

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525680	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/07/2024
NAME OF PROVIDER OR SUPPLIER United Pioneer Home		STREET ADDRESS, CITY, STATE, ZIP CODE 623 S Second St Luck, WI 54853	

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 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48793</p> <p>Based on observation, interview and record review, the facility did not revise the care plan with accurate information for safety interventions when the call light was removed for 2 of 2 residents (R) reviewed. (R2 and R3).</p> <p>Findings include:</p> <p>Example 1</p> <p>R2 was admitted to the facility on [DATE], with diagnoses including unspecified dementia with severe mood disturbance, dysphagia, contracture of right and left knee, muscle weakness, and hypertension.</p> <p>R2's minimum data set (MDS) assessment, completed on 03/14/24, confirmed R2 scored 03 during a brief interview for mental status (BIMS), indicating severely impaired cognition. R2 requires partial/moderate assistance with eating. R2 requires total assistance from staff for personal hygiene, showering/bathing, toileting, transferring, dressing lower body, and putting on/taking off footwear.</p> <p>R2's care plan was initiated on 09/06/19, and included the following interventions:</p> <p>ADL SELF-CARE DEFICIT care plan:</p> <p>Encourage the resident to use bell to call for assistance implemented on 09/06/19.</p> <p>AT RISK FOR FALLS care plan:</p> <p>Be sure residents call light is within reach and encourage the resident to use it for assistance as needed. The resident need prompt response to all requests for assistance.</p> <p>On 05/07/24 at 9:29 AM, Surveyor observed R2 sitting in wheelchair in room sleeping. Surveyor did not observe call light in reach, or a call light connected to wall. Surveyor observed an orange dot sticker on the call light panel on wall. Surveyor did not observe any type of device R2 could use to alert staff.</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 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 05/07/24 at 11:04 AM, Surveyor interviewed Certified Nurse Assistant (CNA) G, CNA H, and Licensed Practical Nurse (LPN) E and asked why R2 does not have a call light in place. CNA H indicated that R2 was found with the call light cord around R2's neck a while back, so staff took call light away and placed an orange sticker on panel on wall.</p> <p>On 05/07/24 at 12:15 PM, Surveyor interviewed Social Worker (SW) C and asked why R2 had no call light. SW C indicated that SW C could retrieve the documentation that was investigated with R2's discontinuation of call light.</p> <p>On 05/07/24 at 12:27 PM, Surveyor observed R2 looking out to the hallway. Surveyor observed R2 asking housekeeping staff walking by if someone can change his TV channel to football. Staff member stopped and tried finding football on for R2.</p> <p>On 05/07/24 at 12:30 PM, Surveyor interviewed CNA H and asked how R2 asks for assistance with any needs R2 may have. CNA H indicated that staff just kind of checks on R2. CNA H indicated there is no set time R2 is checked on. Surveyor asked CNA H the specific time frame that CNA H checks on R2. CNA H indicated that R2 is kind of near the nurse's station so when we walk by, we check on R2. Surveyor explained that Surveyor observed no one near R2 when he asked for assistance with his TV channels while everyone was at lunch in the dining room. CNA H indicated there was no staff nearby during lunch time as R2 refused lunch today and does that sometimes. CNA H indicated that staff check on R2 before meals and after meals. CNA H indicated CNA H will be repositioning R2 after lunch. CNA H walked back to dining room.</p> <p>On 05/07/24 at 12:33 PM, Surveyor interviewed R2 and asked how R2 asks for assistance with no call light in room. R2 stated, Sometimes I have to yell out to the door when I see people walk by, or wait till staff come in.</p> <p>On 05/07/24 at 12:41 PM, SW C provided Surveyor with a progress note for R2's discontinuation of call light dated on 04/21/24 which stated in part, .resident had call light cord laying across his neck (not around) did take the call light out of his room, as he is in close proximity to the nurse's station and had has not been using it. Provider updated on resident's call light being across not around his neck .</p> <p>On 05/07/24 at 1:45 PM, Surveyor interviewed Director of Nursing (DON) B and asked about R2's call light usage and not having a call light in room. DON B indicated that R2's call light usage record was reviewed and R2 did not utilize call light recently after the incident with the call light being draped across R2's neck. DON B indicated that staff felt it was safer to remove call light out of R2's room. DON B indicated that for any residents that don't have a call light, safety interventions are added and checking on resident is individualized in the care plan to inform staff how often to check on residents. Surveyor asked DON B if R2 had safety interventions when staff are to check on R2 for R2's needs on the care plan. DON B reviewed R2's care plan and indicated R2's care plan was not updated with safety interventions or specifications on how often R2 should be checked on if R2 needs assistance.</p> <p>Example 2</p> <p>R3 was admitted to the facility on [DATE], with diagnoses including Alzheimer's disease, unspecified dementia, right artificial hip joint, dysphagia, anxiety, restlessness, and agitation.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R3's MDS assessment, completed on 02/27/24, confirmed R3 scored 02 during a BIMS, indicating severely impaired cognition. R3 requires partial/moderate assistance with eating. R3 requires partial/moderate assistance from staff for personal hygiene, showering/bathing, toileting, transferring, dressing lower body, and putting on/taking off footwear.</p> <p>R3's care plan was initiated on 04/10/24, and included the following interventions:</p> <p>ADL SELF-CARE DEFICIT care plan:</p> <p>Encourage the resident to use bell to call for assistance implemented on 06/22/21.</p> <p>COMMUNICATION PROBLEM R/T DEMENTIA care plan:</p> <p>Ensure/provide a safe environment: call light in reach, adequate low glare light, avoid isolation implemented on 03/17/22.</p> <p>FREQUENT FALLS care plan initiated on 06/22/21:</p> <p>Be sure the resident call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt responses to all requests for assistance.</p> <p>On 05/07/24 at 9:33 AM, Surveyor observed R3 sitting fidgeting in recliner with feet elevated and recliner plugged into wall. Surveyor did not observe R3 having a call light or a device R3 could use to alert staff.</p> <p>On 05/07/24 at 12:15 PM, Surveyor interviewed SW C and asked why R3 had no call light. SW C indicated SW C could retrieve the documentation that was investigated with R3's discontinuation of call light.</p> <p>On 05/07/24 at 12:30 PM, Surveyor interviewed CNA H and asked how R3 asks for assistance with any needs R3 may have. CNA H indicated that staff just kind of checks on R3. Surveyor asked CNA H the specific time frame that CNA H checks on R3. CNA H indicated that R3 is toileted before and after meals and at bedtime. CNA H indicated that staff just checks on R3 whenever staff walk by.</p> <p>On 05/07/24 at 12:41 PM, SW C could not provide Surveyor with a progress note for R3's discontinuation of call light.</p> <p>On 05/07/24 at 1:45 PM, Surveyor interviewed DON B and asked about R3's call light usage and not having a call light in room. DON B indicated that for any residents such as R3 that do not have a call light, safety interventions and checking on residents is individualized in care plan to inform staff how often to check on residents.</p> <p>Surveyor asked DON B if R3 had safety interventions on the care plan as to when staff are to check on R3 for R3's needs. DON B reviewed R3's care plan and indicated that R3 did not have any revised safety interventions or specifications on how often R3 should be checked on if R3 needs assistance. DON B indicated only safety intervention in place for R3 is 1/2-hour checks when R3 is in bed but that pertains to falls.</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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48793</p> <p>Based on observation, interview and record review, the facility did not ensure residents were safe in their environment to prevent the risk of falling. This occurred for 3 of 3 residents (R) reviewed for falls, (R1, R2, and R3).</p> <p>The facility staff did not ensure R1 had pressure alarm pad while R1 was sitting in recliner as care planned.</p> <p>The facility staff did not ensure brakes were locked on EZ-stand lift during R2's transfer from recliner to bathroom.</p> <p>The facility staff did not ensure R3's recliner leg rest was down, and recliner unplugged as care planned.</p> <p>Findings include:</p> <p>Example 1</p> <p>R1 was admitted to the facility on [DATE], with diagnoses including unspecified dementia, non-ST elevation myocardial infarction, arthritis, congestive heart failure, muscle weakness, and hypertension.</p> <p>R1's minimum data set (MDS) assessment, completed on 04/10/24, confirmed R1 scored 09 during a brief interview for mental status (BIMS), indicating moderately impaired cognition. R1 requires partial/moderate assistance from staff for personal hygiene, showering/bathing, toileting, transferring, dressing lower body, and putting on/taking off footwear.</p> <p>R1's care plan AT RISK FOR FALLS was initiated on 04/10/24, and included the following interventions:</p> <p>Pressure alarm in bed, in wheelchair, and when in recliner implemented on 04/24/24.</p> <p>Surveyor reviewed physician orders dated 04/25/24 which state in part: Pressure alarms at all times.</p> <p>Surveyor reviewed progress notes dated 04/17/24 which state in part: R1 had a fall on 04/17/24 in the hallway outside his room.</p> <p>On 05/07/24 at 1:32 PM, Surveyor observed R1 sitting in recliner with no pressure alarm under R1. Surveyor observed pressure alarm pad lying in the wheelchair. Surveyor requested Certified Nursing Assistant (CNA) F to show Surveyor R1's pressure alarm in recliner. CNA F indicated there was not a pressure alarm pad under R1 in the recliner and the pressure alarm was on the wheelchair.</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>Surveyor interviewed CNA F and asked what the expectation was for R1's pressure alarm pad. CNA F indicated that CNA F usually follows the care plan located on door in resident's room. CNA F showed Surveyor R1's specific care plan. CNA F stated, Pressure alarm in bed, in wheelchair, and when in recliner. CNA F indicated R1 should have the pressure alarm pad under R1 in recliner.</p> <p>On 05/07/24 at 1:45 PM, Surveyor interviewed Director of Nursing (DON) B and asked what expectation from staff is for applying pressure alarm pad when R1 is in recliner. DON B indicated that CNA F should follow R1's specific care plan. DON B indicated DON B would have to review R1's care plan to review the exact intervention it states per pressure alarm pad.</p> <p>Example 2</p> <p>R2 was admitted to the facility on [DATE], with diagnoses including unspecified dementia with severe mood disturbance, dysphagia, contracture of right and left knee, muscle weakness, and hypertension.</p> <p>R2's MDS assessment, completed on 03/14/24, confirmed R2 scored 03 during a BIMS, indicating severely impaired cognition. R2 requires total assistance from staff for personal hygiene, showering/bathing, toileting, transferring, dressing lower body, and putting on/taking off footwear.</p> <p>R2's care plan AT RISK FOR FALLS was initiated on 09/06/19, and included the following interventions:</p> <p>Lock brakes of EZ stand while attaching resident implemented on 03/23/23.</p> <p>Surveyor reviewed progress notes dated 02/17/24 state in part:</p> <p>CNA was attempting to transfer resident with the EZ stand, when resident kicked the stand away and she had to lower him to the floor, no injuries noted.</p> <p>On 05/07/24 at 12:55 PM, Surveyor observed CNA G and CNA H enter R2's room and hook R2 to EZ-stand machine to transfer from recliner to bathroom. Surveyor did not observe CNA G and CNA H lock EZ stand brakes before attaching harness and lifting R2 out of recliner. CNA G and CNA H wheeled R2 to bathroom and instructed R2 to ring light when done with bowel movement. CNA G and CNA H exited R2's room.</p> <p>On 05/07/24 at 1:27 PM, Surveyor interviewed CNA G and CNA H and asked about safety interventions with R2's transfer process with EZ stand. CNA G indicated that CNA G always locks brakes before attaching harness and lifting R2 out of recliner or bed. CNA G indicated that CNA G forgot to lock brakes when getting out of recliner. CNA H indicated that CNA H only locks the brakes when R2 is getting out of the bed as that is when R2 originally fell due to being up high and coming down to EZ stand lift. CNA G and CNA H indicated they both follow resident's individualized care plan.</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>On 05/07/24 at 1:45 PM, Surveyor interviewed DON B and asked what expectations from staff are for transferring R2 from recliner with EZ stand and safety interventions to prevent falls. DON B indicated that staff should follow R2's specific care plan. DON B indicated that DON B would have to review R2's care plan to review the exact intervention it states per locking EZ stand brakes. Surveyor showed DON B R2's care plan. DON B confirmed that brakes should be locked on EZ stand before lifting R2 out of bed, recliner, and wheelchair.</p> <p>Example 3</p> <p>R3 was admitted to the facility on [DATE], with diagnoses including Alzheimer's disease, unspecified dementia, right artificial hip joint, dysphagia, anxiety, restlessness, and agitation.</p> <p>R3's MDS assessment, completed on 02/27/24, confirmed R3 scored 02 during a BIMS, indicating severely impaired cognition. R3 requires partial/moderate assistance from staff for personal hygiene, showering/bathing, toileting, transferring, dressing lower body, and putting on/taking off footwear.</p> <p>R3's care plan FREQUENT FALLS care plan initiated on 06/22/21 and included the following interventions:</p> <p>Pressure alarm at all times. Pressure alarm to be set to no delay implemented on 07/29/21.</p> <p>Recliner unplugged and in the stationary position at all times implemented on 08/04/21.</p> <p>Only have folding chair in room for visitor's d/t attempts to self-transfer and chair falling on her implemented 02/14/24.</p> <p>Surveyor reviewed physician orders dated 08/04/21 which state in part: Pressure alarms at all times when in wheelchair and in recliner. Stationary recliner unplugged. Do not elevate footrests every shift.</p> <p>Surveyor reviewed fall incident reports and indicated R3 had fallen on 09/02/23, 09/26/23, 10/22/23, 10/26/23, 11/25/23, 12/04/23, 12/30/23, 01/15/24, and 02/11/24.</p> <p>On 05/07/24 at 9:33 AM, Surveyor observed R3 sitting fidgeting in recliner with feet elevated, and recliner plugged into wall.</p> <p>On 05/07/24 at 10:52 AM, Surveyor interviewed Registered Nurse (RN) D and asked if R3's recliner was supposed to be plugged into wall and R3's legs elevated. RN D and Surveyor walked into R3's room and RN D indicated that R3's recliner footrest was up, and recliner plugged into wall. RN D indicated that RN D doesn't usually work down hall 400 and RN D would need to check care plan located in R3's closet door. RN D looked at care plan and indicated that R3's feet are not supposed to be elevated and recliner was not supposed to be plugged in. RN D unplugged R3's recliner. Surveyor observed RN D leave R3's feet elevated and RN D exited R3's room.</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>On 05/07/24 at 10:56 AM, Surveyor interviewed Licensed Practical Nurse (LPN) E and asked if R3's recliner was supposed to be plugged into wall and R3's legs elevated. LPN E indicated that R3's feet are not supposed to be elevated and recliner was not supposed to be plugged in. LPN E entered R3's room, plugged recliner into wall and lowered footrest to ground and unplugged R3's recliner. LPN E indicated that staff don't usually place R3 in recliner, but R3 must have been really tired after R3's bath performed earlier today.</p> <p>On 05/07/24 at 1:45 PM, Surveyor interviewed DON B and asked what expectations are for staff following R3's safety interventions per care plan. DON B indicated that staff are to follow R3's interventions as care plan states. DON B indicated that normally staff don't place R3 in recliner, but it was R3's bath day. DON B indicated that R3's recliner should not be plugged in, and footrest should not be elevated. DON B confirmed that R3 had fallen out of recliner previously in the past and that's why those safety interventions were in place.</p>		