

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525656	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/22/2024
NAME OF PROVIDER OR SUPPLIER Four Winds Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 303 S Jefferson St Verona, WI 53593	

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 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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30992</p> <p>Based on interview and record review, the facility did not ensure that in response to allegations of abuse, neglect, exploitation, or mistreatment, all alleged violations, were thoroughly investigated, and that steps were taken to prevent further potential abuse for 1 of 4 residents (R4) reviewed for abuse.</p> <p>Med Tech D (Medication Technician/Certified Nursing Assistant) reported an allegation of neglect to the facility that CNA C (Certified Nursing Assistant) did not toilet/change residents during her shift and MED Tech D found all residents on the D-Wing to be soaked. The facility failed to obtain a statement from Med Tech D, failed to obtain a statement from CNA C, failed to interview any residents, and did not provide training to all staff to ensure this does not occur again.</p> <p>Evidenced by:</p> <p>The facility's, Components of Abuse Policy, reviewed 2/2024, states, in part as follows: Investigation: All alleged violations involving mistreatment, abuse, neglect, or exploitation will be thoroughly investigated by the facility under the direction of the Administrator and in accordance with state and federal law.</p> <p>The facility's policy, Suspected/Actual Resident Abuse, Neglect or Mistreatment, Exploitation Investigation Guidelines, reviewed 2/2024, states in part, as follows:</p> <ol style="list-style-type: none"> 1. Ensure the resident(s) involved are protected and abuse/neglect, mistreatment, or exploitation stops. 3. Interview the resident. Do not automatically discount a resident with dementia or other cognitive impairment. 4. Obtain statements from employees, residents and other witnesses including the date, time identification of employee implicated, and the account of the incident as witnessed by the individual being interviewed. Statements should be taken as soon as possible after the incident is reported. 5. The nurse is to notify NHA and DON of the allegation immediately; the supervisor begins the investigation process immediately. 6. All staff on the unit at the time the incident occurred must be interviewed. <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 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 12/27/23, a facility staff member (name not indicated) documented the following note: Call CNA C regarding alleged denial to provide care for a resident or group of residents. I placed CNA C on administrative leave pending an investigation. CNA C became upset indicating to me that she's a good aide, I do all my work. When asked if she did D wing, CNA C indicated that D was not her hall. She works on B wing. When asked if she did any rounds on D wing she again indicated, I was taking care of my people. Placed on leave until investigation was complete.</p> <p>On 12/27/23 RN F documented the following statement: Last night, 12/26/23, I (RN F) was the only nurse working. CNA's - CNA E (A Hall) and CNA C (B Hall) were working with me. CNA E, once settled in, went onto A Hall and that is where she stayed. She could not come out of quarantine to take care of D Hall as a precaution to not spread COVID more.</p> <p>Med Tech D came in around 2:00 AM. When she went to go do rounds on D Hall, she noted that a lot of residents had a soaked bed. She asked if they had been changed or not. I responded, They should have been. That's CNA C's hall. When Med Tech D asked CNA C if she changed anyone on D Hall, she said, No, that is not my hall in a very rude tone. Using common sense, I figured CNA C would know CNA E could not do D Hall due to working on A-Hall. D-Hall was taken care of by Med Tech D this NOC (night) shift.</p> <p>On 12/28/23, the previous DON documented the following training: Education Topic: It is the responsibility of all CNA's, RN's, and LPN's (Licensed Practical Nurses), regardless of assignment, to provide care for our residents. Being assigned to a hall on the schedule is simply a guide for you. If we are down staff, for whatever reason, you will be expected to pick up the load. This includes but is not limited to, showers, answering call lights, doing routine rounds. It is also the expectations the nurses help the CNA's, when possible, to meet resident needs.</p> <p>Note, only 11 staff signed this training sign in sheet. There is no documentation that CNA C was educated on this information or checking the schedule.</p> <p>On 4/22/24 at 9:20 AM, Surveyors spoke with residents on the D hall. No residents were able to voice specific concerns/details regarding being left wet/not assisted to the toilet.</p> <p>CNA C is no longer employed at the facility. Therefore, she is unavailable for interview.</p> <p>On 4/22/24 at 11:10 AM, Surveyor spoke with RN F. RN F had no additional information to share.</p> <p>On 4/22/24 at 1:40 PM, Surveyor spoke with CNA E who had no additional information to share.</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>On 4/22/24 at 1:58 PM, Surveyor spoke with Med Tech D. Med Tech D stated, on 12/27/23 she started her shift at 2:00 AM. Med Tech D stated, she did round on D-wing and noted all the residents to be soaked. Med Tech D stated, there are multiple cognitively impaired residents that reside on D-wing. Med Tech D stated, her first priority was changing the residents and ensuring they are dry and resting comfortably. Med Tech D stated, it's her job to ensure that residents are, Safe, dry and happy. Med Tech D stated, she entered R4's room around 2:30 AM. R4 stated to Med Tech D, Do you know you're the first person I've seen since 7:00 PM? Med Tech D stated, R4 went 8 1/2 hours without being changed. Med Tech D stated everything was soaked. Med Tech D clarified R4's clothes, brief, sheets, blankets, etc. were all soaked. Surveyor asked Med Tech D, was R4 upset. Med Tech D stated, Yes. Surveyor asked Med Tech D, did R4 tell you how this made her feel. Med Tech D stated, I don't remember that. Surveyor asked Med Tech D, when did you notify the facility that residents on D-wing were soaked. Med Tech D stated, 12/27/23 in the morning. Med Tech D stated, she felt this could wait until morning when administration arrived. Med Tech D stated, if she thought an incident was serious enough, she's not afraid to call management at home.</p> <p>Note, there is no reference regarding R4 in the facility's self-report, as the facility did not interview residents.</p> <p>R4 was admitted to the facility on [DATE] with diagnoses including, but not limited to, the following: cerebral infarction (stroke) due to occlusion or stenosis of left middle cerebral artery, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, morbid obesity, major depressive disorder, and fibromyalgia.</p> <p>R4's Brief Interview of Mental Status (BIMS) is 15, indicating she is cognitively intact.</p> <p>R4's Care Card indicates, in part, as follows: 9/14/23 I need 2 people to help me to the bathroom with the EZ stand. Please take me to the bathroom frequently. I am incontinent of bo [sic] and bladder.</p> <p>On 4/22/24 at 3:04 PM, Surveyor spoke with R4, who now resides on a different wing. Surveyor asked R4 if she has concerns with being left wet or soiled. R4 stated, That has happened on more than 1 occasion. R4 stated, she does not recall the incident in December specifically. R4 stated staff usually complete rounds every 2 hours and check on her. R4 stated, on multiple occasions staff left her unattended and wet for extended periods (8 1/2 hours and 16 hours) and it makes her feel, Horrible.</p> <p>On 4/22/24 at 4:14 PM, Surveyor spoke with DON B (Director of Nursing) and NHA A (Nursing Home Administrator). Of note, DON B started her position on 3/27/24 and was not employed at the facility at the time of this incident. Surveyor asked NHA A, did the facility obtain a statement from CNA C. NHA A stated, No. Surveyor asked NHA A, should the facility obtain a statement from CNA C. NHA A stated, Yes. Surveyor asked NHA A, did the facility obtain a statement from Med Tech D. NHA A stated, No. Surveyor asked NHA A, should the facility have obtained a statement from Med Tech D as she was the only witness. NHA A stated, Yes. Surveyor asked NHA A, should the facility have educated all staff following this incident to ensure this does not occur again. NHA A stated, Yes. Surveyor asked NHA A, should the facility have educated CNA C regarding reviewing the schedule that is posted at the nurses station at the start of her shift. NHA A stated, yes.</p>		