STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525680	A. Building B. Wing	07/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
United Pioneer Home	623 S Second St Luck, WI 54853

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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	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46694 Based on interview and record review, the facility did not conduct a thorough investigation into the abuse or protect from future incidents through education for Resident (R) 16. The facility did not conduct a thorough investigation into the abuse as other residents were not interviewed to determine if other residents were affected. The facility did not protect residents from future incidents as education was not provided to staff after this incident occurred. Findings: The facility's policy titled, Resident Abuse Prevention and Reporting revised 01/2017, states in part: 7. Investigation/Reporting Procedures for actual or suspected abuse/neglect: . i) Plan for interviews of staff and residents as appropriate . k) Depending on the results of the investigation: Corrective actions will be taken to prevent abuse/neglect which may include discipline up to and including terminations, additional education, care plan or policy change. R16 was admitted on [DATE] with diagnoses of hemiplegia (paralysis on one side of the body) and hemiparesis (one sided muscle weakness) following a cerebral infarction (occurs as a result of disrupted blood flow to the brain due to problems with the blood vessels that supply it) affecting R16's left non-dominate side. Traumatic subdural hemorrhage (type of bleeding near your brain that can happen after a head injury) with loss of consciousness greater than 24 hours without return to pre-existing conscious level with the patient surviving and muscle weakness. Based on the quarterly Minimum Data Set (MDS), dated [DATE], a Brief Interview of Mental Status (BIMS) of 10 indicates R16 had moderate cognitive impairment. The MDS also indicated the following: (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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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Functional Limitation in Range of Motion: Impairment on one side (left) upper and lower extremities. Mobility devices: wheelchair. Bowel/Bladder: urinary frequently incontinent, bowel always incontinent. Urinary toileting program: yes Bowel toileting program: no. Behaviors not exhibited. Review of the facility's investigation on 06/07/24 R16 requested assistance to the bathroom. Certified Nursing Assistant assisted R16 to the bathroom and said to R16, You better do something this time or I'm not going to help you if you call again for the bathroom tonight. The facility's investigation about the abuse did not include interviews with additional residents to determine if further abuse had occurred. There was no progress note in the medical chart specific to this abuse allegation. On 07/09/24 at 11:31 AM, Surveyor interviewed Licensed Practical Nurse (LPN) H asking about the kind of education they receive for abuse. LPN H replied, We get computer training annually that has things that include abuse and neglect. Surveyor asked LPN H, Have you received this training in the last month? LPN H replied, No. On 07/09/24 at 2:32 PM, Surveyor interviewed Nursing Home Administrator (NHA) A, asking if there were, as part of the abuse investigation, interviews of other residents and training that was provided to all staff about abuse and neglect to prevent abuse from happening in the future. NHA A replied, I don't know. We interview 10 random residents quarterly to ask if there are any abuse concerns, but I don't have anything since this happened. I don't think so, but I will check on that. As part of the staff employment, they do receive annual abuse training but not since this incident. On 07/10/24 at 6:45 AM, Surveyor interviewed Certified Nursing Assistant (CNA) I asking what kind of education they receive for abuse. CNA I replied, A month or two ago on our computer program we had this education on abuse and neglect. On 07/10/24 at 7:06 AM, Surveyor interviewed both CNA J and CNA K asking what kind of education they receive for abuse. CNA J and CNA K replied, We get dementia and abuse training. On 07/10/24 at 9:25 AM, Surveyor interviewed NHA A asking if there was any further documentation regarding resident interviews and staff education provided since this abuse allegation was made. NHA A replied, No.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 47807 Based on observations, interview and record review, the facility failed to ensure the Minimum Data Set (MDS) was documented accurately related to tube feeding for 2 (R2 and R11) of 13 residents reviewed for MDS resident assessments. Findings include: Example 1: Review of R2's care plan, orders, diagnosis, and progress notes did not indicate R2 received tube feedings while a resident in the facility. Review of R2's electronic medical record (EMR) annual MDS comprehensive resident assessment with an Assessment Reference Date (ARD) of 06/27/24, documented in section K: Swallowing / Nutritional Status K0520 B, R2 was receiving tube feeding while a resident. The documentation indicated the response was locked and signed on 06/28/24 at 4:47 PM. On 07/08/24 at 6:45 PM, Surveyor completed initial tour of facility and observed R2 was not receiving tube feeding services. Example 2: A review of R11's care plan, orders, diagnosis, and progress notes did not indicate R11 received tube feedings while a resident in the facility. A review of R11's EMR annual MDS comprehensive resident assessment with an ARD of 06/04/24 documented in section K: Swallowing / Nutritional Status K0520 B, R11 was receiving tube feeding while a resident. The documentation indicated that the response was locked and signed on 06/04/24 at 11:01 AM. On 07/08/24 at 6:45 PM, Surveyor completed initial tour of facility and observed R11 was not receiving tube feeding services. On 07/09/24 at 11:55 AM, Surveyor interviewed Director of Nursing (DON) B regarding the MDS indications for tube feeding. Surveyor asked why R2 and R11 might be labeled for tube feeding on the MDS. DON B said that R2 and R11 were incorrectly labeled for tube feeding and they submitted a request to change them today when the issue was brought forward. On 07/10/24 at 11:52 AM, Surveyor interviewed Licensed Practical Nurse (LPN) M who completed the MDS assessment with the oversight of the DON. LPN M said they believe they just hit the wrong buttons and they are sorry they were not sure what exactly happened. On 07/10/24 at 1:23 PM, Surveyor interviewed DON B regarding expectations for MDS accuracy. DON B said they would have expected this to have been caught and the MDS should be coded accurately.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51095 Based on observation, interview and record review, the facility did not ensure activities of daily living were maintained for 1 out of 2 sampled residents (R31). R31 was not ambulated per recommendation of Physical Therapy (PT). This is evidenced by: The facility's policy titled, Restorative Nursing Program (08/2015) states in part, To promote each Residents ability to adapt and adjust to living as independently and safely as possible .To focus on achieving and/or maintaining the Residents optimal physical functioning in activities of daily living. R31 was admitted to the facility on [DATE]. R31's diagnoses included compression fracture of vertebra, low back pain, unspecified, adult failure to thrive, weakness, and muscle weakness (generalized). R31's Minimum Data Set (MDS), dated [DATE], confirmed R31 scored 14 during Brief Interview for Mental Status (BIMS), indicating intact cognition. R31 understands and is understood by others, and she is able to make her needs known. R31 is totally dependent on staff for all transfers and ambulation. On 05/29/24, Physical Therapy (PT) recommended R31 ambulate to all destinations with roller walker (RW) and Caregiver Assist of 1 (CGAx1) with gait belt including to and from meals in the dining room. On 05/29/24, R31's care plan and the Certified Nursing Assistant (CNA) Kardex indicated R31 is to ambulate to all destinations with RW and CGAx1 with gait belt including to and from meals, in the dining room. Surveyor reviewed documentation related to R31's ambulation. Surveyor noted documentation in minutes per day and evening shifts. Documentation does not indicate that R31 ambulated to and from dining room for all meals. Surveyor did not observe R31 ambulate or being offered to ambulate during survey period of 07/08/2024 - 07/10/2024. On 07/09/24 at 7:13 AM, Surveyor interviewed R31 as she was in her room and in her wheelchair (w/c), R31 reported she would like to have help walking more. That's what I'm here for, to get better. I need to get up and walk. I want to get better so I can go home. They don't walk me here like they did when I was in Eau [NAME]. On 07/09/24 at 8:04 AM, Surveyor observed R31 was taken to dining room in W/C; no ambulation or encouragement to ambulate was observed. After meal, R31 was not offered to ambulate back to room and was taken back to her room in her w/c. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/9/24 at 8:52 AM, Surveyor observed R31 in w/c repeatedly saying, Help me, help me get up. I cannot do it by myself. I want to get up and need help. R31 was not offered to ambulate and was wheeled to hall and news was turned on a laptop for her to watch. On 07/09/24 at 10:50 AM, R31 was observed being pushed outdoors in W/C then brought back in approximately 5 minutes later. R31 sat in W/C by nursing station. On 07/09/24 at 11:37 AM, Surveyor observed R31 in recliner in her room. CNA C was present in room and reported R31 transferred with assist of 1 and her walker. CNA C stated, We ambulate her to the dining room and back when she doesn't have back pain. On 07/10/24 at 8:19 AM, Surveyor observed R31 in dining room in w/c. Surveyor did not observe staff offer R31 to ambulate to or from dining room. On 07/10/24 at 8:50 AM, Surveyor interviewed CNA E regarding R31's ambulation expectations or routine. CNA E reported R31 has pain a lot and was offered to ambulate before going to the dining room for breakfast but refused. CNA E admitted that R31 was not offered to ambulate back from dining room. CNA E asked R31 if she had pain and R31 responded, I'm feeling better, and then CNA E transferred R31 from w/c into recliner chair. No observation that CNA E offered to assist R31 with ambulation. On 07/10/24 at 9:00 AM, Surveyor interviewed R31. R31 reported she would like to walk more. R31 stated, When I was in another facility, they walked me all the time, the doctor made sure of it. When asked if she refuses to walk when she has pain, she reports, When it is real bad, then I don't walk, but if I walk I have less pain, like when I was in the other facility, I have only been here three months but they do not walk me On 07/10/24 at 10:45 AM, Surveyor interviewed Director of Nursing (DON) B. DON B reported it is the expectation R31 is offered to ambulate to and from dining room and then to document if refused in the walking program record. DON reported when R31 was in therapy, Ambulation actually helped her pain.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46694 Based on observation, record review and interview, the facility did not implement a restorative program in attempt to improve or maintain resident's functional abilities for 1 of 2 residents (R19) reviewed for limited Range of Motion (ROM). Findings: The facility's policy titled, Restorative Nursing Program revised 8/2015, states . Policy To promote each Residents ability to adapt and adjust to living as independently and safely as possible. One Restorative Aide (RA) will be scheduled each day. Purpose To focus on achieving and/or maintaining the Residents optimal physical functioning in activities of daily living. Procedure The director of Nursing or designee will supervise the Restorative Program. An RN will be the Restorative Nursing Coordinator. CNA's specially trained in Restorative procedures will implement, assist, and document the restorative activities for assigned Residents. In-service will be held as needed to train and update staff. R19 was admitted on [DATE] with diagnoses of Alzheimer's, dementia, difficulty in walking, weakness, contracture (a condition of shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and rigidity of joints) of right and left ankle, osteoarthritis of knee, and age related osteoporosis. Care plan: (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The resident has an Activities of Daily Living (ADL) self-care performance deficit relate to decline in mobility, advanced age, contractures to right/left ankle, osteoarthritis, osteoporosis. Bathing and showering: The resident is able to: participate to fullest extent. Staff assist x1. Bed mobility: The resident is able to: participate to fullest extent. Assist x1, assist x2 as needed (PRN). Eating: The resident is able to: participate to fullest extent. Supervision/assistance as needed. Has plate guard. Pureed diet with honey thick liquids. Sippy cups for liquids at meals. Personal hygiene/oral care: The resident is able to: participate to fullest extent. Assist x1 with personal hygiene/oral care. Check and change q2h. Peri-care q AM and PM, when incontinent and as needed. Apply barrier cream with every incontinent episode. Toilet use: The resident is able to: Check and change every 2 hours. Assist x1 with peri-care with day and night cares, when incontinent, and as needed. Transfers: The resident is able to: transfers with Hoyer Lift-Assist x2. Encourage the resident to participate to the fullest extent possible with each interaction. Encourage the resident to use bell to call for assistance. Monitor/document/report PRN any changes, any potential for improvement, reasons for self-care deficit, expected course, declines in function. Praise all efforts at self-care. Physical/Occupational evaluation and treatment as per doctor order. The resident has limited physical mobility related to limited ROM of right and left arms. Resident to be Hoyer lift assist of 2 with all transfers. Check and change q2h. The resident will remain free of complications related to immobility, including increased contractures, thrombus formation, skin-breakdown, fall related injury. Elevate lower extremities in recliner for prolonged knee extension stretch. Locomotion: The resident is totally dependent on (1) staff for locomotion using Broda Chair (specialize wheelchair that reclines). Minimum Data Sets (MDS) dated [DATE]: Functional abilities: upper extremity impairment on both sides. Mobility devices: wheelchair. On 07/08/24 at 8:03 PM, Surveyor observed R19 in bed. Resident had heels floated and washcloths in hands bilateral. Both of R19's arms were tight to her chest. On 07/09/24 at 7:07 AM, Surveyor observed Certified Nursing Assistant (CNA) L and CNA J providing AM cares to R19. Staff did not perform any ROM exercises to upper or lower extremities aside from putting on clothing and washing under R19's arms. On 07/10/24 at 8:09 AM, Surveyor interviewed CNA L asking if R19 is to be receiving restorative care for limited ROM. CNA L replied, Yes based on the care plan, but for some reason this month the resident is not on my restorative care schedule. I don't have this resident on my restorative care list. Maybe the Director of Nursing (DON) B would know more about this? On 07/10/24 at 9:30 AM, Surveyor interviewed Physical Therapist (PT) G asking what kind of therapy R19 is getting. PT G replied, I believe this resident is getting restorative care from the staff on the floor. This resident has been known to be combative and they may have discontinued that because of that. Surveyor requested documentation of restorative plan. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/10/24 at 9:37 AM, PT G provided Surveyor a therapy progress note dated 8/2/23. Surveyor asked if there is anything more recent. PT G replied, No this resident should be getting restorative cares by the nursing staff on the floor. On 07/10/24 at 10:14 AM, Surveyor interviewed CNA K, asking if any restorative cares are being provided for R19. CNA K replied, No, this resident had been getting stretching exercises but got sick and was placed on 'End of life care' and the restorative care stopped. Surveyor asked CNA K who decides to restart these therapies. CNA K replied, The order comes from our DON. The DON is the one that writes them. On 07/10/24 at 10:52 AM, Surveyor interviewed DON B, asking based on the care plan for limited ROM, does R19 have a restorative care program. DON B replied, That should be in the restorative care binder on the unit. Surveyor asked to review the binder. On 07/10/24 at 11:09 AM, DON B informed Surveyor, This resident went to palliative care in April and restorative care was discontinued. When R19 came off of palliative care it was never resumed. On 07/10/24 at 11:19 AM, Surveyor interviewed DON B, asking why there is no referral to therapy for restorative care. DON B replied, Because we have not seen a decline in care because R19 is not walking. Advanced directives provided by DON B shows this resident started palliative care on 04/30/24 and removed from palliative care on 05/28/24. Surveyor asked DON B, how do you maintain the resident's level of mobility, and what is your expectation for a timeline for when restorative care should be restarted. DON B replied, I don't know. But the girls are supposed to be doing some stretching with this resident's arms during cares. Surveyor explained observations of cares over the past 3 days during the survey and CNAs have not provided stretching to R19's arms. Surveyor reviewed with DON B the interview with restorative care staff stating R19 has not been on their schedule this month for any restorative care.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44863 Based on interview and record review, the facility did not ensure 1 of 5 residents (R8) were free from unnecessary medications. -R8 was prescribed lorazepam (anti-anxiety) without a documented diagnosis. -R8 was prescribed lorazepam as needed (PRN), beyond the 14-day limit, without a documented rationale. -R8's record did not include interventions to reduce or eliminate the need for administration of medication. -R8's record did not indicate adequate monitoring of anti-anxiety medication, including signs or symptoms to warrant administration of medication, and side effects of the medication. Findings include: R8 was admitted to the facility on [DATE] with diagnoses of chronic obstructive pulmonary disease and heart failure. R8's record did not include a diagnosis of anxiety. R8's Minimum Data Set (MDS) assessment completed on 03/25/24, indicated a significant change related to hospice services. R8's most recent MDS assessment completed on 06/12/24 confirmed R8 scored 07/15 during Brief Interview for Mental Status (BIMS), indicating severe cognitive impairment. R8's physician orders included lorazepam PRN every four hours as needed for anxiety or shortness of breath, dated 03/22/24-06/12/24 and 06/12/24-09/12/24. On 07/10/24, Surveyor reviewed R8's medication administration record (MAR), and noted PRN lorazepam was administered as follows: -April, administered five times. -May, administered 26 times. -June, administered 23 times. -July, administered six times. Progress notes confirmed need for administration of lorazepam was for, Anxiety, SOB for 3 months. Progress noted did not provide detail about signs or symptoms R8 was exhibiting to indicate use of medication. On 07/10/24, Surveyor reviewed R8's care plan and noted: (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident uses antidepressant medication r/t depression. -The resident has a behavior problem verbally aggressive toward others at times. R8's record did not contain a care plan related to anti-anxiety medication, which would include non-pharmacological interventions, signs, or symptoms to indicate need for administration of medication, and adverse consequences related to medication. On 07/10/24, Surveyor reviewed monthly pharmacy reviews, which indicated no irregularities related to lorazepam. On 07/10/24 at 1:46 PM, Surveyor interviewed Director of Nursing (DON) B. DON B stated she will ask the doctor about rationale for PRN lorazepam, As he is here right now. This happens with a lot of hospice residents. DON B provided Surveyor with a printed progress note dated 06/12/24. Progress note reads, New order to extend Ativan end date x 3 months from [Dr. Name], see TO. The printed note included a handwritten note that read, On hospice. He has anxiety and likely will require more medication as he progresses through end of life. Signed by [Dr. Name] on 07/10/24. Surveyor was unable to find a documentation in R8's record to confirm a rationale was provided prior to 07/10/24.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 49353 Based on observation, record review and interview, the facility did not ensure drugs and biologicals used in the facility are labeled in accordance with current accepted professional principles for 1 of 26 medications reviewed during medication administration observation. This had the potential for harm to affect Resident (R)30. This is evidenced by: R30 was admitted to facility on 12/08/23 with a pertinent diagnosis of diabetes mellitus II. R30 has a prescription order for insulin Glargine Subcutaneous Solution Pen-injector 100 UNIT/ML (Insulin Glargine) inject 28 unit subcutaneously one time a day related to type 2 diabetes. On 07/10/24 at 7:50 AM, Surveyor observed Licensed Practical Nurse (LPN) F complete medication administration of insulin to R30. Surveyor observed R30's insulin glargine injection pen had a pharmacy label stating name, received date of 06/14/24, open date of 06/24/24, and dose to be administered of 22 units subcutaneously every AM. Surveyor reviewed physician order and Medication Administration Record (MAR) in R30's Electronic Medical Record (EMR) and noted as being to administer 28 units. Surveyor asked LPN F to verify this finding. LPN F verified that the current order was to administer 28 units. Surveyor asked LPN F why the medication label from pharmacy on the insulin pen was for 22 units. LPN F stated it must have been missed and corrected the dosage with a handwritten sticker stating the correct dose and placed it over this part of the label. On 07/10/24 at 11:20 AM, Surveyor interviewed Director of Nursing (DON) B regarding the facility policy of medication labeling. DON B stated the expectation for verifying medication labels would be completed when medication was received from pharmacy and when staff are administering the medication during verification of right resident, medication, dose, route, and frequency. DON B stated that if an error is observed, then the nurse would use a handwritten sticker to correct the date, apply to the current label, and notify the pharmacy. Surveyor asked what timeframe this would be expected to be completed. DON B stated immediately. Surveyor explained the finding of the incorrect dosage on the medication label. DON B stated that this should have been corrected when the insulin pen was first received on 06/14/24. No evidence was provided that the pharmacy had been notified of this error or was corrected.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49353 Based on observation, interview and record review, the facility did not maintain an infection prevention program designed to provide a safe and sanitary environment to prevent the transmission of communicable disease and infection. This has the potential to affect all 33 residents residing in the facility. The facility did not implement Standard of Practice (SOP) for documentation of Infection Control Surveillance and Monitoring with isolation precaution type, start date, and stop date. Staff did not perform appropriate hand hygiene with glove use during cares provided to R19 and R16. Findings: Example 1 The facility policy titled, Infection Prevention & Control Surveillance, with most recent review date 03/2024, states in part: The Infection Preventionist will conduct ongoing surveillance for HAIs and other epidemiologically significant infections that have substantial impact on potential resident outcome and that may require transmission-based precautions and other preventative interventions. .the Infection Preventionist/designee will record actual and suspected infections noting date of symptom onset, location of resident, symptoms, any relevant labs, treatment and precautions initiated. Surveyor reviewed the facility's Infection Control Surveillance logs dated 01/2024-06/2024 including monthly infection rate and noted the following: January 2024: 01/02/24 R30 had date of symptom onset 1/02/24, symptoms hyperglycemia and advantageous lung sounds, diagnosis of Upper Respiratory Infection (URI), and treatment with ZPak (antibiotic). No isolation type, start or end date documented. 01/12/24 R30 had date of symptom onset 1/12/24, diagnosis of suspected respiratory infection, and treatment with ZPak. No isolation precaution type, start/stop date listed documented. 01/31/24 R195 had date of symptom onset 1/31/24, symptoms of cough, Shortness of Breath (SOB), isolation start date 2/1. No type or end date of isolation precautions documented. No diagnosis documented. February 2024: (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
United Pioneer Home	623 S Second St Luck, WI 54853

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	R30 had symptoms of SOB, lethargy, hyperglycemia, suspected URI, and treatment with Levaquin (antibiotic). No symptom onset date documented. No isolation precautions documented. 02/27/24 R6 had date symptom onset of 2/27/24, symptoms of cough, wheeze, fever, lab date 2/28/24, diagnosis of covid-19, isolation start date 2/28/24. No treatment documented. No end date of isolation precautions documented. Isolation precautions were not implemented with onset of symptoms. 02/28/24 R21 had date symptom onset 2/28/24, symptoms of cough, lab date 02/28/24, diagnosis of respiratory syncytial virus (RSV), isolation start date of 02/28/24. No end date of isolation noted. Type of isolation precaution not documented. 02/29/24 R191 had date symptom onset of 02/29/24, symptoms of cough and nasal congestion, lab date 02/28/24, isolation start date 02/29/24 and end date 03/02/24. No diagnosis documented. No treatment documented. Type of isolation precaution not documented. 04/02/24 R193 had symptoms of facial rash and burning pain, diagnosis of possible shingles, treatment Valacyclovir 500mg three times a day for 7 days, isolation start date 4/2/24. No isolation type or end date for precautions documented. 04/26/24 R28 had symptoms of decreased oxygen saturation, increased blood pressure, and shortness of breath, lab date 04/26/24 with negative 4plex and 04/26/24 chest x-ray (no result noted), diagnosis of possible pneumonia, treatment of Doxycycline 100mg twice a day for 5 days. No isolation precaution type, start/end date documented. No confirmed diagnosis documented. May and June 2024: All surveillance documentation did not include isolation precaution type, start and end dates. 46694 Example 2 The facility policy titled, Hand Hygiene revised 05/2020, states in part: .Policy Interpretation and Implementation . 8. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap and water for the following situations: . b. Before and after direct contact with residents; . h. Before moving from a contaminated body site to a clean body site during resident care. i. After contact with a resident's intact skin; . l. After contact with objects (e.g., medical equipment) in the immediate vicinity of the resident. m. After removing gloves; . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	9. Hand hygiene is the final step after removing and disposing of personal protective equipment . Procedure: . Applying and Removing Gloves 1. Perform hand hygiene before applying non-sterile gloves. R19 was admitted on [DATE] with diagnoses of Alzheimer's, dementia, and weakness. On 07/09/24 at 7:07 AM, Surveyor observed morning cares provided to R19 by Certified Nursing Assistant (CNA) L and CNA J. Both CNAs performed hand hygiene and glove use appropriately. After cleaning and drying R19's top half, the staff removed pillows from under R19's legs and between the knees. R19's legs were cleaned, dried and lotion applied. Compression socks were applied to both legs. Non-skid footwear placed to feet and pants put on and pulled to R19's knees. CNA J cleaned R19's front and peri area with wipes, wiping front to back. R19 was then rolled onto the left side and R19's buttocks were cleaned by CNA J using wipes and a new brief was placed. CNA J did not remove gloves and perform hand hygiene. With the contaminated gloves that CNA J was using to wipe R19's buttocks clean, R19 was then rolled onto back. CNA L washed R19's peri area with a clean washcloth and then dried. R19 was rolled onto the right side with CNA J holding R19 with the contaminated gloves and R19's bottom was washed with washcloth and dried by CNA L. New brief was pulled through and secured in the front. The remaining observations of care were appropriate. On 07/10/24 at 7:14 AM, Surveyor interviewed CNA J about the observations from the previous day and asked CNA J, What should you have done differently in this situation? CNA J replied, I should have removed the dirty gloves and cleaned my hands and put on new gloves. On 07/10/24 at 8:36 AM, Surveyor interviewed DON B about the observations of cares for R19 from the previous day and asked, What is the expectation in this case regarding hand hygiene? DON B replied, She should have removed the dirty gloves, performed hand hygiene, and put on new gloves to proceed with cares with this resident. R16 was admitted on [DATE] with diagnoses of hemiplegia (paralysis on one side of the body) and hemiparesis (one sided muscle weakness) following a cerebral infarction (occurs as a result of disrupted blood flow to the brain due to problems with the blood vessels that supply it) affecting R16's left non-dominant side. Based on the quarterly Minimum Data Set (MDS) date 06/10/24, R16 had a Brief Interview of Mental Status (BIMS) score of 10 which indicates R16 had moderate cognitive impairment. On 07/09/24 at 7:40 AM, Surveyor observed morning cares provided to R16 by CNA N and CNA L. CNAs assisted R16 with socks, pants, left ankle brace, and shoes. Pillow was removed from R16's left arm pit and washcloths removed from both hands. R19 was taken to the toilet from the bed via the E-Z stand lift. Once on the toilet both CNAs put on gloves without performing any hand hygiene. On 07/10/24 at 7:42 AM, Surveyor interviewed CNA L about the observations made from the previous day and asked CNA L, What is the expectation of hand hygiene with glove use? CNA L replied, From what I can remember from CNA class is you need to at least use hand sanitizer or wash hands before and after glove use. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 07/10/24 at 8:36 AM, Surveyor interviewed DON B about the observations of care performed on R16 and asked DON B if this observation is OK? DON B replied, Yes, as long as they perform hand hygiene between gloves changes and when they remove the dirty gloves at the end of the care provided. Surveyor then asked for a copy of the facility's hand hygiene with glove use policy. On 07/10/24 at 10:55 AM, DON B provided policy titled Hand Hygiene and showed Surveyor under section M. After removing gloves, you are to perform hand hygiene but not when putting gloves on unless using sterile gloves. Surveyor reviewed the policy and under the procedure section titled Applying and Removing Gloves 1. Perform hand hygiene before applying non-sterile gloves. Surveyor showed this to DON B and DON B replied, It looks like we have conflicting guidelines for hand hygiene.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49353 Based on interview and record review, the facility did not establish an Infection Prevention and Control Program (IPCP) that must include, at a minimum, the following elements: An antibiotic stewardship program that includes a system to monitor/review antibiotic use. This has the potential to affect all 33 residents residing in the facility. The facility did not follow a Standard of Practice (SOP) for antibiotic stewardship for antibiotic use for residents on the line list logs from January 2024 through June 2024 line lists. The facility did not implement a SOP for antibiotic stewardship to monitor/review antibiotic usage, outcome measures, and summarizing of antibiotic resistance. The facility did not outline and implement a SOP for antibiotic stewardship concerning mode and frequency of education for prescribing providers and nursing staff on antibiotic use and protocols. R6 was prescribed Keflex for wound infection. Culture and sensitivity results did not indicate sensitivity to Keflex. The facility did not communicate with R6's provider to ensure R6 was receiving an appropriate antibiotic. This is evidenced by: The facility policy titled, Antibiotic Stewardship, with most recent review date of 03/2024, states in part: .The purpose of our Antibiotic Stewardship Program is to monitor the use of antibiotics in our residents . .Orientation, training and education of staff will emphasize the importance of antibiotic stewardship and will include how inappropriate use of antibiotics affects individual residents and the overall community . .When a culture and sensitivity (C&S) is ordered lab results and the current clinical situation will be communicated to the prescriber as soon as available to determine if antibiotic therapy should be started, continued, modified, or discontinued . The facility policy titled, Infection Prevention & Control Surveillance, with most recent review date of 03/2024, states in part: .purpose of surveillance of infections is to identify both individual cases and trends of epidemiologically significant organisms .to guide appropriate interventions and to prevent future infections . Using the current suggested criteria for HAIs (McGeer, Loeb, etc.), determine if the resident has a HAI. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interpreting Surveillance Data .analyze the data to identify trends and reported to QAPI committee quarterly. Surveyor reviewed facility's guiding infection criteria dated 11/2017 titled, Interactions to Reduce Acute Care Transfers (INTERACT) Care Paths, which included McGeer Criteria dated 2012, and noted the following: The INTERACT Care Path provides an outline of the common criteria for infection surveillance and initiation of antibiotics (McGeer, Agency for Healthcare Research and Quality (AHRQ), and Loeb). INTERACT encourages facilities to select a specific criterion for infections and a criterion for when to notify the provider to maintain consistency. .purpose of INTERACT criteria is to provide a set of clinically sound criteria that is consistent with published guidelines about when to notify a clinician about a change in condition. The INTERACT criteria are not designed to define any specific infection or to indicate the need for antibiotic therapy. .antibiotic therapy should not be initiated unless a patient/resident meets criteria for an infection. Surveyor reviewed facility's Infection Control Surveillance logs dated 01/2024-06/2024 including monthly infection rate and noted the following: January 2024 01/01/24 R4 had no symptoms documented - stated diagnosed in emergency room with urinary tract infection (UTI), treatment with Bactrim DS twice a day for 5 days. 01/02/24 R30 had symptoms of hyperglycemia and advantageous lung sounds, diagnosis of upper respiratory infection (URI), and treatment with ZPak (antibiotic). No start date, dosage or duration of antibiotic documented. 01/03/24 R194 had symptoms of increased confusion decline with a diagnosis of UTI and treatment with Rocephin 1g. 01/12/24 R30 had no symptoms listed - stated diagnosed at appointment with suspected respiratory and treatment Zpak. 01/18/24 R236 had symptoms of hallucinations and increased weakness, diagnosed with UTI, and treated with Bactrim DS for 7 days. 01/20/24 R13 had symptoms of agitation, striking out, and increased confusion with a diagnosis of UTI and treatment with Bactrim DS twice daily for 5 days. 01/31/24 R186 had symptoms of confusion, hallucinations, anxiety diagnosed with UTI and treated with Bactrim DS twice daily for 5 days. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The surveillance for R4, R30, R194, R30, R236, R13 and R186 had no start date or dosage of antibiotic documented. No documentation to indicate appropriate antibiotic is being used for a specific bacterium causing infection. Symptoms listed do not meet updated 2024 Revised McGeer Criteria for surveillance of UTI and respiratory infection. February 2024 R30 has symptoms of shortness of breath (SOB), lethargy, hyperglycemia with an undiagnosed URI and treatment with Levaquin 750mg every other day for 4 doses. No documentation of diagnostic confirming respiratory infection. Symptoms listed do not meet updated 2024 Revised McGeer Criteria for surveillance of URI. March 2024 03/07/24 R9 had symptoms of increased behaviors and cloudy urine with a diagnosis of UTI treated with Keflex three times daily for 7 days. 03/13/24 R5 had no symptoms documented - stated bypassing urine ordered by MD without rationale why urinalysis was bypassed. Listed diagnosis of UTI and treated with Bactrim DS twice a day for 5 days. 03/14/24 R35 had symptoms of increased confusion, diagnosis of UTI, and treatment of Cipro twice a day for 5 days. Under symptom column it states - ordered by nurse practitioner (NP). Line was crossed through stating no growth and Cipro was discontinued. Provider ordered antibiotics prior to receiving C&S. No documentation of when antibiotic was initiated or discontinued. Symptoms listed do not meet updated 2024 Revised McGeer Criteria for surveillance of UTI. 03/18/24 R21 had symptoms of increased confusion and stated - ordered by NP, diagnosis UTI and treated with Levaquin 750 every 48 for 4 days. The surveillance for R9, R5, R35 and R21 had no start date of antibiotic documented. No documentation to indicate appropriate antibiotic is being used for a specific bacterium causing infection. Symptoms listed do not meet updated 2024 Revised McGeer Criteria for surveillance of UTI. April 2024 04/17/24 R19 had symptoms of cough/choke, vomit, diarrhea, wet lungs, decreased oxygen saturation, diagnosis of suspected aspiration pneumonia, and treatment of Rocephin x2 then Levaquin 750 x3 days. No lab/diagnostic data documented for confirmation of aspiration pneumonia. No start date of antibiotic documented. No documentation to indicate appropriate antibiotic is being used for a specific bacterium causing infection. June 2024 (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	06/06/24 R28 had symptoms of increased confusion since hospitalization - ordered by NP, diagnosis of UTI, and treated with Keflex 500 three times a day for 7 days. No start date of antibiotic documented. No documentation to indicate appropriate antibiotic is being used for a specific bacterium causing infection. Symptoms listed do not meet updated 2024 Revised McGeer Criteria for surveillance of UTI. Monthly infection rate: January monthly infection rate was 10.28 (Urinary 7.19, Respiratory 2.06, Skin 1.03). February monthly infection rate was 5.18 (Urinary 1.04, Respiratory 4.15). March monthly infection rate was 6.03 (Urinary 6. 03). April monthly infection rate was 8.12 (Urinary 1.02, Respiratory 6.09, Skin 1.02). June monthly infection rate was 7.79 (Urinary 2.92, Respiratory 0.97, Skin 1.95, Other 1.95). No documentation of facility reviewing/monitoring prescribed antibiotic use for trends in infection rates related to specific bacteria. Incomplete documentation of infectious cause including bacteria identified through lab analysis, antibiotic start/end dates, and symptoms of illness. Surveyor reviewed facility's Antibiotic Stewardship policy which did not include the mode (e.g., verbal, written, online) and frequency of education for prescribers or nursing staff on antibiotic use protocols. Surveyor requested documentation of education provided to staff and no information was provided. On 07/10/24 at 7:50 AM, Surveyor interviewed Licensed Practical Nurse (LPN) F regarding education for infection prevention and antibiotic stewardship. LPN F stated that infection prevention training is completed via Relias (an electronic-based education program for staff) annually, but unable to recall antibiotic stewardship education specifically. Surveyor asked LPN F the criteria used for determining if a resident had signs/symptoms of an infection. LPN F stated that staff use INTERACT Care Path and the standing orders for any labs. On 07/10/24 at 11:15 AM, Surveyor interviewed Director of Nursing (DON) B with dual role of Infection Preventionist (IP). Surveyor asked DON B for clarification of antibiotic stewardship policy regarding criteria used for infection surveillance. DON B stated that McGeer Criteria was used. Surveyor asked DON B what criteria the provider uses for prescribing antibiotics. DON B stated that they use whatever guideline the provider uses. Surveyor asked which guideline was used. DON B stated not knowing which particular one, but that whichever one the provider used was the most current guideline. Surveyor asked DON B how nursing staff determine when a provider should be notified. DON B stated they use INTERACT Care Paths, which are located at each nursing station. Surveyor asked for further explanation of INTERACT Care Paths. DON B stated it is a guidance for infection surveillance based on current standards of practice that are used in addition to the current standing orders from the provider to conduct a urinalysis if the Care Path says to do so. Surveyor asked DON B to explain the facility's policy for how antibiotic review was completed. DON B stated the pharmacy sends a report monthly stating what antibiotics were prescribed. Surveyor asked DON B how this information is reviewed. DON B stated it is compared to the surveillance log and it is reviewed as soon as it comes in, but sometimes so much stuff comes through the office, some can be missed - especially if not in the office for vacation. Surveyor asked DON B how education for infection control and antibiotic stewardship was completed. DON B stated that nursing staff complete training via Relias for infection control upon hire and annually. DON B stated that providers are not included in this education. No documentation for antibiotic stewardship education provided. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 07/10/24 at 1:30 PM, Surveyor interviewed Nursing Home Administrator (NHA) A. Surveyor asked NHA A regarding frequency of the Quality Assurance and Performance Improvement (QAPI) committee and topics addressed. NHA A stated that QAPI meets quarterly and discusses resident/staff concerns and areas identified needing improvement. Surveyor asked NHA A if resident illness and antibiotics use/trends were reviewed. NHA A stated the infection rate numbers were reviewed, but no investigations as to causation or trends related to antibiotic use were reviewed, monitored, or investigated. NHA A further stated that the first time this was discussed was during the QAPI meeting held on 07/09/24 during survey. 44863 R6 was admitted to the facility on [DATE]. Diagnoses included Alzheimer's disease and osteomyelitis of right ankle and foot. Care plan: -Contact precautions d/t active wound infection. May resume enhanced barrier precautions after antibiotic treatment. Chronic enhanced barrier precautions related to chronic wounds to right foot and left hip. Date initiated 07/03/24, revised 07/09/24. Orders: -06/20/24, Keflex (cephalexin) for infection x 14 days. -07/02/24, Keflex (cephalexin) for infection, no end date. On 07/10/24, Surveyor reviewed R6's progress notes, and noted the following: -06/17/24, provider updated, two white pustules left hip. -06/19/24, left hip wound draining serous drainage, provider updated and ordered Keflex (antibiotic). -06/21/24, wound culture results staphylococcus and enterococcus faecalis-sensitivity completed and indicated Ampicillin, Linezoid, Vancomycin, Ampicillin/Sulbactam. -06/24/24, provider updated on darkening drainage and ordered to send to ER for evaluation of left hip wound. CT completed and indicated fluid around hip. Wound culture completed. Referral to orthopedics and continue Keflex. -06/27/24, culture results from the ER. Organism: enterococcus faecalis. Sensitivities to Ampicillin, Linezoid, Vancomycin, Ampicillin/Sulbactam. -07/01/24, request from provider to continue Keflex ordered to end on 07/04/24 or start a new one. -07/02, provider ordered to continue Keflex, no end date. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 07/10/24 at 10:47 AM, Surveyor interviewed Director of Nursing (DON) B. DON B stated per Antibiotic Stewardship program, R6's provider should have been updated on or around 06/21/24, to question if Keflex was appropriate based on culture and sensitivity results. DON B stated, This would be the expectation; however, I am unsure of the delay. I was off that week.