

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 01/24/2025
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 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30260</p> <p>Based on staff interviews and record review, the facility failed to ensure the rights of 1 of 1 resident's (R4) to be free from physical restraints imposed for the purposes of convenience.</p> <p>Findings:</p> <p>Review of the facility's policy titled For Alleged Incidents of Abuse, Neglect, Misappropriation, Injuries of Unknown Origin, and Exploitation dated 02/2024 provided by the facility revealed, .Definitions .The resident has the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's symptoms .</p> <p>Review of R4's Face sheet provided by the facility revealed she was admitted to the facility on [DATE] with diagnosis that included dementia. R4 was discharged from the facility on 10/30/24.</p> <p>Review of R4's quarterly Minimum Data Set (MDS) with assessment reference date (ARD) of 10/21/24 provided by the facility revealed R4 had a Brief Interview for Mental Status (BIMS) score of 6 out of 15 which indicated severe cognitive impairment.</p> <p>Review of R4's Care plan dated 07/24/24 provided by the facility revealed R4 had a Potential for Difficulty with self-cares r/t[(related to] impaired mobility . Potential for injury related to falls due to my impaired mobility . loss of memory, cognitive impairment, Alzheimer's/dementia, distractibility, and cognitive change. The care plan did not indicate the need for the use of a restraint as an intervention to prevent R4 from getting up out of her wheelchair.</p> <p>Review of R4's Physician orders dated 07/17/24 provided by the facility failed to reveal an order for a restraints to be used for R4.</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 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The investigative report revealed the facility reported the incident to the state survey agency (SSA) on 10/15/24 and the facility submitted a follow up report the SSA on 10/21/24 with the conclusion that the facility's investigation was inconclusive. The investigative report indicated, The morning of 10/14/24, it was reported to the D.O.N [Director of Nursing] by the night nurse on duty Registered Nurse [RN1] that C.N.A. [Certified Nursing Assistant, CNA1] had used a bed sheet placed around the midsection of resident [R4] in her wheelchair at some point during the night shift to keep her safe and keep her from falling out of the wheelchair. The resident was able to move about in her wheelchair and throughout the facility, which is normal activity for this resident.</p> <p>The investigative report revealed the facility reported the incident to the state survey agency (SSA) on 10/15/24 and the follow up report on 10/21/24 with the conclusion that the facility's investigation was inconclusive.</p> <p>Administrator 2 provided the following staff interviews of the event concerning R4. Review of the written statement from CNA3 dated 10/15/24 indicated, . I [CNA3] noticed resident [R4] with a sheet around her in her wheelchair, tightened (sic) to the back of her chair. I told my co-worker, [CNA1], we cannot do this. She mumbled some words and walked away. So, I then reported what I saw to my supervisor.</p> <p>Administrator 2 provided the following statement dated 10/14/24 which indicated, This writer met with [CNA1's name] and the Assistant Director of Nursing [ADON] to discuss the incident that allegedly occurred during the night shift of 10/13/24 -10/14/24. Per reports to this writer, [CNA1] had used a bed sheet to secure R4 to her wheelchair during the night shift. While interviewing [CNA1], this writer asked [CNA1] to explain what she had done and to demonstrate how she had used a bed sheet on [R4's] wheelchair. [CNA1] explained that she was doing whole bed changes from the start of her shift [10 PM] on 10/13/24 due to some staffing issues that had occurred on the p.m. [evening] shift before she arrived at work. With her having to do all of these bed changes, she was not sure that she could check on resident [R4] every hour as is her customary practice. [CNA1] indicated that resident [R4] had fallen out of her wheelchair on the previous night [10/13/24] and she did not want her to fall from it again. [CNA1] stated that when she walked past resident [R4's] room while on her way to get linens, she did not state what time this was, she saw resident's briefs laying on the floor. [CNA1] indicated this is a daily occurrence with [R4], that she will often take her briefs off during the night and throw them on the floor. [CNA1] said that when she saw this, she knew that [R4] was going to try to get out of bed, because this is what she usually does. So [CNA1] stated that she went into R4's room, cleaned her up, reapplied a brief and pajamas, and got her up into her wheelchair, as this is many times what [R4] does/wants. Because [CNA1] was afraid [R4] was going to try to get up from the wheelchair which is also a common occurrence and that [CNA1] did not want her to fall again, she took a bed sheet, and wrapped it around the armrest of the wheelchair, across [R4's] lap, and around the other armrest of the wheelchair, with both ends ending up behind the wheelchair. [CNA1] stated she did not tie the bed sheet but rather crossed the two ends around each other and pushed the ends into the bottom of the wheelchair. She then stated that she put [R4's] notebook on her lap .[CNA1] indicated that [R4] was able to move from side to side in the wheelchair, and turn her body in the wheelchair, indicating the bedsheets was not tight up against [R4] or her midsection. She said that [R4] then proceeded to go out to the dining room, sat at a table, had a snack, and was writing in her notebook when she left her to continue doing her rounds [CNA1] would be off the schedule until a complete investigation could be conducted. This writer also indicated to [CNA1] that she needed to write a very complete, detailed statement on what she had done and re-educated [CNA1] that this type of use of a bed sheet is not ever allowed, [it] is not on the resident's care plan .</p> <p>(continued on next page)</p>		

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<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the statement by RN1 dated 10/14/24 indicated, At around 1:00 AM on 10/14/24, [CNA1] brought [R4] out in a wheelchair, due to the resident expressing inability to sleep. I told [CNA1] we need to supervise the resident, so she doesn't fall. The CNA wrapped a sheet around the resident in the wheelchair after bringing her to the dining room. [CNA1's] reason was so resident doesn't get up and fall. I said we shouldn't do that as could be considered a restraint; and the DON would say the same. The CNA disagreed and said she'd show the DON. [CNA1] explicitly refused my instruction to not wrap the resident with the sheet, expressing that the DON would observe later and be ok with it. Later in the morning, the ADON was on site, and [CNA1] claimed the ADON already saw the resident with the wrapped sheet, and didn't make any specific observation. This is my account of the of the event listed.</p> <p>Review of the statement by CNA1 indicated, . I took a conscious step by loosely laying a flat sheet on their (sic) [R4's] lap under their chip card, I allowed 10 of space in the front and twisted and tucked the excess behind their wheelchair. This was not done to restrain or punish her, but rather to provide additional safety should they attempt to stand up and have another fall. They (sic) remained fully able to move their limbs, roll around in their wheelchair and engage in their usual activities. At no point did [R4] express discomfort or attempt to remove the sheet. Nor did they exhibit any signs of distress, which is typically what she does when she is uncomfortable or restrained in any way. If this precaution had been a true restraint before R4 would have screamed and fought to remove it, as she does in other situations, such as when using the easy stand harness. In this instance, she was calm and fully mobile. It is important to note that no injuries occurred as a result of this incident. There were no injuries, bruising, chafing, or any of the sort and her ability to complete daily activities remained unimpaired. I want to emphasize that my actions were motivated purely by concern for [R4's] safety after her fall, and to prevent further harm. I would never restrain a resident for convenience, and the sheet was not used in any manner to restrict her freedom of movement.</p> <p>Review of CNA1's personnel record revealed she was hired on 08/26/24 and had passed the background check prior to employment. CNA1 completed all prerequisite initial training, including abuse training, and was still within the first 90 days of employment.</p> <p>During an interview with the Administrator 2 on 01/23/25 at 4:52 PM she stated on the morning of 10/14/24, when she came to work, the ADON and CNA3 had informed Administrator 2 of an allegation that CNA1 had used a bed sheet to tie R4 to the wheelchair. Administrator 2 stated she and the Assistant Director of Nursing (ADON) interviewed CNA1 who stated that R4 had been up during the night, was in her wheelchair and so CNA1 decided to take a bed sheet and set it across R4's lap in a wheelchair and draped the sheet around the handles of the wheelchair but did not tie the sheet to the back of the wheelchair. The resident could move and propel herself in her wheelchair. Administrator 2 stated she asked CNA1 why she did it, and CNA1 stated it was because she thought if the sheet was on R4 it would remind R4 not to stand. Administrator 2 stated she informed CNA1 that her actions were inappropriate and that she needed to leave. CNA1 was suspended pending an investigation.</p> <p>During an interview with ADON on 01/24/2025 at 4:37 PM she stated that the incident regarding R4 and CNA1 was brought to her attention when she came to work on 10/14/24, since it had occurred during the night shift. ADON stated she recalled CNA1 stated she placed a sheet over R4 to prevent R4 from getting up and did not seem to understand this was considered a restraint. CNA1 did not realize she could not use a sheet as a restraint and could not take corrective criticism. Education was provided for CNA1 and then was let go shortly after the incident.</p> <p>(continued on next page)</p>		

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Administrator 2 and DON on 01/23/25 at 6:37 PM, Administrator 2 and the DON admitted the incident occurred and that CNA1 did use a bed sheet as a restraint for R4, as confirmed by witness statements and CNA1's written account of the incident.		

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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30260</p> <p>Based on interview, record review, and review of facility policy, the facility failed to provide documentation of a person-centered baseline care plan within 48 hours of admission to ensure that 1 of 1 resident's (R8's) initial care needs would be provided.</p> <p>Findings include:</p> <p>Review of the facility's policy titled COMPREHENSIVE CARE PLANNING - COMPLETION OF RESIDENT assessment dated ,d+[DATE] revealed, .Facility will create an Initial Resident Baseline Care Plan upon admission .</p> <p>Review of R8's admission Minimum Data Set (MDS) with and Assessment Reference Date (ARD) of 10/22/24 revealed R8 was admitted to the facility on [DATE] with diagnoses that included orthostatic hypotension, atrial fibrillation, and hypertension.</p> <p>Review of the undated document titled Initial Resident Baseline Care Plan signed by RN2 and provided by Patient Care Advocate/Registered Nurse (RN)2 revealed hand-written entries indicating cares to be performed by the CNA.</p> <p>During an interview on 01/24/25 at 1:03 PM, RN2 stated this document was the patient's care card use as a tool for Certified Nurse Aides (CNAs) and would be in the resident's closet so the staff would have easy access to it and can see how to take care of that resident. When asked if this was the mandated baseline care plan that must be shared with the resident and/or their representative, RN2 stated, no.</p> <p>During an interview with the Administrator and the Director of Nursing (DON) on 01/24/25 at 4:37 PM, they both acknowledged that R8's baseline care plan could not be located, and it could not be determined if initial care expectations were addressed and a copy given to R8 and the resident representative.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>30260</p> <p>Based on observation, interview and record review the facility failed to follow appropriate infection control practices for hand hygiene before donning and after doffing gloves during indwelling urinary catheter care for 1 of 1 resident's (R9).</p> <p>Findings include:</p> <p>Review of the facility's policy titled INFECTION CONTROL HAND HYGIENE dated April 2023 provided by the facility revealed:</p> <p>It is the policy that hand hygiene is an integral component of an effective program to prevent, control, and treat infection among residents and staff. The hands of staff and those who are in contact with the care environment are potential for the spread of infection. Effective hand hygiene is a key component in preventing infection. The use of ABHR (alcohol based hand rub) is the preferred method in healthcare settings; however, hands must be washed with soap and water if visibly soiled. Avoid touching the face at all times as eyes, nose, and mouth are common sites for entry of infection. Avoid touching door knobs and handles with bare hands. Gloves are never worn from one resident to another, one room to another, or after leaving a resident care area. If in doubt, clean your hands C. The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves and immediately after removing gloves.</p> <p>During observation of R9's indwelling urinary catheter care on 01/24/25 at 7:00 AM, Certified Nurse Aide (CNA4) performed hand hygiene and donned a pair of gloves. CNA4 performed R9's peri-care with a towel and warm soapy water. CNA4 performed several glove changes during the peri-care due to the presence of fecal matter until R9 was clean. No hand hygiene was performed after doffing gloves and prior to donning new pair of gloves. At 7:30 AM, CNA4 changed gloves, touched her pocket, paper towel, and the door of R9's room, while calling for the nurse in the hallway for nystatin powder to apply to R9's peri-area. At 7:33 AM, CNA4 donned new gloves without performing hand hygiene, and applied the nystatin powder to R9's peri-area. At 7:37 AM CNA4 doffed nystatin-stained gloves and donned another pair of gloves without performing hand hygiene in between glove changes. CNA4 dressed R9 and with the assistance of CNA 2, moved R9 from the bed to the wheelchair. No hand hygiene was performed before glove changes. CNA4 doffed her gloves and performed hand hygiene for the first time since observation began at 7:00 AM.</p> <p>During an interview on 01/24/25 at 8:00 AM, CNA4 confirmed that she did not perform hand hygiene between gloves changes during R9's peri care.</p> <p>During an interview on 01/24/25, at 4:37 PM, the Director of Nursing (DON) stated it was her expectation that staff perform hand hygiene before and after each glove change.</p>		