

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525681	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/09/2025
NAME OF PROVIDER OR SUPPLIER  Nazareth Health and Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38725</b></p> <p>Based on observation, interview and record review, the facility did not ensure that residents with pressure injuries receive necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new injuries from developing for 2 of 3 residents (R34 and R51) reviewed for pressure injuries.</p> <p>R34 did not have wound care treatments documented as completed in October and December.</p> <p>R51's pressure injury was left open to air for approximately 2 hours.</p> <p>This is evidenced by:</p> <p>The facility policy and procedure entitled Documentation of Wound Treatments dated 9/19/24, documents the following in part: .3. Wound treatments are documented at the time of each treatment. If no treatment is due, an indication on the status of the dressing shall be documented each shift (i.e., clean, dry, intact) .</p> <p>Example 1</p> <p>R34 is a long-term resident of the facility who is receiving Hospice services. R34's goal for her pressure injury is to be as comfortable as possible and be free from infection. R34 has the following diagnoses: myotonic muscular dystrophy (genetic disorder that causes progressive muscle weakness), protein-calorie malnutrition, palliative care (end of life care), neoplasm of endocrine glands (tumor), neoplasm of spinal cord, weakness, benign neoplasm of spinal meninges, underweight, and cord compression.</p> <p>R34's October Physician Orders include:</p> <p>-Wound care to ischial tuberosity: - cleanse SNS (sterile normal saline), - skin prep to peri wound, - Apply Manuka honey/Alginate to wound bed (cut to size), - cover with foam dressing daily and PRN (as needed) until healed then DC (discontinue) every day shift for wound care. Start date 8/30/24. End date 10/4/24.</p> <p>-Wound care to ischial tuberosity: - cleanse SNS (sterile normal saline), - skin prep to peri wound, - Apply Medi-honey GEL to wound bed, - cover with bordered foam dressing daily and PRN until healed then DC every day shift for wound care. Start date 10/4/24. End date 11/8/24.</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 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R34's October TAR (Treatment Administration Record):</p> <p>Ischial tuberosity had a blank box in TAR on 10/4/24, 10/11/24, 10/19/24, 10/24/24, and 10/28/24.</p> <p>R34's December Physician Orders include:</p> <p>-Cleanse wound with cleanser, protect periwound with Skin Prep, Apply Manuka honey/Alginate to wound bed, Cover wound with Foam, change daily, Change PRN for soiling and/or saturation, every day shift for wound care. Start date 11/8/24.</p> <p>R34's December TAR:</p> <p>Blank box in TAR on 12/6/24 and 12/27/24.</p> <p>It is important to note that despite the TAR not being signed out for the above dates, R34's wounds did not cause more pain or become infected.</p> <p>On 1/9/25 at 1:34 PM, Surveyor interviewed LPN C (Licensed Practical Nurse). Surveyor asked LPN C if there is a blank in the TAR what does that indicate, LPN C said someone didn't click it off, if they would have clicked it and put refused or whatever it would show their initials and a number code, if blank someone probably didn't do it. Surveyor asked LPN C should treatments be signed out and completed as ordered, LPN C stated yes, the order should be done, if not signed out it wouldn't have been done, physician orders should be carried out as ordered and signed off.</p> <p>On 1/9/25 at 3:28 PM, Surveyor interviewed DON B (Director of Nursing). Surveyor asked DON B if there is a blank in the TAR what does that indicate, DON B said they forgot to sign it out. Surveyor asked DON B if the blank could indicate that the treatment was not completed, DON B stated it could. Surveyor asked DON B if she expects all treatments to be done as ordered, DON B stated yes.</p> <p>49436</p> <p>Example 2</p> <p>R51 admitted to the facility on [DATE].</p> <p>R51's physician orders for January 2025 include left inner gluteal cleft: cleanse with wound cleanser, pat dry, apply Santyl to wound bed, zinc to peri-wound, cover with foam dressing change daily and as needed.</p> <p>On 1/7/25 at 10:53 AM, Surveyor observed R51 in bed with no dressing on her gluteal pressure injury. Surveyor interviewed RN F (Registered Nurse) regarding R51's pressure injury being open to air with no dressing in place. RN F indicated R51 had a shower earlier and the dressing had not replaced after R51's shower. RN F indicated a wound should not remain uncovered for more than 30 minutes. RN F indicated prolonged exposure to air can hinder wound healing.</p> <p>On 1/7/25 at 11:30 AM, Surveyor interviewed CNA H (Certified Nursing Assistant) regarding R51's shower. CNA H indicated R51's shower was done before 9:00 AM.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 1/9/25 at 9:05 AM, Surveyor interviewed DON B (Director of Nursing) regarding wound care. DON B indicated a wound should not be left uncovered and the dressing should have been applied after R51's shower without delay.</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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 44552</p> <p>Based on observation, interview, and record review, the facility failed to ensure they provided adequate supervision and assistance to prevent accidents for 1 (R11) of 4 residents reviewed for accidents and supervision.</p> <p>R11's care plan indicates R11 needs supervision for all meals. Surveyor observed R11 eating meal in his room alone. R11 indicated it was difficult to eat the meal.</p> <p>Evidence by</p> <p>The facility policy, Activities of Daily Living, dated 8/24, states, in part; .2. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene .</p> <p>R11 was admitted to the facility on [DATE] with a diagnoses including parkinsonism (collection of movement symptoms- slow movements, stiffness, walking/balance issues, and/or tremors), dysphagia (difficulty swallowing), osteoporosis (bones become weak and brittle), tremor, and mild cognitive impairment.</p> <p>R11's most recent MDS (Minimum Data Set) dated 12/20/24, states that R11 has a BIMS (Brief Interview of Mental Status) of 15 indicating R11 is cognitively intact. R11 is own person.</p> <p>R11's care plan states, in part; .At nutrition risk r/t (related to) Parkinson's, mild cognitive impairment, weakness, tremors I would prefer finger foods as they are easiest for me to eat .I do not want items I have trouble eating such as spaghetti .date initiated 4/20/23 .revision 12/19/24 .The resident has a swallowing problem r/t coughing or choking during meals .Resident to eat only with supervision .initiated: 9/30/24 .</p> <p>On 1/7/25 at 12:10PM, Surveyor observed R11 eating in his room alone. R11 was eating spaghetti and having difficulty scooping up the noodles. Surveyor asked R11 how lunch was going. R11 stated difficult, and that R11's food was delivered cold.</p> <p>On 1/8/25 at 10:41AM, RN I (Registered Nurse) indicated R11 needs supervision for all meals.</p> <p>On 1/8/25 at 11:03AM, ST J (Speech Therapist) indicated R11 should have supervision for meals. ST J indicated it is her expectation if a resident care plan states they should have supervision for meals the facility must follow care plan.</p> <p>On 1/9/25 at 9:14AM, NHA A (Nursing Home Administrator) and DON B (Director of Nursing) indicated they would expect staff to follow resident care plan for supervision and preferred food items. NHA A and DON B indicated understanding with concern for R11.</p> <p>The facility failed to ensure they provided adequate supervision and supports per resident care plan.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 38725</p> <p>Based on interview and record review the facility did not ensure that pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident, this affected 2 of 2 residents reviewed for med errors, 1 sampled resident (R38) and 1 supplemental resident (R50).</p> <p>R38 had the wrong pain medication administered on 8/15/24 and 8/16/24.</p> <p>R38's narcotic count was not accurate on 9/26/24.</p> <p>RN G (Registered Nurse) used a contaminated pill cutter to cut an unscored tablet for R50.</p> <p>This is evidenced by:</p> <p>The Facilities Policy and Procedure entitled Medication Administration dated 10/2024 documents in part: .9. Ensure that the six rights of medication administration are followed: a. Right resident, b. Right drug, c. Right dosage, d. Right route, e. Right time, f. Right documentation .16. Administer medication as ordered in accordance with manufacturer specifications .c. Crush medications as ordered. Do not crush medications with do not crush instructions .</p> <p>The Facilities Policy and Procedure entitled Medication Errors dated 2/22/24 documents in part: .Medication error means the observed or identified preparation of administration of medications or biologicals which is not in accordance with the prescriber's order; manufacturer's specification (not recommendations) regarding the preparation and administration of the medication or biological; or accepted professional standards and principles which apply to professionals providing services .Policy Explanation and Compliance Guidelines: 1. The facility shall ensure medications will be administered as follows: a. According to physician's orders. b. Per manufacturer's specifications regarding the preparation, and administration of the drug or biological. c. In accordance with accepted standards and principles which apply to professionals providing services .4. The facility will consider factors indicating errors in medication administration, including, but not limited to, the following: a. Medication administered not in accordance with the prescriber's order. Examples include, but not limited to: i. Incorrect dose, route of administration, dosage form, time of administration .b. Medication administered not in accordance with the manufacturer's specifications (not recommendations) regarding the preparation and administration of the medication or biological. Examples include, but not limited to: .ii. Crushing do not crush medications .7. To prevent medication errors and ensure safe medication administration, nurses should verify the following information: a. Right medication, dose, route, and time of administration b. Right resident and right documentation .</p> <p>R38 is a long-term resident of the facility. R38 has the following diagnoses: polyosteoarthritis (arthritis that affects 5 or more joints), pain in right shoulder, pain in right elbow, osteoarthritis (chronic disease that causes breakdown of cartilage and other tissues in the joints), gout (form of arthritis), and low back pain.</p> <p>RN G (Registered Nurse) used a contaminated pill cutter to cut an unscored tablet for R50.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Example 1</p> <p>R38's August Physician Orders document:</p> <p>-Hydrocodone-Acetaminophen Oral Tablet 5-325 mg (milligrams) Give 1 tablet by mouth four times a day for pain</p> <p>R38's Telephone Orders for 8/14/24 document:</p> <p>1) Oxycontin ER 10 mg tablet po (by mouth) BID (twice per day) Dx (diagnosis): pain</p> <p>2) Oxycodone 5 mg every 6 hours PRN (as needed) Dx: pain</p> <p>3) D/C (discontinue) Hydrocodone</p> <p>4) Monitor every shift for increased sedation r/t (related to) Oxycontin, update</p> <p>R38's MAR (Medication Administration Record) documents:</p> <p>-Oxycodone HCl Tablet 10 mg Give 1 tablet by mouth two times a day for pain. Start date 8/14/24. End date 8/16/24.</p> <p>This medication is signed out twice (AM and PM) on 8/15/24 and once (AM) on 8/16/24.</p> <p>-Oxycontin Oral Tablet ER 12 Hour -Abuse-Deterrent 10 mg (Oxycodone HCl) Give 10 mg by mouth two times a day for pain. Start date 8/16/24.</p> <p>-Oxycodone HCl Oral Tablet 5 mg (Oxycodone HCl) Give 1 tablet by mouth every 6 hours as needed for pain. Start date 8/14/24.</p> <p>R38's Controlled Drug Record Count Sheet documents:</p> <p>-Oxycodone HCl (IR) 5mg tablet issued 8/14/24, 10 tablets dispensed</p> <p>-8/16/24 at 0830 (8:30 AM) 2 tablets were signed out</p> <p>The medication errors on 8/15/24 and 8/16/24 were due to the incorrect order being transcribed twice a day for scheduled pain medication.</p> <p>R38's September Physician Orders document:</p> <p>-Oxycontin ER 12 Hour Abuse-Deterrent 10 mg Give 10 mg by mouth two times a day for pain</p> <p>-Oxycodone HCl Oral Tablet 5 mg Give 1 tablet by mouth every 6 hours as needed for pain</p> <p>R38's Controlled Drug Record Count Sheet documents:</p> <p>-Oxycodone HCl (IR) 5mg tablet issued 8/23/24, 8 tablets dispensed</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-9/26/24 count on this form goes from 5 tablets to 3 tablets</p> <p>The facility identified that the count on R38's controlled drug record was wrong and identified that someone had taken 2 tablets from R38's card instead of another residents' card. Therefore, R38's care was inaccurate with 2 few tablets and the other resident's card was also inaccurate with 2 many tablets.</p> <p>On 1/9/25 at 10:06 AM, Surveyor interviewed DON B (Director of Nursing). Surveyor asked DON B if R38 had any medication errors August 2024-present, DON B stated there are no medication errors for R38.</p> <p>On 1/9/25 at 3:29 PM, Surveyor interviewed DON B. Surveyor asked DON B if on 8/15-8/16/24 if the medications Oxycodone and Oxycontin could have been inverted (used in place of the other), DON B replied yes. Surveyor asked DON B if she could explain how the error occurred on 9/26/24, DON B explained that the wrong card of medication was taken for another resident and that is why R38's count was incorrect. Surveyor asked DON B if there should be medication error reports for these issues, DON B said yes.</p> <p>49436</p> <p>Example 2</p> <p>R50 admitted to the facility on [DATE].</p> <p>R50's physician orders dated 1/9/25 include Vitamin D3 oral capsule 25 mcg, give 1 capsule by mouth in the morning.</p> <p>On 1/8/25 at 8:06 AM, Surveyor observed RN G (Registered Nurse) prepare R50's medications. During this observation, RN G removed a Vitamin D 50 mcg tablet from the medication bottle. Surveyor observed the Vitamin D 50 mcg tablet was not a scored tablet. RN G opened the pill cutter to cut the Vitamin D 50 mcg tablet in half. Surveyor observed the pill cutter contained white chunks and powder from previously cut medications. Surveyor also observed the cutting blade contained white powder. RN G placed the Vitamin D 50 mcg tablet into the pill cutter and cut the pill in half. RN G placed the cut Vitamin D into a medication cup to administer to R50. Surveyor stopped RN G and interviewed RN G regarding the preparation of R50's medications. RN G indicated the pill cutter was contaminated with unknown medication residue and she should have cleaned the pill cutter prior to cutting R50's Vitamin D. Surveyor interviewed RN G regarding which medications are allowed to be cut in half. RN G indicated only medications that are scored should be cut in half. RN G indicated she should not cut the Vitamin D tablet in half since it was not a scored tablet.</p> <p>On 1/9/25 at 9:07 AM, Surveyor interviewed DON B (Director of Nursing) regarding medication administration. DON B indicated the pill cutter should be clean prior to cutting a medication. DON B also indicated an unscored tablet should not be cut.</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44552</b></p> <p>Based on observation, interview, and record review, the facility did not ensure that each resident receives food and drink that is palatable and at a safe and appetizing temperature. This has the potential to affect all 65 residents residing at the facility.</p> <p>Residents (R) voiced concern with hot foods being served cold and cold foods being served warm. (R46, R11, R5, R31, R4, R58, and R55)</p> <p>2 of 2 test trays were observed to not be served at desirable temperatures.</p> <p>Evidenced by:</p> <p>The facility policy Food Temperatures, dated 2023, states in part: .1. All hot food items must be cooked to appropriate internal temperatures, held and served at a temperature of at least 135 F .</p> <p>Example 1:</p> <p>R46 was admitted to the facility on [DATE]. On 1/7/25 at 9:58AM, R46 indicated hot food is often served cold in the dining room. R46 indicated they discuss food concerns at the monthly resident council meeting.</p> <p>Example 2:</p> <p>R11 was admitted to the facility on [DATE]. On 1/6/25 at 3:17PM, R11 indicated the food was supposed to get better under new management in the kitchen. R11 indicated R11 still has concerns with the meals. R11 indicated he eats in his room and that food is not always palatable, hot foods are served cold, and the portions are small.</p> <p>Example 3:</p> <p>On 1/7/25 at 8:28AM, Surveyor received the last tray that was being served in dining room on the first floor. Scrambled eggs temped at 98.9 F, bacon 85.4 F, oatmeal 105.8 F, and the toast was hard. All food tasted cold and was not palatable.</p> <p>Example 4:</p> <p>On 1/7/25 at 11:59AM, Surveyor received the last room tray that was being served on the third floor. Spaghetti with meat temped at 125 F, garlic bread 108 F, and mixed vegetables 109 F. The milk temped at 45.5 F and juice 42.8. The hot food was cold and the milk and juice warm and not palatable.</p> <p>On 1/8/25 at 3:11PM, Food and Service Director D and District Manager E Indicated they would expect hot foods to be served hot and cold foods to be served cold. Both indicated understanding with the concerns voiced by residents and test tray temperatures.</p> <p>(continued on next page)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>The facility failed to ensure that each resident receives food and drink that is palatable and at a safe and appetizing temperature.</p> <p>38725</p> <p>Example 5:</p> <p>On 1/6/25 at 11:02 AM, Surveyor interviewed R58. Surveyor asked R58 how the food is at the facility, R58 said not good. Surveyor asked R58 if his hot foods are hot and cold foods are cold. R58 stated hot foods are lukewarm and cold foods are warm. Surveyor asked R58 if there was anything else about the food he wanted to share. R58 replied all the meat is mysterious.</p> <p>Example 6:</p> <p>On 1/6/25 at 2:50 PM, Surveyor interviewed R31. Surveyor asked R31 how the food is at the facility, R31 said it's ok. Surveyor asked R31 what would make it better? R31 said if the vegetables weren't cold.</p> <p>49436</p> <p>Example 7:</p> <p>R5 admitted to the facility on [DATE] with diagnoses including rheumatoid arthritis in left and right hand (a chronic inflammatory disorder usually affecting small joints in the hands) and acquired absence of right and left leg above knee (amputation of both legs above the knee).</p> <p>On 1/7/25 at 9:58 AM, Surveyor interviewed R5 regarding food temperatures at mealtimes. R5 indicated he eats his meals in the dining room and the resident lounge. R5 states the hot foods are served cold. R5 states there is a small microwave in the other room (not in the dining room) the facility can use to warm up the food, but it takes forever for the staff to warm up the food.</p> <p>50285</p> <p>Example 8:</p> <p>R55 was admitted to the facility on [DATE]. Her most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/11/24, indicates her cognition is intact with a Brief Interview for Mental Status (BIMS) of 15 out of 15.</p> <p>On 1/6/25 at 10:14 AM, Surveyor interviewed R55 who indicated that most of the time the food that is served is not hot. R55 stated especially the french fries are always cold, and that every day the food that is served is lukewarm at best.</p> <p>On 1/6/25 at 12:04 PM, Surveyor observed dining service on the 300 unit, and noted that french fries were being served for lunch. Surveyor approached R55 and asked her about the french fries on her plate. R55 indicated they were not warm at all and that they looked undercooked. R55 then held up a french fry from her plate and stated, See they are soft and limp. They should not really even call them french fries because they are not.</p> <p>(continued on next page)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Example 9:</p> <p>R4 admitted to the facility on [DATE]. His most recent MDS with an ARD of 11/5/24 indicates his cognition is intact with a BIMS score of 15 out of 15.</p> <p>On 1/6/25 at 11:59 AM, Surveyor observed dining service on the 300 unit and noted that R4 declined what was being served for lunch and requested soup. Staff brought R4 a bowl of soup at 12:04 PM. Surveyor heard R4 comment to his tablemates that the soup was a little bit warm.</p> <p>On 1/6/25 at 2:52 PM, Surveyor interviewed R4 who stated that breakfast is okay but after that the food is downhill. R4 stated that the meals were not very good and that the food is never hot. R4 indicated that breakfast is sometimes lukewarm. R4 stated that all the staff know that the food is cold and sometimes they have to heat it up in the microwave, but usually he tries to eat it as fast as he can and go back to his room.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525681	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/09/2025
NAME OF PROVIDER OR SUPPLIER  Nazareth Health and Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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.			
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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>44552</p> <p>Based on observation, interview, and record review, the facility did not maintain a safe and sanitary environment in which food is prepared, stored, and distributed. This has the potential to affect all 65 residents who reside in the facility.</p> <p>FSD D (Food Service Director) was taking temperatures of lunch on 1/6/25. Surveyor observed FSD D wearing gloves touching items in FSD D pocket, thermometer, alcohol wipes, hot pad, lids on pans, and then directly touch chicken with same pair of gloves. Surveyor observed FSD D then go to dishwashing room and touch items, use cell phone, and touch steam table with same pair of gloves on. Surveyor observed no changing of gloves or hand washing.</p> <p>Evidenced by</p> <p>The facility policy, General Food Preparation and Handling, dated 2023, states, in part; .Food items will be prepared to conserve maximum nutritive value, develop, and enhance flavor and keep free of harmful organisms and substances .h. Bare hands should never touch ready to eat raw food directly. Disposable gloves are a single use item and should be discarded after each use. Employees should wash their hands prior to putting gloves on and after removing gloves .</p> <p>On 1/6/25 at 10:18AM, Surveyor observed FSD D (Food Service Director) temping food that was being served for lunch. Surveyor observed FSD D wearing gloves. FSD D was observed touching items in FSD D's pocket, including a thermometer, alcohol wipes, a hot pad, 2 lids on pans, and then directly touch chicken multiple times with the same pair of gloves on. Surveyor observed FSD D then go to dishwashing room and touch items, use cell phone, and touch steam table with the same pair of gloves on. Surveyor observed no changing of gloves or hand washing.</p> <p>On 1/8/25 at 3:11PM, Food and Service Director D and District Manager E indicated they would expect staff to change gloves and wash hands before and after directly touching food items.</p> <p>The facility failed to maintain a safe and sanitary environment in which food is prepared, stored, and distributed.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49436</p> <p>Based on observation, interview and record review the facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections</p> <p>RN F touched items within resident room with dirty gloves.</p> <p>R319 was admitted with a pressure injury (PI) and previous wound infection. During observation of wound care, the facility failed to utilize standard infection control practices.</p> <p>This is evidenced by:</p> <p>The facility policy Clean Dressing Change dated 10/2024, states, in part: .17. Discard disposable items and gloves into appropriate trash receptacle and wash hands. 18. Return resident to a comfortable position .</p> <p>Example 1</p> <p>On 1/7/25 at 10:53 AM, Surveyor observed RN F (Registered Nurse) perform wound care for R51. Surveyor observed RN F complete R51's dressing change. RN F removed the old dressing and RN F proceeded to discard the used wound care supplies and with same gloves, RN F touched the bed side table and bed controller. RN F then stated she should take the gloves off. RN F removed gloves and then performed hand hygiene. Surveyor observed RN F complete wound care. Surveyor observed RN F, with gloved hands, apply R51's dressing. Surveyor interviewed RN F regarding touching the bed side table and bed controller with dirty gloves. RN F indicated she should have removed her gloves and performed hand hygiene prior to touching anything.</p> <p>On 1/9/25 at 9:05 AM, Surveyor interviewed DON B (Director of Nursing) regarding wound care. DON B indicated RN F should have performed hand hygiene before touching the bed side table and bed controller.</p> <p>50285</p> <p>Example 2</p> <p>R319 was admitted to the facility on [DATE] with diagnoses that include pressure ulcer of sacral region, stage 4, type 2 diabetes mellitus without complications, need for assistance with personal care, cognitive communication deficit, unspecified abnormalities of gait and mobility, and depression unspecified.</p> <p>R319's Admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/24/24, documented R319 was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 15. Section M of the MDS indicates that R319 had a Stage 4 (full thickness tissue loss with exposed bone, tendon, or muscle, slough or eschar may be visible on some parts of the wound bed, may include undermining or tunneling) PI on admission.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R319's discharge paperwork from the hospital dated 12/10/24 indicates in part: (R319) who is being admitted today with sacral wound infection . she developed a sacral wound and has been following at wound care clinic . today she was at the wound care clinic and there was suspicion for abscess so she was sent back to ED (Emergency Department) . CT (computed tomography) showed abscess and General Surgery debrided it at the bedside . previous culture shows MRSA (methicillin-resistant Staphylococcus aureus, a bacterial infection that does not get better with usual antibiotics) and Morganella (an opportunistic pathogen that mainly causes post-operative wound infections) with some resistance . Patient Active Problem List includes pressure injury of buttock, unstageable and Skin ulcer of sacrum, unspecified ulcer stage.</p> <p>R319's admission Weekly Skin Charting on 10/20/24 indicates that R319 had a pre-existing open area to left buttock.</p> <p>R319's admission Skin Assessment on 12/20/24 indicates a wound Stage 4 to left gluteus with measurements of 1.96 cm (centimeters) by 1.44 cm.</p> <p>R319's physician orders include an order to treat the left gluteus wound: Cleanse wound with saline, protect periwound with skin prep, apply Hydrofera Blue or Derma Blue (cut to size) to wound bed, cover wound with Bordered Gauze, change daily, change PRN (as needed) for soiling and/or saturation, as needed.</p> <p>R319's Care Plan includes in part: . Focus: (R319) has actual impairment to skin integrity of the left gluteus , stage 4 at risk for further skin breakdown . Intervention: pressure reducing cushions, to protect the skin while up IN CHAIR. pressure reducing mattress to protect the skin while IN BED . Intervention: Assist me with my general hygiene and comfort measures . Intervention: Consult Dietary for my nutritional needs, Encourage good nutrition and hydration in order to promote healthier skin . Intervention: Encourage/assist me to elevate heels, Encourage/assist me with reposition as needed . Intervention: Follow facility protocols for treatment of injury . Intervention: My skin will be assessed on a weekly basis on my scheduled bath day and document findings on a weekly skin assessment, Report any skin redness/impaired integrity areas to my nurse . Intervention: Weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate and any other notable changes or observations . Intervention: Use barrier cream to prevent skin impairment issues, as needed, Wound doctor to follow wound progression .</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 1/7/25 at 10:15 AM, Surveyor observed wound care for R319. RN F (Registered Nurse) gathered the supplies to perform wound care, entered R319's room and performed hand hygiene. RN F donned appropriate PPE (personal protective equipment) including gown and gloves. RN F placed an unused garbage bag at the end of R319's bedside table. RN F stated she planned to tape the garbage bag to the end of the bedside table but forgot the tape. RN F assisted R319 to bed and completed the wound care according to physician orders, performing hand hygiene and glove changes as appropriate. RN F then began to clean up, but the loose garbage bag fell on the floor with the old, soiled dressing falling out onto the floor, as well as used gloves and paper towels. RN F picked up the trash and placed it back in the garbage bag. As RN F was walking toward R319's door, the soiled trash fell on to the floor again. RN F picked up the trash and placed it back in the garbage bag a second time. RN F placed trash bag into a larger trash receptacle inside R319's door. RN F then stated that she had forgotten to give R319 back her call light. Surveyor observed RN F go back to R319's bedside and gave her the call light and put bedside table back near R319's bed, still wearing the soiled gloves she had used to pick up the trash off the floor. RN F then removed soiled gloves and washed hands before leaving R319's room. Surveyor asked RN F when it was appropriate to change gloves during wound care. RN F answered any time touching a dirty area and going to a clean area. Surveyor asked RN F if she had changed gloves after picking up the trash and soiled dressing and before she touched the resident's belongings such as call light and bedside table. RN F stated she couldn't remember but that she probably forgot because she had been so nervous. Surveyor asked RN F if touching dirty paper towels, dirty gloves, and soiled bandage would be a potential for infection. RN F stated yes, that would be possible.</p> <p>On 1/9/25 at 7:32 AM, Surveyor interviewed DON B (Director of Nursing) about infection control practices. Surveyor asked DON B when it is appropriate to change gloves and perform hand hygiene during wound care. DON B stated gloves should be changed and hand hygiene should be performed anytime the nurse goes from dirty to clean and hand hygiene should be performed before putting on gloves and after removing them. Surveyor asked DON B if the nurse should remove soiled gloves and perform hand hygiene after picking up soiled bandages, paper towels, and gloves and before touching the resident's belongings. DON B stated yes, the soiled gloves should be removed and hand hygiene performed before touching resident's belongings.</p>		