STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525681	A. Building B. Wing	09/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nazareth Health and Rehab Center	814 Jackson St Stoughton, WI 53589

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36253 Based on observation, interview, and record review, the facility did not ensure each resident received adequate supervision to prevent accidents for 4 of 5 residents (R1, R2, R3, and R5) reviewed for wandering and elopement potential. R1 is severely cognitively impaired and has an Activated Power of Attorney for Health Care (APOAHC). R1 eloped from the facility on [DATE] and fell outside the facility, resulting in a fracture of his jaw. The facility did not have adequate supervision to ensure they were aware of R1's whereabouts and did not have security measures and monitoring in place to ensure R1 could not access various locations in the building, allowing him to exit the rear of the facility. Door alarms did not function correctly, allowing R1 to exit his wing into the elevator, go down 2 floors, propel himself in his wheelchair the length of the building on the ground floor, then through the kitchen, through the maintenance area, and walk up a flight of stairs to exit through the employee entrance. R1 then walked through the parking lot, down the sidewalk, and attempted to enter an adjacent church just off the facility grounds and fell , breaking his jaw. The facility's failure to provide adequate supervision to R1 and ensure all the alarmed doors were armed created a finding of Immediate Jeopardy which began on [DATE]. NHA A (Nursing Home Administrator) was notified of the immediate jeopardy on [DATE] at 2:10 PM. The Immediate Jeopardy was removed on [DATE]; however, the deficient practice continues at a scope/severity of D (potential for harm/isolated) as the facility continues to implement its action plan and as evidenced by: R3 and R5 reside on the first floor which does not have a Wanderguard alarm system. R3 and R5 were at risk for elopement and had a Wanderguard. There was no alarm system to prevent R3 and R5 from exiting the building on the first floor. R2's Wanderguard tab was expired and still on R2's person. Findings include: The facility's policy titled Elopements and Wandering Residents states the following: *This facility ensures that residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk. (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 - Immediate jeopardy to resident health or safety Residents Affected - Few	*The facility is equipped with door locks/alarms to help avoid elopements. *Alarms are not a replacement for necessary supervision. Staff are to be vigilant in responding to alarms in a timely manner. *The facility shall utilize and establish a systematic approach to monitoring and managing residents at risk for elopement or unsafe wandering, including identification and assessment of risk, evaluation and analysis of hazards and risk, implementing interventions to reduce hazards and risks, and monitoring for effectiveness and modifying interventions when necessary. *Residents will be assessed for risk of elopement and unsafe wandering upon admission and throughout their stay by the interdisciplinary care team. *The interdisciplinary team will evaluate the unique factors contributing to risk in order to develop a person-centered care plan. *Interventions to increase staff awareness of the resident's risk, modify the resident's behavior, or to minimize risk associated with hazards will be added to the resident's care plan and communicated to appropriate staff. *Adequate supervision will be provided to help prevent accidents or elopements. *Charge nurses and unit managers will monitor the implementation of interventions, response to interventions, and document accordingly. *The effectiveness of interventions will be evaluated, and changes will be made as needed. Any changes or new interventions will be communicated to relevant staff. R1 was admitted to the facility on [DATE] and has diagnoses that include dementia with psychotic disturbance and agitation. His most recent Minimum Data Set (MDS), dated [DATE], shows a Brief Interview for Mental Status (BIMS) score of 3, indicating R1 is severely cognitively impaired. A [DATE] elopement risk assessment indicates R1 is at risk for wandering. R1's care plan states, Focus .is potential elopement risk/wanderer related to diagnoses of dementia, history of sundowning, independently mobile .Interventions: . resident's behavior is de-escalated by 1:1, talk about Alabama sports, initiated [DATE]. The facility documented the following progress notes for R1: *[DATE] at 4:44 PM: .increase in behaviors of exit seeking 1530 (3:30 PM) until 1600 (4:00 PM). Unsuccessful using distraction: drinks, snacks, stuffed dog in resident's room, use of wheelchair, folding towels, walking with staff in hallways, conversing with other residents. Staff kept eyes on resident while gathering residents to dining room for dinner meal. At 1610 (4:10 PM) writer inquired staff of resident's whereabouts, resident not seen on primary floor. Writer in search of resident, noted to be in front of facility building, with dirt on hands. Denied falling or hitting head, vitals, and neuros (neurological checks to check for head/brain injury) completed all within normal limits .resident stated, I don't remember I might have slipped or tripped or whatnot. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Of note, the facility did not have a report or investigation of R1's elopement from the facility on [DATE]. Although administration was aware of the incident, it is not known or documented as to whether the alarm system was working at that time. No documentation was provided to surveyors. The facility documented the following progress notes for R1: *[DATE] at 3:42 AM: Reported to writer in report that resident had been at nurse station with previous nurse for supervision. When previous nurse left floor, resident began pacing, attempting to leave on the elevator, going into other residents' rooms, yelling down hallways. *[DATE] at 1:11 PM: Continues pacing hallway wanting to leave to get to his wife. Resident first stated he needed to get to the grocery store on Main Street, that his wife was waiting for him there. Resident was seen in dining room after he had taken the screen off a window and was attempting to climb out the window to get to his house four blocks down the road. *[DATE] at 3:00 PM: Resident has been awake all AM shift. He has been walking all around the floor also went into the elevator and down to the ground floor. He also was running at top speed he came running around a corner by the nurses station and stumbled but writer caught him before he was able to fall. He was undirectable, agitated at times, very strong physically with staff when they tried to redirect him for safety sake. Again, insisting at times to go out the fire doors, to the car lot, or the farm. The facility documented and reported to the State Agency an incident which occurred on [DATE], stating, On Sunday [DATE], at approximately 11:00 PM R1 was discovered in the rear parking lot of the facility. CNA (Certified Nursing Assistant) was in the process of going outside to meet her husband who had brought her food for the night shift. As CNA went to exit the building, she observed an unattended wheelchair by the rear exit. She immediately exited the building and was met by her husband who noted that there was a man walking by the building. CNA continued her pursuit and found resident (R1) approximately 30 feet from the property at the entrance of the adjacent church. She noted he was standing upright and attempting to gain access to the church. Additional details of the event as documented in the report: *911 was called and EMS (Emergency Management Services) was contacted. *R1 was transferred to the local ED (Emergency Department) and returned the next morning ([DATE]) at 4:00 AM. *R1 was wearing a Wanderguard, but no alarm sounded on his second-floor unit when he exited. Facility documentation shows R1's Wanderguard was checked to be functioning correctly at 10:16 PM the night of [DATE]. *The maintenance director was contacted and reported to the facility around 1:00 AM ([DATE]) and found the Wanderguard system to be functioning properly. The ED (Emergency Department) found R1 to have a closed fracture of left condylar process of mandible (broken jaw close to left ear), 3 mm (millimeter) chin laceration that is 3 mm deep - not down to bone with 6 sutures placed, and a contusion of the left knee. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility's plan after the event to prevent a similar event included: *Maintenance to check the entire wander system to ensure functioning properly and to audit the wander system weekly x 4 weeks to ensure functioning properly. *Any resident who is exit seeking and not able to redirect, Administrator, DON (Director of Nursing) or Unit Manager will be updated, and resident will be placed on 1:1 until DON or Administrator removes 1:1. *All staff education regarding double doors near the kitchen, doors at the equipment room, doors at locker room and near employee entrance near stairs will be kept closed at all times. Signs were placed on the doors. On [DATE] at 3:50 PM, Surveyor interviewed CNA C, who was the staff member to find R1 in the parking lot. CNA C stated that her husband saw R1 fall onto his face in front of the church prior to her arrival in the parking lot. According to CNA C, her husband stated that R1 had fallen onto his face and let out a gasp in pain. On [DATE] at 3:40 PM, Surveyor interviewed CNA F who stated that she was working on the second floor on [DATE] and had just walked past his (R1's) room while doing rounds around 10:30 PM. CNA F stated she went downstairs to take her 15-minute break and saw R1's wheelchair wedged in the doorway of the staff stairwell exit. CNA F stated she saw CNA C outside and the ambulance was already there. CNA F stated that she had not heard any alarms sounding at any point during her shift and had not been aware of an issue until she had seen R1's wheelchair wedged in the stairwell doorway on her way out of the building on her break. On [DATE] at 11:34 AM, Surveyor walked with MD D (Maintenance Director) the length of distance R1 traveled from his 2nd floor unit to the exterior of the building on the night of [DATE]. The path started on the second-floor elevator which had a Wanderguard sensor on it and went down 2 levels to the ground floor. From the ground floor elevator, R1 propelled himself in his wheelchair the entire length of the building, approximately 300 feet, which goes by the facility's front reception desk, went through the double-doors to the kitchen, through the kitchen, into a maintenance area, through the employee section of the building, then left his wheelchair in a doorway at the base of a stairwell that leads out the back of the building, where staff enter through a rear parking lot area. R1 walked up the stairs and out the of the building. R1 then walked approximately 100 feet through the rear parking lot to an adjacent church. MD D stated that the facility was sure this was his route as his wheelchair was found in the doorway at the base of the stairs that leads to the rear exit of the building. Of note, the rear exit door that R1 exited on [DATE] was found to be unlocked from the inside when surveyors walked the route on [DATE] at 11:34 AM. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	It should be noted that the doors to the kitchen, maintenance area, and staff area remain open at all times. The front desk near the ground floor elevator is not staffed in the evening hours. The rear exit where R1 exited is unlocked on the inside but requires a key code entry from the outside. Additionally, the audit sheet MD D uses to audit the doors in accordance with the facility's proposed plan shows that the doors being audited are main entrance, rear entrance (no Wanderguard), small elevator, large elevator, and 4 additional stairwell doors on the second floor. According to MD D, doors on the 1st floor were not checked. There is no Wanderguard or alarm system on the first floor or ground floor elevator. On [DATE] at 11:54 AM, MD D showed Surveyor the doors on the second floor that he had been auditing/checking since the event took place on [DATE]. MD D used a handheld device to check the Wanderguard system on the 2nd floor elevator and one of the stairwell exit doors at the back of a wing on the second floor, both tested in working condition. However, 2 Wanderguard sensors on stairwell doors on the second floor were not being monitored. These doors have keypads that require a certain code to open. If the door is pushed without entering a code, the door alarms. However, if the code is entered and door opened, the Wanderguard system would provide a secondary alarm in the event that a resident with a Wanderguard attempted to go through the door before it closed. The Wanderguard system on these doors is a different brand than the others MD D had just checked. MD D attempted to use the handheld device to check the Wanderguard system on the magnetic doors and nothing happened. MD D then stated that he had not been checking the Wanderguard alarms on these magnetic-release type doors as he was not sure how to do so. R1's Progress Notes dated [DATE] at 10:11 PM: Resident was agitated during supper tonight. He was using abusive language, hitting, and kicking towards staff, and continuously wandering the hallways trying to escape. Resident had been given food and 1:1 conversation for redirection. R1's Progress Notes dated [DATE] at 9:54 PM: Around 7:30 PM resident was wandering into other residents' rooms and agitating other residents. Staff had to redirect him, and staff did 1 on 1. On [DATE] at 4:27 PM, during interview with Surveyor, LPN E (Licensed Practical Nurse), who wrote the [DATE] progress note regarding R1 in another resident's room, stated R1 was supposed to be 1:1 with a CNA on [DATE]. The CNA must have started rounding and getting other residents ready for bed. LPN E stated she looked where R1 had been near the nurse's station with the CNA on 1:1 and did not see him. LPN E stated that she started looking for R1 and found him in another resident's room. LPN E stated that she made sure that R1 remained 1:1 the remainder of the night. R1's Progress Notes dated [DATE] at 2:40 PM: Resident extremely agitated, continuously wandering the hallway and trying to leave facility. Writer notified by activity staff resident was found on the ground in dining room. Resident resistive to staff helping off ground, taking vitals or assessing .Resident on 1:1 with staff to ensure safety at this time. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility failed to ensure R1, who was at risk for elopement, had adequate supervision after a previous elopement on [DATE]. The facility did not document this event, it is unknown if the security features of the building were working at this time, and they were not regularly auditing these doors. R1 continued to exhibit exit-seeking behavior, attempting to exit a second story window on [DATE] and taking the elevator from the second floor to the ground floor on [DATE] before his eventual elopement later in the evening, which resulted in a fractured jaw. The facility did not put measures into place to ensure a similar event did not occur. R1 was to be placed on 1:1 when he was displaying exit-seeking behavior but he was not monitored on [DATE] when he was supposed to be on 1:1 due to his behaviors and was eventually found in another resident's room. Facility maintenance was not auditing their Wanderguard system on all doors on the second floor as was stated the facility would do and were not monitoring doors on the first or third floors where other residents reside. These failures created a reasonable likelihood for serious harm to occur, thus leading to a finding of immediate jeopardy. The immediate jeopardy was removed on [DATE] when the facility began implementing the following: *All other residents that had the potential for elopement and other safety concerns were assessed and care plans reviewed. *Maintenance to check the entire wander system to ensure proper functionality. This will include all 4 floors of the facility that contain wander system elements, as well as both the [NAME] and Wanderguard systems. *All residents that have a Wanderguard will have their Wanderguard bracelet checked to ensure proper functionality. This will include validation of activation dates and a replacement cycle equal to or less than 90 days. *All other residents who have the potential to leave out the doors were assessed. *Wander books were updated To ensure safety of residents, staff were educated prior to next working day on: Residents at Risk for Elopement Definition of 1:1 How to check Wanderguards Standing orders for Wanderguard's implementation Assigning staff to daily schedule in the event 1:1 is needed who will take 1:1 task. Educate staff with a clear understanding of what 1:1 means. Educate staff on how to input new standing orders for Wanderguards. *DON/designee audit conducted to ensure all standing orders for Wanderguards are clear accurate and match for when they need to be changed every 90 days. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	*Audit all Wanderguard bracelets to ensure an accurate date of change. *All staff will be provided with education prior to next working day regarding the double fire doors near the kitchen, the door at the equipment room, the door at the locker room and the door at the base of the employee entrance that these doors will be mandated always closed. *Signs were placed on the doors noting the need to keep them closed. *A secure key code lock will be placed on the equipment room door to ensure residents cannot access staff or unsecure outside exits. A staff person will be designated to monitor this door to prevent a resident from exiting until the key code lock is in place. *Maintenance will coordinate with a Wanderguard Vendor the possible installation of a Wanderguard sensor at the rear entrance and/or modification to the existing system *Maintenance will enhance the lighting in the rear employee parking area/service entrance. *The facility will complete an initial round of elopement drills on each shift. Facility reviewed the following policies: Elopement and Wandering residents Accidents and Supervision *Nursing will test the residents Wanderguard bracelets to ensure functionality weekly going forward. The facility will then audit all resident Wanderguard bracelet tests weekly to ensure compliance for 4 weeks. *The facility will audit the 4 doors identified in the path of egress to ensure closure status for 4 weeks. *Maintenance will test the wander guard sensors at all doors on all 4 floors to ensure proper functionality weekly going forward. The facility will then audit all tests weekly to ensure compliance for 4 weeks. *The facility will review during the daily clinical IDT all residents that demonstrated exit seeking behavior during the previous day to ensure appropriate elopement interventions are implemented and the care plan is reviewed/revised as necessary. R3 and R5 had new elopement risk assessments completed, and it was determined they are no longer at risk. *All new admissions will have an elopement risk assessment upon admission *All current residents will have a quarterly elopement assessment and as needed with change. *Audits will be reviewed at QAPI. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	*Facility Assessment will be updated to reflect staffing needs to ensure proper management of individuals with exit seeking behavior. The deficient practice continues at a scope/severity of D (potential for harm/isolated) as the facility continues to implement its action plan and as evidenced by the following examples: Example 2: The facility employs a Wanderguard system that alarms when a resident with a Wanderguard (either on their person or wheelchair) passes through a doorway that has a compatible alarm system installed. The facility uses a model of Wanderguard tab that is good for 90 days once activated. At the end of 90 days, a new Wanderguard tab must be placed on the resident. The Wanderguards have an activation date printed on them, much like an expiration date, and the Wanderguard must be activated to start the 90-day clock. Residents in the facility that are deemed elopement risks have Wanderguards and orders for them to be changed every 90 days. R2 was admitted to the facility on [DATE] and has diagnoses that include dementia with psychotic disturbance. Her most recent Minimum Data Set (MDS), dated [DATE], shows a Brief Interview for Mental Status (BIMS) score of 2, indicating R2 is severely cognitively impaired. Her care plan indicates she is at risk to wander due to her dementia and has increased episodes of exit seeking in late afternoon/early evening. Her care plan states, Apply Wanderguard, monitor for placement/function, replace as needed ([DATE]). On [DATE] at 11:10 AM, R2's Wanderguard on her wheelchair was observed by Surveyor to say, in black handwriting, changed on [DATE]. RN G (Registered Nurse), who was with Surveyor, stated he would change the Wanderguard. Of note, R2's Wanderguard was beyond the recommended 90-day change date and there is no evidence that R2's Wanderguard was changed in July and if it had exceeded its life of 90 days of usage. Example 3: R3 was admitted to the facility on [DATE] and has diagnoses that include dementia. His most recent Minimum Data Set (MDS), dated [DATE], shows a Brief Interview for Mental Status (BIMS) score of 7, indicating R3 is severely cognitively impaired. His care plan states, Resident is an elopement risk/wanderer related to history of attempts to leave facility unattended. Goal: the resident will not leave facility unattended through the review date (target date [DATE].) The resident's safety will be maintained through the review date (target date [DATE]) .Interventions: Wanderguard to right wrist. R3's Treatment Administration Record (TAR) indicates the facility checks the placement and function of his Wanderguard three times per day. R3 resides on the first floor where there is no Wanderguard or alarm system on the elevator, nor are any doors on the first floor being audited or monitored. R3 was noted at the time of survey to be at risk for elopement according to R3's current plan of care. The facility was completing and the once-per-shift monitoring of their Wanderguard function and placement but there was no monitoring of the doors on the first floor and the first-floor elevator had no alarm at all, potentially allowing R3 to take the same route as R1 did on [DATE] without sounding any alarms. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 11:10 AM, Surveyor observed R3's Wanderguard on his right wrist and noted it read activate by [DATE] but did not have a date it was placed on resident. R3's TAR indicates this Wanderguard was to be replaced on [DATE] but it was not signed out as having been changed. No other documentation was provided indicating when it was replaced. Example 4: R5 was admitted to the facility on [DATE] and has diagnoses that include alcohol-induced dementia. His most recent Minimum Data Set (MDS), dated [DATE], shows a Brief Interview for Mental Status (BIMS) score of 1, indicating R5 is severely cognitively impaired. R5's care plan states he is an elopement risk/wanderer related to exit seeking. His care plan states, Wanderguard bracelet on right wrist . ([DATE]). R5's TAR indicates the facility checks the placement and function of his Wanderguard three times per day. R5 resides on the first floor where there is no Wanderguard or alarm system on the elevator, nor are any doors on the first floor being audited or monitored. At the time of the survey, R5 was noted to be at risk for elopement according to R5's current plan of care. The facility was completing the once-per-shift monitoring of their Wanderguard function and placement but there was no monitoring of the doors on the first floor and the first-floor elevator had no alarm at all, potentially allowing R5 to take the same route as R1 did on [DATE] without sounding any alarms. On [DATE] at 3:49 PM, NHA A (Nursing Home Administrator) stated that he had recently contacted the manufacturer of the alarms that the facility uses to find out how long they can function. NHA A stated the manufacturer recommended to not wear them beyond 90 days as they could not be guaranteed beyond that time, although they may still work. When Surveyor asked why R3 and R5 were residing on the 1st floor when there was no Wanderguard on the first-floor elevator, nor were the other stairwell doors being audited for functioning, NHA A stated R3 and R5 were probably not capable, at this point, of elopement. When asked if it was possible for R3 and R5 to take the same route R1 took on [DATE] given the first-floor elevator had no alarm and all other doors along that route were unlocked, NHA A stated yes and stated that the kitchen doors are now to remain shut at all times, even though they are not locked, they are heavy.