

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

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 08/29/2025
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)		
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility did not ensure the resident's environment remains as free of accident hazards as possible. The facility did not implement new interventions and increase supervision when needed to prevent accidents for 2 of 3 residents (R) (R1, R2) reviewed.-R1 is at risk for falls and fell on [DATE], 12/30/24, 01/01/25, 01/09/25, 05/13/25, 06/06/25, 08/04/25, 08/05/25, and the facility did not place new interventions or increase supervision to prevent further fall incidents. On 08/06/25, x-ray results revealed a left humeral head fracture. On 08/08/25, additional x-rays of left knee related to complaints of pain, revealed an acute transverse non-displaced fracture of the mid portion of the left patella. The facility failure to place new interventions and increase supervision for R1 led to harm, when R1 suffered a left humeral head fracture and an acute transverse non-displaced fracture of the mid portion of the left patella. This example is cited at a scope/severity level of G.-R2 was at risk for falls. R2 has had a fall resulting in a fractured right ankle on 6/29/25. On 8/26/25 and 08/27/25, R2 continues to self-transfer without assist increasing risk for a fall. No new interventions were put into place to prevent further fall incidents. The failure of the facility to implement interventions to prevent future fall incidents due to R2 self-transferring will be a deficient practice cited at a scope/level severity of D.Findings include:Facility policy titled, Fall Protocol, dated reviewed in February 2025, states in part:Definition: A fall refers to unintentionally coming to rest on the ground, floor, or other lower level.An episode where resident lost his/her balance and would have fallen, if not for staff intervention, is considered a fall.Procedure: After a fall:-If a resident has fallen or is observed on the floor without a witness to the event, nursing staff will evaluate for possible injuries to the head, neck, spine, and extremities.-Nursing staff will notify the resident's Attending Physician/Nurse Practitioner for injuries or alteration in function. If the residents Attending Physician/Nurse Practitioner is not available, or the fall occurs outside normal business hours the nurse may notify the on-call physician to update him/her about the fall and obtain any necessary orders/treatments. A provider will be notified of the fall and resulting injuries at the time of the fall of significant injuries occur including: any injury to the head or face, open cuts or skin tears, new onset or change in pain, any change in condition or functional ability, or any other injury deemed significant by the nurse on duty or Registered Nurse (RN) on call. If there are no significant injuries or changes in function, the Medical Doctor/Nurse Practitioner (MD/NP) may be notified via fax or on the next business day.-Nursing staff will observe for delayed complications of a fall each shift for approximately seventy-two hours after an observed or suspected fall. Findings will be documented in the resident's medical record.-Documentation will include any observed signs or symptoms of pain, swelling, bruising, deformity, and/or decreased mobility, changes in level of responsiveness/consciousness and overall function.-An incident report will be completed for all falls whether witnessed or not. Nurse on duty and nurse managers will work collaboratively to make sure all notifications are completed. Nursing management team will ensure completion of the Interdisciplinary Review portion of the incident.Identifying causes of a fall or fall risk:-Within 24 hours of a fall, the nursing staff will begin to identify possible or likely causes of the incident.-Nursing management will review the resident's history of falls for any identifiable patterns.-IDT meets weekly to review falls and discuss patterns or trends.Documentation: When a resident falls, the following information should be recorded in the resident's medical record:-Vital signs-Injuries-Any first aid or treatment rendered. -Notification of physician and family.-Completion of the Incident Report.-New interventions to minimize risk for further falls .Example 1R1 was re-admitted to the facility on [DATE], readmitted on [DATE], with following diagnosis, in part, Parkinson's disease, insomnia, weakness, idiopathic progressive neuropathy, atherosclerotic heart disease, chronic kidney disease stage 3, primary osteoarthritis, gout, dysphagia, dementia, major depression, essential primary hypertension, hypothyroidism, and unsteadiness.R1's Minimum Data Set (MDS) assessment, completed on 06/09/25, confirmed R1 scored 13/15 during a Brief Interview for Mental Status (BIMS), indicating intact cognition. R1 was at risk for falls. R1 requires minimal assistance from staff for toileting, sit to stand, transferring, dressing lower body, and putting on/taking off footwear.R1's MDS dated [DATE] confirmed R1 requires substantial to maximal assistance from staff for toileting, sit to stand, transferring, dressing lower body, and putting on/taking off footwear. R1's Activities of Daily Living (ADL)s care plan states:-TRANSFER: Independent in the facility with Four-wheeled walker (FWW) revised on 09/26/24.-AMBULATION: Independent in facility with FWW revised on 09/26/24. -AMBI II ATION: Contact Guard Assist (CGA) x1 in facility with FWW revised on 12/30/24 -AMBI II ATION-		