Surveyor interviewed CNA D about the observation. CNA D indicated she has been on staff 8 years and works R6's and R11's unit. CNA D indicated the residents who eat in the small dining room require supervision while eating. The tray cart comes up with those residents' trays and resident room trays. The residents in the dining room are served first and staff proceed to serve the residents in their rooms as normal procedure. Surveyor asked CNA D if any of the residents in the dining room have specific guidelines to follow while they eat. CNA D expressed there are no guidelines but the residents who eat in the small dining room need supervision to eat. Surveyor asked CNA D if the residents in the small dining room including R6 and R11 are provided supervision to eat if staff serve them and leave to pass room trays. CNA D responded No, I see what you mean.</p> <p>On 07/23/24 at 2:19 PM, Surveyor interviewed Director of Nursing (DON) B about the observations. DON B expressed she would absolutely expect staff to remain present in the dining room to supervise residents who require supervision to eat. Residents who eat in the dining room are there because they need supervising.</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44863</b></p> <p>Based on interview and record review, the facility failed to adequately assess and provide necessary care and services to attain or maintain the highest practicable physical wellbeing for 1 of 2 residents (R1) reviewed for pain management.</p> <p>R1 expressed increased pain utilizing a pain scale. The facility did not administer as needed medications when R1's pain was elevated. The facility did not document the effectiveness of as needed pain medications, when used. The facility did not follow R1's care plan to provide maximum comfort related to hospice care and terminal diagnosis.</p> <p>Findings:</p> <p>R1 was admitted to the facility on [DATE] at approximately 9:30 AM, after hospitalization . Diagnoses included vertebral osteomyelitis (bone infection), lumbar fractures, inferior vena cava (IVC) thrombus (a blood clot in a large abdominal vein), blood clots in bilateral femoral veins, abdominal cavity bleed, pulmonary blood clot, recurring urinary tract infections, heart failure, muscle pain and stiffness due to inflammatory disorder, and osteoporosis. R1's IVC clot was discussed during her hospitalization , and it was determined she was not a candidate for an IVC filter to prevent blood clots from traveling to her heart and lungs. If left untreated IVC can cause sudden death. Hospice care was discussed with R1 during her hospitalization , and she was enrolled on [DATE]. R1 expired at the facility on [DATE] at approximately 5:40 PM.</p> <p>R1's care plan included the following:</p> <p>Hospice related to terminal diagnosis. Provide maximum comfort for resident.</p> <p>Pain related to disease process. Administer medications as ordered, monitor for effectiveness. Report if interventions are unsuccessful.</p> <p>Anti-anxiety medications related to anxiety. Administer medications as ordered. Monitor for effectiveness.</p> <p>R1's physician orders, related to pain, included:</p> <ul style="list-style-type: none"> <li>-Lovenox 80 mg twice daily to reduce development of blood clots</li> <li>-Gabapentin 300 mg twice daily for pain, 8:00 AM and 12:00 PM</li> <li>-Lidocaine patch every morning for pain</li> <li>-lorazepam 0.5 mg every hour as needed for anxiety</li> <li>-oxycodone 10 mg every 12 hours for pain, 9:00 AM and 9:00 PM</li> <li>-oxycodone every 4 hours as needed for pain</li> </ul> <p>(continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-morphine 100 mg/ml, give 0.25 ml every hour as needed for pain</p> <p>-acetaminophen 1000 mg three times daily for pain</p> <p>On [DATE], facility progress note related to R1's admission to the facility: Fifty-two-year-old female admitted at 9:30 AM from hospital. Resident is alert, oriented and pleasant. She is being admitted to hospice at this time.</p> <p>MAR indicated, (note: as needed medications require effectiveness to be documented, scheduled medications do not):</p> <p>[DATE]:</p> <p>-3:00 PM, pain rating ,d+[DATE], scheduled acetaminophen administered.</p> <p>-7:00 PM, pain rating ,d+[DATE], scheduled acetaminophen administered.</p> <p>-9:00 PM, Progress notes at 11:58 PM, injection (Lovenox) given late due to receiving medication from pharmacy on night shift.</p> <p>-9:00 PM, pain rating ,d+[DATE], scheduled oxycodone administered. Progress notes at 11:59 PM, given late due to receiving from pharmacy on night shift.</p> <p>[DATE]:</p> <p>-12:00 AM, as needed lorazepam administered, documented as effective.</p> <p>-12:02 AM, pain rating ,d+[DATE], as needed morphine administered. Progress note reads given morphine to get in front of pain. Documented as effective.</p> <p>-2:05 AM, Progress notes, R1 complained of pain rated at a 9. Writer went over pain medications resident may receive and reassured her staff wants her to use call light and let us know if she is having pain. Will continue to monitor closer.</p> <p>-2:05 AM, pain rating ,d+[DATE], as needed morphine administered. Documented as ineffective.</p> <p>-2:16 AM, R1 is much calmer than beginning of shift. Breathing is better controlled and not as restless. Will continue to monitor for increased anxiety.</p> <p>-3:39 AM, pain rating ,d+[DATE], as needed morphine administered. Documented as effectiveness unknown. (Note, effectiveness not documented for pain rating ,d+[DATE], no documentation to support how R1's pain was managed due to ineffectiveness).</p> <p>-3:39 AM, pain rating ,d+[DATE], as needed oxycodone administered. Documented as effectiveness unknown. (Note, effectiveness not documented for pain rating ,d+[DATE], no documentation to support how R1's pain was managed due to ineffectiveness).</p> <p>(continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-7:00 AM, pain rating ,d+[DATE], scheduled acetaminophen administered. (Note, R1 had pain rating of , d+[DATE] for approximately 3.25 hours, without administration of as needed pain medications).</p> <p>-7:30 AM, pain rating ,d+[DATE], as needed morphine administered. Documented as effective.</p> <p>-8:00 AM, scheduled Gabapentin administered.</p> <p>-8:50 AM, as needed lorazepam administered. Documented as effective.</p> <p>-9:00 AM, scheduled Lovenox administered.</p> <p>-9:00 AM, scheduled oxycodone administered.</p> <p>-11:46 AM, pain rating ,d+[DATE], as needed morphine administered.</p> <p>-12:00 PM, scheduled Gabapentin administered. Documented as effective.</p> <p>-3:00 PM, pain rating ,d+[DATE], scheduled acetaminophen administered.</p> <p>-03:11 PM, pain rating ,d+[DATE], as needed oxycodone administered. Documented as effective.</p> <p>-3:17 PM, pain rating ,d+[DATE], as needed morphine administered. Documented as effective.</p> <p>-7:00 PM, pain rating ,d+[DATE], scheduled acetaminophen administered.</p> <p>-8:12 PM, as needed lorazepam administered. Documented as ineffective.</p> <p>-9:00 PM, pain rating ,d+[DATE], scheduled oxycodone administered.</p> <p>-11:04 PM, as needed lorazepam administered. Documented as effective.</p> <p>-11:05 PM, pain rating ,d+[DATE], as needed oxycodone administered. Documented as ineffective. (Note, effectiveness not documented for pain rating ,d+[DATE], no documentation to support how R1's pain was managed due to ineffectiveness).</p> <p>[DATE]:</p> <p>-2:48 AM, pain rating ,d+[DATE], as needed morphine administered. Documented as effective. (Note, R1 waited approximately 3.5 hours with pain rating of ,d+[DATE] without administration of as needed medications).</p> <p>-3:48 AM, pain rating ,d+[DATE], as needed oxycodone administered. Documented as ineffective. (Note, effectiveness not documented for pain rating ,d+[DATE], no documentation to support how R1's pain was managed due to ineffectiveness).</p> <p>-7:00 AM, pain rating ,d+[DATE], scheduled acetaminophen administered. (Note, R1 had pain rating of , d+[DATE] for approximately 8 hours. As needed medications were documented as ineffective, no documentation to support how R1's pain was managed due to ineffectiveness).</p> <p>(continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-7:53 AM, pain rating ,d+[DATE], as needed morphine administered. Documented as effective.</p> <p>-7:54 AM, as needed lorazepam administered. Documented as effective.</p> <p>-8:00 AM, scheduled Gabapentin administered.</p> <p>-8:00 AM, scheduled Lidocaine patch administered.</p> <p>-9:00 AM, pain rating ,d+[DATE], scheduled oxycodone administered. (No effectiveness documented)</p> <p>-9:00 AM, scheduled Lovenox administered.</p> <p>-12:00 PM, scheduled Gabapentin administered.</p> <p>-1:45 PM, as needed lorazepam administered. Documented as effective.</p> <p>-1:46 PM, pain rating ,d+[DATE], as needed morphine administered. Documented as effective.</p> <p>-3:00 PM, pain rating ,d+[DATE], scheduled acetaminophen administered.</p> <p>-6:14 PM, as needed lorazepam administered. Documented as effective.</p> <p>-6:15 PM, pain rating ,d+[DATE], as needed morphine administered. Documented as effective.</p> <p>-7:00 PM, pain rating ,d+[DATE], scheduled acetaminophen administered.</p> <p>-9:00 PM, pain rating ,d+[DATE], scheduled oxycodone administered. Documented as effective.</p> <p>-9:00 PM, scheduled Lovenox administered.</p> <p>-11:04 PM, pain rating ,d+[DATE], as needed oxycodone administered. Documented as effective.</p> <p>[DATE]:</p> <p>Morphine, lorazepam and Oxycodone were given timely with effectiveness documented.</p> <p>Resident expired in the afternoon of [DATE].</p> <p>On [DATE] at 1:18 PM, Surveyor interviewed Licensed Practical Nurse (LPN) F. LPN F stated she worked on [DATE] at 10:00 PM. LPN F reported pharmacy delivered all of R1's medications on the night shift of [DATE]-[DATE] but was unsure what time. LPN F reported when she started her shift, R1 was physically uncomfortable but was not crying out and was expressing symptoms of anxiety. LPN F stated she did administer oxycodone, morphine, and lorazepam when medications arrived at the facility. LPN F reported she did not feel R1's pain was managed adequately.</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44863</b></p> <p>Based on interview and record review, the facility did not ensure licensed nurses had the specific competencies and skill set necessary to care for a resident's needs, as identified through resident assessment, and described in the plan of care, for 1 of 1 resident (R2) reviewed for negative pressure wound therapy (NPWT).</p> <p>R2's NPWT malfunctioned, and staff were unable to continue R2's NPWT.</p> <p>Findings:</p> <p>R2 was admitted to the facility on [DATE] after hospitalization for occlusion of right popliteal artery (the main artery supplying blood to the lower leg). A surgical procedure was performed to reduce pressure in R2's right lower leg, by making two incisions to the inner and outer right calf.</p> <p>R2's admission orders included NPWT to right outer calf and follow up with vascular surgery in 7-10 days.</p> <p>R2's hospital discharge summary stated, NPWT was indicated to promote tissue formation and increase healing time. Consequences of not using NPWT include delayed wound healing, infection, and sepsis.</p> <p>R2's care plan dated 07/12/24 included: wound vac to right lower extremity, check wound vac each shift. Call vascular surgery for any fever, uncontrolled pain, redness at incision, drainage of pus, swelling at incision, or any additional questions.</p> <p>On 07/12/24, R2's progress notes read: nurse called provider stating the patient was admitted with some wounds and a wrap and she is insisting she is supposed to have a wound V.A.C. Provider ordered to unwrap wounds, cleanse wounds, wash them with wound wash, pat them dry and cover with a non-adherent dressing until seen by wound care. Consult wound care this morning.</p> <p>Surveyor was unable to find wound care consult.</p> <p>R2's NPWT was applied on 07/13/24 by Licensed Practical Nurse (LPN) F. Progress note entered by LPN F read in part .Writer did call to verify correct placement for correct suction with MDS coordinator. Wrap left off until day RN [Registered Nurse] assess and verifies working properly.</p> <p>On 07/15/24, R2's progress notes read, Quality nurse was called into resident's room as wound vac system was beeping. RN and DON [Director of Nursing] checked the system and code and followed instructions. Beeping continues. Nurse called number on the system, and they advised to watch wound vac video. MDS nurse to come in and change the dressing. Resident stated that wound vac was working properly until she got up to go to the bathroom.</p> <p>On 07/16/24, R2's primary provider was updated NPWT was malfunctioning and an order for wet to dry dressing changes twice daily was received.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525654	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/23/2024
NAME OF PROVIDER OR SUPPLIER  Heritage Lakeside		STREET ADDRESS, CITY, STATE, ZIP CODE  1016 Lakeshore Dr Rice Lake, WI 54868	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 07/22/24, Surveyor requested employee training and evaluations. Surveyor reviewed a sample of employee training and evaluations and noted no training related to NPWT was provided. Surveyor reviewed the Facility Assessment and noted it included a resident population related to wound care and treatment but was not specific to NPWT.</p> <p>On 07/22/24 at 10:37 AM, Surveyor interviewed R2. R2 reported she was admitted to the facility because she required a wound vac to one of her incisions. R2 stated she arrived at the facility on 07/11/24 and the wound vac came on 07/12/24. R2 reported, No one knew what it was, and the night nurse came in and put it on. On Sunday it started acting up, I know they called the manufacturer. I think a lot of this is new to them, I don't think any of them knew what they were doing with the wound vac, they have a lot of turn-over. The wound vac was never really sucking, some stuff in the tube but nothing in the chamber. I went to the clinic last week Thursday, and my wound is doing good, they did not order another wound vac. I will be seeing wound care nurse today.</p> <p>Surveyor observed R2's right leg and noted a healing incision to her inner right calf. The incision was open to air, still contained surgical staples, was clean, and without signs of infection. Surveyor observed a dressing to the front and outer area of R2's right calf. The dressing was clean, dry, initialed, and dated, 07/21/24.</p> <p>On 07/22/24 at 12:20 PM, Surveyor interviewed LPN I. LPN I was not present in the facility or scheduled to work the dates of 07/12/24-07/15/24. LPN I reported she is in the process of completing her employee orientation and had not been provided with education related to NPWT, however she is wound care certified. LPN I reported the facility had a certified wound care nurse who was terminated on or around 07/14/24.</p> <p>On 07/22/24 at 12:25 PM, Surveyor interviewed RN H. RN H has worked at the facility intermittently for approximately one year, and reported she did not receive NPWT training or education. RN H did work at the facility between 07/12/24-07/15/24, and reported she was comfortable monitoring R2's NPWT as it was functioning properly while she was assigned to work.</p> <p>On 07/22/24 at 12:26 PM, Surveyor interviewed LPN G. LPN G stated he is employed through an agency. LPN G reported he had not received training through the facility related to NPWT. LPN G stated if there were concerns related to NPWT, staff could call certified wound care nurse (terminated on or around 07/14/24) or MDS Coordinator J.</p> <p>On 07/22/24 at 1:07 PM, Surveyor interviewed DON B. DON B reported she has been employed at the facility for approximately 8 weeks and has not had any employee orientation. DON B reported a former employee was assisting her in her learning her role, but that employee had recently been terminated on or around 07/12/14. DON B was not able to provide additional information related to NPWT training and education.</p> <p>On 07/22/24 at 2:29 PM, Surveyor interviewed Nursing Home Administrator (NHA) A. NHA A confirmed R2 was the only resident with a recent or current NPWT. NHA A reported staff are educated on NPWT each time there is an order. NHA A reported the manufacturer provides education through videos or pamphlets. NHA A stated the facility tries to educate staff prior to a resident admission but is not always able to do this. NHA A acknowledged the facility was not able to provide documentation to support evidence of employee education related to NPWT.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Heritage Lakeside		STREET ADDRESS, CITY, STATE, ZIP CODE  1016 Lakeshore Dr Rice Lake, WI 54868	
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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 07/23/24, Surveyor reviewed R2's 07/22/24 wound care clinic notes, and noted R2's wound is healing well and NPWT was not recommended, facility to continue with dressing treatments.</p>		