STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525671	A. Building B. Wing	11/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Schmitt Woodland Hills	1400 W Seminary St Richland Center, WI 53581

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)
F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41788 Based on observation, interview and record review, the facility did not ensure that all residents are clinically appropriate to self-administer medications for 1 of 6 residents (R4) observed during medication pass. R4 was observed to have her medications left at bedside. This is evidenced by: The facility policy entitled Resident Self-Administration of Medication, with a date reviewed 11/26/24, states, in part: . Policy: It is the policy of this facility to support each resident's right to self-administration medication. A resident may only self-administer medications after the facility's interdisciplinary team has determined which medications may be self-administered safely. Policy Explanation and Compliance Guidelines: 1. Each resident is offered the opportunity to self-administer medications during the routine assessment by the facility's interdisciplinary team. 2. Resident's preference will be documented on the appropriate form and placed in the medical record . 4. The results of the interdisciplinary team assessment are recorded on the Medication Self-Administration Assessment, which is placed in the resident's medical record . 14. The care plan must reflect resident self-administration and storage arrangements for such medications and CGM devices . The facility policy entitled Medication Administration, dated 7/15/24, states, in part: . Policy: Medications will be administered by RNs (registered nurses), LPNs (licensed practical nurse) . Policy Explanation and Compliance Guidelines: (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	.15. Observe resident consumption of medication . R4 was admitted to the facility on [DATE], and has diagnoses that include Hemiplegia (a condition that causes paralysis or weakness on one side of the body, usually due to a brain injury or other brain-related issue) and Hemiparesis (partial paralysis or weakness on one side of the body) following unspecified Cerebrovascular Disease (a term for a group of conditions that impact the brain's blood vessel and blood supply, including stroke, brain aneurysms, and transient ischemic attacks, or mini strokes) affecting right dominant side, and major depressive disorder. R4's most recent Minimum Data Set (MDS) dated [DATE] states that R4 has a Brief Interview of Mental Status (BIMS) score of 15/15, indicating that R4 is cognitively intact. R4's Medication Self-Administration Safety Screen, dated 9/18/24, states, in part: . Approvals: IDTC (Interdisciplinary Team) 1a. IDTC Review Summary (safety concerns/recommendations, communication to physician): All medications are stored and administered by licensed nursing staff. 1b. IDTC feels resident is safe to self-administer listed medications? No . On 11/25/24, at 4:12 PM, Surveyor observed RN C (Registered Nurse) leave R4's medications: Tylenol 325mg (milligrams) 2 tablets, atorvastatin 80 mg 1 caplet, baclofen 20 mg 1 tablet, carvedilol 3.125 mg 3 tablets, and mucus relief 400 mg 1 tablet on R4's bedside table. On 11/26/24, at 8:26 AM, Surveyor interviewed LPN D (Licensed Practical Nurse). Surveyor asked LPN D what the process is for leaving a resident's medications at bedside. LPN D indicated the resident would have to have completed a medication self-administration evaluation and deemed safe. LPN D indicated the evaluation would be in the resident's chart. LPN D indicated there are no residents on this floor that can have medications left at bedside. LPN D indicated R4 always wants staff to dump medications on bedside table and leave them, but staff are not to leave them. On 11/26/24, at 4:22PM, Surveyor interviewed DON B (Director of Nursing). Surveyor asked what the process is for a resident to have medications left at bedside. DON B indicated the resident should have a care plan for medication self-administration. DON B looked at R4's Care Plan and indicated R4 is not care planned for medication self-administration. DON B indicated if R4 was care planned for it we would have a medication self-administration evaluation assessment. Surveyor informed DON B of observation on 11/25/24 with R4's medications being left on bedside table and the nurse leaving R4's room without observing R4 take the medications. Surveyor informed DON B of R4's medication self-administration assessment dated [DATE] and results of R4 deemed unsafe to self-administrate medications. Surveyor asked DON B by looking at R4's assessment would you expect medications to be left at bedside, DON B indicated by looking at what is on the assessment, no but looking at R4 as we know her would be different.

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50285 Based on interview and record review, the facility failed to protect 1 of 35 residents (R19's) right to be free from verbal/mental/emotional abuse by a CNA (Certified Nursing Assistant). R19 stated CNA E was rude and demeaning to her, yelled at her, and was rough with her during AM (morning cares). R19 stated she was treated like a dog, or worse than a dog, treated like dirt, because she wouldn't treat a dog that way. Evidenced by: Facility policy titled Reporting Resident Abuse, Neglect, and Exploitation, dated 9/17/2007, with last revision date of 9/12/2024, states in part: .All allegations of resident/client physical, mental or sexual abuse, neglect, mistreatment . are to be reported to one's supervisor immediately . Incidents will be reported to the Administrator and licensing agency as required . Definitions: 1. Abuse: The willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain, or mental anguish . Verbal Abuse: The use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents . Mental Abuse: Humiliation, harassment, threats . If there is an allegation or belief that a resident/client has/or could be harmed, staff shall immediately take action to ensure the resident/clients are free from physical and emotional harm. Staff shall immediately notify their supervisor of the allegation when sure resident/client is safe. The Supervisor will take the following actions as appropriate to situation . Provide protection from the alleged abuser . According to the State Operations Manual (SOM), abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. Willful, as defined at S483.5 in the definition of abuse, and means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. Mental abuse is the use of verbal or nonverbal conduct which causes or has the potential to cause the resident to experience humiliation, intimidation, fear, shame, agitation, or degradation. Verbal abuse may be considered to be a type of mental abuse. Verbal abuse includes the use of oral, written, or gestured communication, or sounds, to residents within hearing distance, regardless of age, ability to comprehend, or disability. Examples of mental and verbal abuse include, but are not limited to: o Harassing a resident; o Mocking, insulting, ridiculing; (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	o Yelling or hovering over a resident, with the intent to intimidate; o Threatening residents, including but limited to, depriving a resident of care or withholding a resident from contact with family and friends; and o Isolating a resident from social interaction or activities. R19 was admitted to the facility on [DATE]. Her most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/7/24, indicates R19 has a Brief Interview for Mental Status (BIMS) of 15 out of 15, indicating R19 is cognitively intact. On 11/25/24 at 10:58 AM, during an interview, R19 indicated that on Saturday morning, 10/26/24, a staff member, CNA E, was rude and demeaning to her, yelled at her, and was rough with her during AM cares. R19 stated at about 20 minutes after 7:00 AM, CNA E came into her room and told her, I'm your caretaker and I do things my way! CNA E began to put R19's compression stockings on, and R19 asked CNA E to apply lotion first. CNA E told R19 she was too damned bossy and left the room. About 10 minutes later CNA E came back into R19's room and put R19's compression stockings on without lotion. R19 said that it was a good thing she had been sitting on the toilet at the time, because CNA E was so rough she would have fallen backwards. At that time, CNA E left R19's room. R19 stated she waited another 20 minutes for CNA E to come back and assist her, but she did not come back so R19 finished getting herself dressed. R19 stated she was treated like a dog, or worse than a dog, treated like dirt, because she wouldn't treat a dog that way. Please note: CNA E left R19's room and came back into R19's room several times. At no time did CNA E change her tone or approach with R19; CNA E was rude and dismissive of R19 each time. On 11/26/24 at 9:58 AM, Surveyor interviewed CNA F, who said she knew about the situation between CNA E and R19. CNA F indicated that she would consider the way CNA E treated R19 as abuse. CNA F stated that R19 was very hurt by the interaction and that if R19 sees CNA E working, she becomes really upset for the rest of the day. CNA F stated that CNA E is also not professional or appropriate in her interactions with other residents. On 11/26/24 at 10:23 AM, Surveyor interviewed LPN G (Licensed Practical Nurse), who stated she was aware of the situation that occurred between CNA E and R19. LPN G indicated that CNA E is aware of her anger and that this was an isolated incident. LPN G stated that CNA E had tried to apologize to R19, but she didn't think R19 accepted her apology. On 11/27/24 at 8:23 AM, Surveyor interviewed CSW H (Certified Social Worker) about the incident between CNA E and R19. CSW H stated she was notified of the incident on 10/28/24. CSW H said it was her understanding that CNA E had been demanding, disrespectful, and unprofessional. CSW H indicated that normally she follows up with the residents on grievances, but because it involved a staff member, DON B (Director of Nursing) completed the follow up with R19. CSW H stated she did not consider the situation abuse, but rather treated it as a grievance. On 11/27/24 at 10:19 AM, Surveyor spoke with R19 who stated that the previous day (on 11/26/24), CNA E served her dinner tray to her, even though she has requested that CNA E not have any further interaction with her. R19 stated she was really upset by this, and that she doesn't feel safe when CNA E is working. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Please note: Despite over a month of time passing between the incident on 10/24/24 and Surveyor interviewing R19 on 11/27/24, R19 continued to be affected by the interaction between R19 and CNA E. R19 reported CNA E delivering her tray caused her to feel fearful and upset. On 11/27/24 at 10:40 AM, Surveyor interviewed DON B (Director of Nursing), who stated he was aware of the incident between CNA E and R19. DON B indicated that CNA E is not always professional with the residents, and that he has been coaching her on her approach. DON B stated that on 10/28/24, he had taken CNA E to R19's room, where CNA E apologized to and hugged R19. At that time, R19 stated she did not want any further help from CNA E. Surveyor asked DON B if he was aware that CNA E served R19 her dinner tray the previous evening. DON B replied that he had been aware of that, and he had CSW H follow up with R19. Surveyor asked DON B if this could be considered intimidation. DON B stated it was not willful, it was just a personality conflict between CNA E and R19. Surveyor asked DON B if he had followed up with R19 regarding her psychosocial well-being. DON B replied that after R19 accepted a hug and apology from CNA E, he thought the grievance was done and the solution was satisfactory. Surveyor asked DON B if he had protected the other residents from potential abuse. DON B stated it was not considered abuse, but a grievance. The facility did not follow their policy to keep residents safe following an abuse allegation. The facility failed to protect R19 from ongoing mental anguish, as CNA E continued to work 9 of the 10 days following the incident and was continuing to interact with R19 at the time of the recertification survey. Cross Reference F609, F610.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50285 Based on interview and record review, the facility did not ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment are reported immediately, but no later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse to the appropriate agencies for 1 of 1 abuse allegations of residents (R19). R19 reported an abuse allegation involving CNA E (Certified Nursing Assistant) that occurred on 10/26/24. This incident was reported to NHA A (Nursing Home Administrator), DON B (Director of Nursing), and CSW H (Certified Social Worker), but was not reported to the state agency. Evidenced by: Facility policy titled Reporting Resident Abuse, Neglect, and Exploitation, dated 9/17/2007, with last revision date of 9/12/2024, states, in part: .All allegations of resident/client physical, mental or sexual abuse, neglect, mistreatment . are to be reported to one's supervisor immediately . Incidents will be reported to the Administrator and licensing agency as required . Definitions: 1. Abuse: The willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain, or mental anguish . Verbal Abuse: The use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents . Mental Abuse: Humiliation, harassment, threats . R19 was admitted to the facility on [DATE]. Her most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/7/24, indicates R19 has a Brief Interview for Mental Status (BIMS) of 15 out of 15, indicating R19 is cognitively intact. On 11/25/24 at 10:58 AM, during an interview, R19 indicated that on Saturday morning, 10/26/24, a staff member was rude and demeaning to her, yelled at her, and was rough with her during AM (morning cares). R19 stated CNA E told her she was too damned bossy and that she was the caretaker and would be doing things her way regardless of R19's preferences. R19 indicated she told CNA E that she needed to have lotion on her legs prior to donning (putting on) compression stockings, however CNA E put R19's stockings on without lotion and was rough while putting them on. R19 stated she was treated like a dog, or worse than a dog, treated like dirt, because she wouldn't treat a dog that way. Surveyor reviewed the Facility Grievance Log for October 2024 which indicated a grievance dated 10/28/24, Resident shared that CNA E that was providing care to R19 was disrespectful. Resident felt she was not heard by the CNA, and she was rude. Facility Grievance Log states this grievance was assigned to CSW H, and the resolution indicated in part: Spoke with resident, Administrator, and DON. CNA will not be providing care to resident. Education also provided to nursing staff regarding respect and approach. Please note: The facility provided Surveyor with grievance forms, one completed by CSW H and another completed by LPN G (Licensed Practical Nurse), both indicate the date of the occurrence as 10/26/24, however nothing was addressed until 10/28/24. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/27/24 at 8:23 AM, Surveyor interviewed CSW H about the incident between CNA E and R19. CSW H stated she was notified of the incident on 10/28/24. CSW H said it was her understanding that CNA E had been demanding, disrespectful, and unprofessional. CSW H indicated that normally she follows up with the residents on grievances, but because it involved a staff member, DON B (Director of Nursing) completed the follow up with R19. CSW H stated it was her opinion that the situation was not reportable because it was simply a personality conflict between CNA E and R19. CSW H stated she did not consider the situation abuse, but rather treated it as a grievance. Please note: The Facility Grievance Officer (CSW H) did not follow up with R19 about the incident until 11/13/24 at a regularly scheduled Care Conference which was not attended by the DON B or NHA A. Facility Progress Notes indicate in attendance for the Care Conference with R19 was CSW H and the MDS Coordinator (Minimum Data Set). The Psychosocial Note entered by CSW H on 11/13/24 states in part: . Resident expressed concerns with a staff . writer along with MDS Coordinator let resident express her feelings . On 11/27/24 at 10:40 AM, Surveyor interviewed DON B, who stated he was aware of the incident between CNA E and R19. DON B indicated that CNA E is not always professional with the residents, and that he has been coaching her on her approach. DON B stated that on 10/28/24 he had taken CNA E to R19's room, where CNA E apologized to and hugged R19. At that time, R19 stated she did not want any further help from CNA E. Surveyor asked DON B if he was aware that CNA E served R19 her dinner tray the previous evening. DON B replied that he had been aware of that, and he had CSW H follow up with R19. DON B stated he did not feel the incident rose to the level of abuse, as R19 simply didn't like CNA E's tone, and therefore it was handled as a grievance. The facility considered this a grievance instead of an abuse allegation, therefore, they did not follow their policy and did not report this accusation of abuse to the state reporting agencies. Cross Reference F600, F610.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50285 Based on interview and record review, the facility did not ensure all alleged allegations of abuse were thoroughly investigated for 1 of 1 resident (R19) reviewed for abuse. On 10/28/24, the facility became aware R19 reported an allegation of verbal/mental abuse by a Certified Nursing Assistant (CNA); the facility did not conduct a thorough investigation. Evidenced by: Facility policy titled Reporting Resident Abuse, Neglect, and Exploitation, dated 9/17/2007, with last revision date of 9/12/2024, states, in part: .All allegations of resident/client physical, mental or sexual abuse, neglect, mistreatment . are to be reported to one's supervisor immediately . Incidents will be reported to the Administrator and licensing agency as required. A full investigation will follow and be completed within 5 working days . Definitions: 1. Abuse: The willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain, or mental anguish . Verbal Abuse: The use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents . Mental Abuse: Humiliation, harassment, threats . The Administrator or Director of Social Services or Director of Nursing or supervisor will immediately initiate a thorough investigation meeting with the Investigative Committee in whole or part. All allegations of mistreatment, misappropriation, neglect, or abuse . that involve a NH (Nursing Home) resident will be immediately reported to the Administrator and Bureau of Quality Assurance not to exceed 24 hours of the discovery of the incident . The Investigative Committee will determine the proper course of action to ensure residents/clients are protected. This may include the following . Determine all persons with knowledge of the allegation and complete interviews with such persons . R19 was admitted to the facility on [DATE]. Her most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/7/24, indicates R19 has a Brief Interview for Mental Status (BIMS) of 15 out of 15, indicating R19 is cognitively intact. On 10/28/24, the facility became aware of an allegation of abuse between a CNA E and R19 that happened on 10/26/24. The facility began an investigation on 10/28/24 and collected a statement from the charge nurse, but did not interview residents or other staff members, including CNA E, whom the allegation was against. The statement from the charge nurse, RN L (Registered Nurse), stated in part: .(R19) was visibly upset when I went to her room . She said she did not want 'that CNA' in her room ever again due to (CNA E) calling her 'bossy' and what sounded like a dismissive attitude towards her requests . A Grievance Form completed by LPN G (Licensed Practical Nurse) stated in part: Resident stated (CNA E) was rude and unfair to resident. CNA E stated I'm the caregiver and I will do things my way! (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/25/24 at 10:58 AM, during an interview, R19 indicated that on Saturday morning, 10/26/24, a staff member was rude and demeaning to her, yelled at her, and was rough with her during AM (morning cares). R19 stated CNA E told her she was too damned bossy and that she was the caretaker and would be doing things her way regardless of R19's preferences. R19 indicated she told CNA E that she needed to have lotion on her legs prior to donning compression stockings, however CNA E put R19's stockings on without lotion and was rough while putting them on. R19 stated she was treated like a dog, or worse than a dog, treated like dirt, because she wouldn't treat a dog that way. On 11/27/24 at 8:23 AM, Surveyor interviewed CSW H (Certified Social Worker) about the incident between CNA E and R19. CSW H stated she was notified of the incident on 10/28/24. CSW H said it was her understanding that CNA E had been demanding, disrespectful, and unprofessional. CSW H indicated that normally she follows up with the residents on grievances, but because it involved a staff member, DON B (Director of Nursing) completed the follow up with R19. CSW H stated she did not consider the situation abuse, but rather treated it as a grievance. On 11/27/24 at 10:40 AM, Surveyor interviewed DON B, who stated he was aware of the incident between CNA E and R19. DON B indicated that CNA E is not always professional with the residents, and that he has been coaching her on her approach. DON B stated that on 10/28/24 he had taken CNA E to R19's room, where CNA E apologized to and hugged R19. At that time, R19 stated she did not want any further help from CNA E. Surveyor asked DON B if he was aware that CNA E served R19 her dinner tray the previous evening. DON B replied that he had been aware of that, and he had CSW H follow up with R19. DON B stated he did not feel the incident rose to the level of abuse. Surveyor asked DON B if he had done a thorough investigation and collected other resident statements. DON B replied that he did not because he treated it as a grievance. The facility did not follow their policy to complete a thorough investigation, as no other residents were interviewed to identify any further abuse by CNA E. The facility failed to protect the residents, as CNA E continued to work 9 of the 10 days following the incident. At no time was CNA E removed from caring for residents. Cross Reference F600, F609.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50285 Based on observation and interview, the facility did not ensure that each resident receives food and drink that is palatable and at a safe and appetizing temperature for 1 of 12 sampled residents (R19) and 2 supplemental residents (R34 and R29). R19, R29, and R34 voiced concerns of food being dry and cold. 1 of 1 test trays were noted to have dry pork served. Evidenced by: The facility policy, titled Dining Room Service, dated 2019, states in part: . Meals will be served promptly to maintain adequate temperature and appearance . Example 1 R19 was admitted to the facility on [DATE]. Her most recent Minimum Data Set (MDS), with an ARD (Assessment Reference Date) of 11/7/24, indicates her cognition is intact with a Brief Interview of Mental Status (BIMS) of 15 out of 15. On 11/25/24 at 10:58 AM, Surveyor interviewed R19 who indicated the food is so dry, particularly the pork, that at times it is inedible. Example 2 R29 admitted to the facility on [DATE]. Her most recent MDS with an ARD of 11/7/24 indicates her cognition is intact with a BIMS score of 15 out of 15. On 11/25/24 at 11:30 AM, Surveyor interviewed R29 who indicated that the meat is always so dry that oftentimes her and the other residents just don't eat it. R29 stated she seldom eats any of the meat at the facility, and that she hasn't had a decent pork chop since admitting to the facility 2 years ago. Example 3 R34 admitted to the facility on [DATE]. Her most recent MDS with an ARD date of 9/16/24 indicates her cognition is intact with a BIMS score of 15 out of 15. On 11/25/24 at 2:01 PM, Surveyor interviewed R34 who indicated that the food served to her in her room is only lukewarm. R34 said she oftentimes will have to send the soup back for reheating because it is never hot. Example 4 On 11/26/24 at 12:10 PM, Surveyor received a test tray and noted that the pork was hard and dry.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525671	A. Building B. Wing	11/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Schmitt Woodland Hills	1400 W Seminary St Richland Center, WI 53581

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 36253 Based on observation, interview and record review, the facility did not store, prepare, distribute and serve food in accordance with professional standards for food service safety. This has the potential to affect the facility census of 35. A kitchenette dishwasher was not registering the correct wash and rinse temperatures. Facility staff were observed touching multiple items in the kitchenette while serving and handling food without performing proper hand hygiene. Evidenced by: The 2022 FDA (Food and Drug Administration) Food Code states under 4-501.110 Mechanical Warewashing Equipment, Wash Solution Temperature and 4-501.112 Mechanical Warewashing Equipment, Hot Water Sanitization Temperatures state that wash temperatures of a high temperature sanitizing dishwasher must reach 160 degrees Fahrenheit, and the rinse temperature must reach 180 degrees Fahrenheit. The facility's policy titled, High Temperature Dish Machine Temperature Testing states that dietary staff will test high temperature dish machines to ensure the thermostat/machine is reaching the correct temperature. The procedure for this is as follows: 1) Using proper dishwasher temperature test strips test the inside temperature of each unit once weekly. 2) Follow test strips printed instructions on how to properly test the cycles temperature. 3) Tape test strip to temp log to keep for documentation. 4) If the dishwasher is not getting to the proper temperature and fails testing, notify dietary manager and maintenance and write a work order Facility policy, titled Hand Hygiene, dated 9/20/23 with revision date of 8/14/24, states in part: . Staff will perform hand hygiene when indicated, using proper technique consistent with accepted standards of practice . 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 . Example 1 (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility has a kitchenette on the first floor and second floor. Each kitchenette has its own high temperature dishwasher where temperatures are documented by dietary staff 3 times daily from the dishwasher's digital interface. The log for this documentation states that wash temperatures must reach 160 degrees Fahrenheit and rinse temperatures must reach 180 degrees Fahrenheit. Additionally, these dishwashers are tested weekly using a temperature test strip. This test strip has a visible black line on the strip, which is to turn orange when the test strip reaches the appropriate rinse temperature of 180 degrees Fahrenheit. On 11/26/24 at 10:48 AM, Surveyor observed the facility's 1st floor dishwasher log with documented temperatures for the month of November 2024. The log indicated that on 13 occasions the dishwasher did not meet the necessary 160-degree wash temperature. Additionally, there was 3 temperature test strips affixed to the log, 2 of which still had visible black lines on them, indicating that on 11/6/24 and 11/12/24 the dishwasher did not reach the appropriate rinse temperature of 180 degrees. On 11/27/24 at 10:45 AM, Surveyor interviewed DM J (Dietary Manager) who stated that if dietary staff had gathered temperatures either from the external digital readout or the internal temperature from the test strip and did not get the right temperature, she would expect them to contact her. DM J stated that she would then contact the technical representative for the dishwasher manufacturer as it is leased through them. DM J stated that she had not received any information, either from her dietary staff or from maintenance, that any issues had occurred with the temperature of the dishwasher on the first floor. DM J stated that she was told by technical representative that the wash temperature does not matter as the sanitizer (high temp) is what matters. When presented the test strips that were affixed to the November 2024 temperature log, DM J indicated that it did not look like the dishwasher was meeting the appropriate rinse temperature. DM J stated that she does follow the FDA (Food and Drug Administration) food code. On 11/27/24 at 11:10 AM, Surveyor interviewed TR I (Technical Representative), who represents the manufacturer of the dishwasher on the first floor of the facility and coordinates with the facility to provide any technical service or maintenance to the machine. TR I stated that the dishwasher must always reach a temperature of 160 degrees Fahrenheit and if it does not, the machine must be serviced. Additionally, TR I stated that the facility was currently using the wrong test strips for the dishwasher, which is why they only sporadically turn the correct color (indicating the rinse temperature of 180 degrees Fahrenheit). 50285 Example 2 On 11/25/24 at 12:13 PM, Surveyor observed dining room service on the 2nd floor of the facility. Surveyor observed [NAME] K serve food at the steam table, step away from the steam table and change gloves before touching ready to eat food, but without performing proper hand hygiene between glove changes. [NAME] K continued to serve food, stepped away from the steam table, removed gloves, and used the wall phone to call down to the kitchen for a hot dog for a resident. [NAME] K put on new gloves after touching the phone with bare hands and without performing proper hand hygiene and before putting on new gloves. Surveyor observed [NAME] K touch other surfaces in the kitchen, such as the cabinet door, refrigerator door, toaster lever, all with gloved hands then return to serving food and touching ready to eat items. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 11/25/24 at 12:36 PM, Surveyor interviewed [NAME] K. Surveyor asked [NAME] K when it is necessary to change gloves and perform hand hygiene during meal service. [NAME] K replied hand hygiene should be performed before and after meal service and if necessary, such as something gets on the glove, or it breaks. Surveyor asked [NAME] K if hand hygiene should be performed after removing soiled gloves. [NAME] K replied yes but if she stays within her station in the kitchenette, she can change gloves without washing her hands. [NAME] K indicated that she only needs to wash her hands if she leaves the kitchenette or if she touchs uncooked food. Surveyor asked [NAME] K how often the surfaces in the kitchenette were sanitized. [NAME] K replied that the resident tables are wiped down after each meal but that the doors, cupboards, et cetera in the kitchenette were only cleaned once per week. On 11/27/24 at 10:06 AM, Surveyor interviewed DM J (Dietary Manager). Surveyor asked DM J what her expectation was for hand hygiene in the dining room. DM J replied staff are to wash their hands before they start serving. Surveyor asked DM J what her expectation was for wearing gloves during meal service. DM J replied that she prefers that staff not wear gloves during meal service so that they don't get confused when touching everything. Surveyor asked DM J if it was appropriate for staff to remove gloves, make a telephone call, put on new gloves and resume meal service without performing hand hygiene. DM J replied no, staff should be washing their hands in between glove changes. Surveyor asked DM J if it was her expectation that staff change gloves and perform hand hygiene when changing tasks such as touching multiple services during meal service. DM J answered yes, that was her expectation.