STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525655	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fond Du Lac Lutheran Home	244 N Macy St Fond Du Lac, WI 54935

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40342 Based on observation and staff and resident interview, the facility did not provide a safe, sanitary, or home-like environment for 1 resident (R) (R5) of six sampled residents. On 3/25/25, bowel movement (BM) soiled cloths were observed on R5's bathroom sink. Findings include: The facility provided an undated Standard Activities of Daily Living (ADL) Protocol that did not mention where staff should place soiled items during the provision of care. On 3/25/25, Surveyor reviewed R5's medical record. R5 was admitted to the facility on [DATE] and had diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting the left non-dominant side and post-polio syndrome. R5's Minimum Data Set (MDS) assessment, dated 1/17/25, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R5 had no cognitive impairment. R5 was responsible for R5's healthcare decisions. On 3/25/25 at 11:56 AM, Surveyor interviewed R5 who was in bed. When asked about the cleanliness of the facility R5 stated, It could be better. I think the bathroom should be cleaned better. Surveyor observed R5's bathroom and noted BM soiled cloths on the rim of R5's sink. At 12:01 PM, Medication Technician (MT)-C entered the room and administered medication to R5. Surveyor interviewed MT-C who verified the cloths on the rim of the sink were soiled with BM. MT-C indicated soiled linens should not be placed on the sink during cares and should be put in a bag to be taken to the utility room. MT-C indicated MT-C had assisted with R5's cares earlier that day. MT-C indicated the BM soiled cloths were not on the sink at that time. R5 indicated R5 was incontinent of BM and other staff assisted R5 with care at approximately 11:20 AM. On 3/25/25 at 1:48 PM, Surveyor interviewed Director of Nursing (DON)-B who indicated staff usually put soiled linens directly in a bag to take to the utility room. DON-B verified BM soiled cloths should not have been placed on R5's sink. On 3/25/25 at 2:15 PM, Surveyor interviewed DON-B who indicated the facility does not have a policy that addresses what staff should do with soiled items and provided Surveyor with the above mentioned policy.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48794 Based on staff interview and record review, the facility did not ensure 1 resident (R) (R1) of 1 resident received adequate supervision to prevent elopement. On 2/23/25, R1 was assessed to be at risk for elopement after R1 attempted to elope fromv the facility. Staff placed a WanderGuard bracelet on R1. On 2/24/25, R1 expressed a desire to leave the facility and go to a local store. On 2/26/25, R1 cut off R1's WanderGuard and a new WanderGuard was applied. On 2/28/25 at 8:35 AM, R1 left the facility without staffs' knowledge and was redirected back into the facility. On 2/28/25 at 3:30 PM, staff found R1 outside walking back from a local store that was approximately 0.3 miles from the facility. R1 had eloped from the facility without staffs' knowledge. The facility's failure to supervise a resident who was assessed as an elopement risk and had a history of elopement attempts and cutting off a WanderGuard led to a finding of Immediate Jeopardy that began on 2/28/25. Surveyor notified Nursing Home Administrator (NHA)-A of the Immediate Jeopardy on 3/25/25 at 4:22 PM. The Immediate Jeopardy was removed and corrected on 3/26/25; however, the deficient practice continues at a scope/severity level D (potential for more than minimal harm/isolated) as the facility continues to implement its action plan. Findings include: The facility's Elopement Prevention policy, dated 8/10/23, indicates interventions for individuals at risk for elopement will be identified and implemented. Procedure: A) At the time of screening and/or upon admission, gather data regarding history of wandering or elopement. B) A licensed nurse will complete the Elopement Risk Evaluation upon admission to the facility, quarterly, and change of condition .An interim plan of care for minimizing the risk for elopement will be initiated upon high-risk determination .D) The Interdisciplinary Team (IDT) will initiate a plan of care for any individual determined at high risk for elopement. Facility-specific measures as well as individual-specific measures will be included in each high-risk individual's plan of care to minimize risk factors .F) Interventions to decrease risk of wandering such as devices and monitoring will be initiated as deemed appropriate by the IDT and documented in the individual's plan of care. On 3/25/25, Surveyor reviewed R1's medical record. R1 was admitted to the facility on [DATE] and had diagnoses including hepatic encephalopathy, alcoholic cirrhosis of liver, delirium due to known physiological condition, anxiety disorder, depression, and history of falling. R1 was ambulatory and used a front-wheeled walker and wheelchair for mobility. R1 was semi-independent and required minimal assistance and cueing with activities of daily living (ADLs). An Admission Minimum Data Set (MDS) assessment, dated 1/29/25, had a Brief Interview for Mental Status (BIMS) score of 12 out of 15 which indicated R1 had moderate cognitive impairment. A Discharge MDS assessment, dated 3/10/25, had a BIMS score of 11 out of 15 which indicated R1 had moderate cognitive impairment. R1 had an activated Power of Attorney for Healthcare (POAHC) who was responsible for R1's healthcare decisions. R1 discharged from the facility on 3/10/25. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An Elopement Risk Assessment, dated 1/22/25, indicated R1 was at low risk for elopement and was non-ambulatory. On 2/2/25, R1 was hospitalized with a diagnosis of hepatic encephalopathy and increased confusion. R1 was readmitted to the facility on [DATE]. An Elopement Risk Assessment, dated 2/12/25, indicated R1 was at low risk for elopement. A progress note, dated 2/15/25 at 9:56 PM, indicated R1 was forgetful and had difficulty finding words to express R1's self. There was a noted increase in wandering the halls after supper. By 9:00 PM, R1 had changed clothes 3 times, wandered into another resident's room, and went to the elevator. Staff redirected R1 back to R1's room. Staff talked with R1 and indicated R1's behavior could be due to an increased ammonia level. Staff offered an additional dose of lactulose but R1 refused. The night nurse was updated. A progress note, dated 2/16/25 at 1:14 AM, indicated R1 wandered quite a bit and went into other residents' rooms. R1 was easily redirected, however as soon as staff left R1's room, R1 started to wander again. A progress note, dated 2/16/25 at 4:09 AM, indicated R1 asked to leave the facility and went to the emergency room (ER) via ambulance at approximately 4:05 AM due to increased confusion, restlessness, wandering, and decreased urination. A progress note, dated 2/21/25 at 4:48 PM, indicated R1 was alert and oriented and was readmitted from the hospital in a wheelchair with a diagnosis of hepatic encephalopathy. An Elopement Risk Assessment, dated 2/21/25, indicated R1 was at high risk for elopement. The assessment indicated R1's risk could be related to confusion and the hospital's statement that R1 was sundowning. A progress note, dated 2/23/25 at 8:05 PM, indicated R1 attempted to elope twice on the AM shift. R1 attempted to use the door at the stairwell but staff intervened. When family arrived later in the day, R1 was in the lobby signing R1's self out in the visitor log. Family was concerned that R1 may try to leave again and requested a WanderGuard be placed. A progress note, dated 2/23/25 at 11:26 PM, indicated R1 was up ad lib (as desired) and wandered in and out of rooms and hallways frequently from 9:00 PM to 10:00 PM. An Elopement Risk Assessment, dated 2/23/25, indicated R1 was at high risk for elopement. The assessment indicated R1 attempted to elope twice on the AM shift. Family was concerned R1 may try to leave again and requested a WanderGuard. A progress note, dated 2/24/25 at 2:14 AM, indicated R1 walked the hallways with and without a walker, repeatedly changed clothes, and moved items around R1's room. R1 did not use a call light or ask for assistance and was put back to bed several times. R1 thanked staff and closed R1's eyes but was up again in the hallway a few minutes later. R1 declined to sit in a recliner in the sunroom. Lorazepam (an anxiety medication) was ineffective. There was a WanderGuard on R1's right ankle. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A progress note, dated 2/24/25 at 7:23 AM, indicated staff spoke with R1's POAHC about moving R1 to a room closer to the nurses' station on the first floor or a room on the second floor for better WanderGuard monitoring. R1's POAHC asked to consult with other family members and R1's physician before making a decision. A progress note, dated 2/24/25 at 4:17 PM, indicated staff notified R1's family that R1 wanted to walk to a local store. R1's family was in agreement with a WanderGuard. The Nurse Practitioner was notified and a WanderGuard was placed on R1. An Elopement Risk Care Plan, initiated 2/24/25, indicated R1 attempted to leave the facility unattended. The care plan contained the following interventions: Distract R1 from wandering by offering pleasant diversions, structured activities, food, conversation, television, books. R1 prefers gardening, floral design, word games, socializing with others (initiated 2/24/25); Provide structured activities: toileting, walking inside and outside, reorientation strategies including signs, pictures and memory boxes (initiated 2/24/25); Identify pattern of wandering: Is wandering purposeful, aimless, or escapist? Is resident looking for something? Does it indicate the need for more exercise? Intervene as appropriate (initiated 2/24/25); Wander alert bracelet placed. Staff to check placement every shift and functioning every day (initiated 2/24/25); Monitor location of R1 via frequent checks. 1:1 if available and needed. Family to assist with 1:1 visits as able (initiated 3/4/25). On 3/25/25 at 1:00 PM, Surveyor interviewed Director of Nursing (DON)-B who clarified WanderGuard placement was initiated on 2/23/25 following R1's elopement assessment. The WanderGuard was placed on R1 early on 2/24/25 after review with family. DON-B indicated the note from later in the day on 2/24/25 is when WanderGuard monitoring was placed on R1's medication administration record (MAR). DON-B indicated R1 cut off R1's WanderGuard prior to the elopement on 2/28/25. DON-B stated the first time R1 cut off the WanderGuard was either 2/24/25 or 2/25/25. DON-B stated after R1's request to leave and go to a local store on 2/24/25, it was recommended to R1's family to move R1 to the second floor for closer monitoring. DON-B stated R1 initially did not want to move but was moved to the second floor on 2/26/25. DON-B indicated no other interventions were put in place. On 3/25/25 at 2:02 PM, Surveyor followed-up with DON-B who reported a correction to DON-B's original statement that on 2/25/25, DON-B checked the placement of R1's WanderGuard and noted the WanderGuard was intact. DON-B stated housekeeping staff alerted DON-B on 2/26/25 that R1's WanderGuard was found in the garbage. DON-B stated 2/26/25 was the first time R1 had cut off the WanderGuard. A progress note, dated 2/27/25 at 9:17 PM, indicated R1 cut the WanderGuard off again. A WanderGuard was placed on R1's wheelchair. A progress note, dated 2/28/25 at 8:35 AM, indicated R1 continued to exit seek and left the building without staffs' knowledge. R1 was educated on the risk of leaving the building. R1 did not understand and stated R1 would go out if R1 wanted. Family was aware that R1 needed supervision at all times when awake and R1 should not have any items that could be used to cut off the WanderGuard. A progress note, dated 2/28/25 at 3:58 PM, indicated R1 disappeared from the unit and was found walking back from a local store after buying wine and other items. New WanderGuards were placed on R1's left wrist and 2-wheeled walker. R1 was placed on 1:1 supervision. The note indicated if there were not enough Certified Nursing Assistants (CNAs) for 1:1 supervision, R1 needed to follow the nurse during medication pass. Family agreed to help with 1:1 supervision. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 3/25/25 at 1:58 PM, Surveyor interviewed DON-B who stated R1 cut off R1's WanderGuard on 2/28/25 and used the elevator to get to the ground floor and leave the facility via the front door. DON-B stated R1 may have been cognizant enough to use the stairwell door code to get down the stairs, however, R1 had a walker at the time and DON-B did not feel R1 was able to maneuver the stairs with a walker. On 3/25/25 at 2:33 PM, Surveyor interviewed Licensed Practical Nurse (LPN)-F who worked the PM shift on 2/28/25. LPN-F stated R1 was not on 1:1 supervision but was on frequent checks and staff left R1's door open for monitoring. LPN-F stated R1 was quick and fast. A progress note, dated 3/1/25 at 1:39 PM, indicated R1 attempted to leave the unit multiple times during the shift and asked for scissors all shift. Staff were unable to locate R1 at one point. R1 was found fully dressed in a bathtub with the water running and stated, I need my hair washed. R1 was assisted out of the bathtub by staff. R1 self- propelled a wheelchair in the hallway and asked to go downstairs. An Elopement Risk Assessment, dated 3/4/25, indicated R1 was at high risk for elopement. The assessment indicated a WanderGuard was in place, however, R1 removed several WanderGuards from R1's body and mobility devices. Staff continued to replace the WanderGuards and attempted to put them in places R1 was not aware of. 1:1 supervision was in place when available. If 1:1 supervision was not available, frequent checks were in place. On 3/25/25 at 2:37 PM, Surveyor interviewed Registered Nurse (RN)-E who was R1's nurse on 3/1/25. RN-E confirmed staff found R1 in the bathtub fully clothed. RN-E stated R1 was not missing for long. RN-E could not recall if R1 was on 1:1 supervision prior to 3/1/25 or after. RN-E confirmed R1 was not on 1:1 supervision on 3/1/25 when R1 went missing. On 3/25/25 at 2:47 PM, Surveyor interviewed DON-B who stated R1 was started on 1:1 supervision immediately after R1's 2/28/25 elopement. DON-B confirmed R1 should have been on 1:1 supervision on 3/1/25 unless family was there or hourly checks were completed. DON-B stated hourly checks should have been documented in R1's MAR or treatment administration record (TAR). Surveyor reviewed R1's MAR and TAR and noted a nursing order, dated 3/6/25, to check on R1's location and WanderGuard placement (walker, wheelchair, purse and left ankle to ensure still on) hourly. Surveyor could not locate any hourly checks prior to 3/6/25. On 3/25/25 at 2:21 PM, Surveyor observed the second floor stairwell doors. The doors were secured with an electronic door pad that required a code to open. Surveyor observed a permanent sign on each of the stairwell doors that contained the code to open the door and deactivate the alarm. The failure to supervise a resident with a history of elopement attempts and who eloped from the facility without staffs' knowledge created a reasonable likelihood for serious harm thus leading to a finding of Immediate Jeopardy. The facility removed the jeopardy on 3/26/25 when it completed the following: 1. Reviewed the facility's Elopement Prevention Policy and updated elopement protocol. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	2. Provided all staff education upon next working shift regarding supervision for residents at risk for elopement and steps to take if a resident cuts off a WanderGuard, requests a tool to cut off a WanderGuard, and/or continues to express a desire to leave the unit. 3. Removed plaques at each stairwell doorway that contained a code to enter and exit the unit and placed a small label with the door code at the top of the door frame. 4. Conducted a thorough sweep of all residents for elopement risk and exit-seeking behavior on 3/26/25 and ensured care plans were updated with interventions to address exit-seeking/unsafe behavior and/or statements to ensure safety. 5. Initiated audits of residents with exit-seeking behavior for proper documentation, effectiveness of interventions, and elopement events. Audits will be completed weekly for 4 weeks. Audit results will be brought to the monthly Quality Assurance Performance Improvement committee for review.

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F 0846 Level of Harm - Potential for minimal harm Residents Affected - Many	Have policies and procedures ensuring the administrator's responsibilities for facility closure are completed successfully. 40342 Based on staff interview, the facility did not have policies and procedures in place to use in the case of a facility closure. This had the potential to affect all 56 residents residing in the facility. The facility did not have policies and procedures to address a facility closure. Findings include: On 3/27/25 at 12:53 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A who indicated the facility would follow state regulations in the event of a closure. NHA-A indicated the facility does not have a written policy to address a facility closure.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 51043 Based on staff interview and record review, the facility did not ensure required nurse aid training was completed for 1 of 5 sampled Certified Nursing Assistants (CNAs). CNA-D was hired on 8/23/23. CNA-D did not have 12 hours of in-service training during CNA-D's most recent anniversary hire year. Findings include: According to the Wisconsin Department of Health Services' Webpage titled Nurse Aide Program: Maintaining Registry Status, when an individual is placed on the Wisconsin Nurse Aid Registry, they are given two eligibilities: federal and state. Federal eligibility is mandated by federal law for individuals who work in federally licensed nursing homes. (https://www.dhs.wisconsin.gov/caregiver/nurse-aide/maintain-status.htm) The facility's Quality Assurance and Performance Improvement (QAPI) Plan policy indicates all staff will participate in ongoing annual QAPI training which includes quality improvement principles and practices, how to identify areas for improvement, updates on current performance improvement projects, and how staff can be involved in performance improvement projects. On 3/27/25, Nursing Home Administrator (NHA)-A indicated the facility follows Wisconsin state laws to maintain nurse aid registration requirements. On 3/27/25 at 12:30 PM, Surveyor reviewed CNA-D's in-service training during the most recent anniversary hire year. Surveyor reviewed electronic training hours for CNA-D and noted CNA-D had only completed 2.25 hours of training over the last anniversary hire year. Surveyor noted CNA-D attended 5 meetings between 8/23/23 and 8/23/24. The 2.25 hours CNA-D completed did not cover any of the required education on resident rights, abuse and reporting requirements, dementia training, QAPI process, infection control, compliance and ethics, or resident behavioral health; however, the 5 meetings CNA-D attended covered all the aforementioned education requirements except QAPI. On 3/27/25 at 1:43 PM, Surveyor interviewed Director of Nursing (DON)-B who indicated staff meetings are usually an hour long depending on the material covered. DON-B verified CNA-D had attended 5 staff meetings and completed 2.25 hours in the facility's electronic training system which indicated CNA-D had completed 7.25 hours of the 12 required hours. DON-B indicated NHA-A sent emails containing meeting content and questions about the content to staff that did not attend meetings. DON-B contacted NHA-A to ascertain if NHA-A had emails from CNA-D. (continued on next page)

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/27/25 at 2:02 PM, Surveyor interviewed NHA-A who indicated it had been difficult to ensure CNA-D completed the required education. NHA-A indicated since CNA-D was hired on 8/23/23, CNA-D failed to complete online training by the due date and was expected to complete the required training by 1/5/25. NHA-A provided a copy of an email NHA-A sent to CNA-D on 3/16/25 that indicated CNA-D had overdue electronic trainings that were due on 4/1/25. The content of the email was a list of 5 trainings from the facility's electronic training system. NHA-A did not provide a response from CNA-D from the email sent on 3/16/25.