| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 525686 | A. Building<br>B. Wing | 02/25/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Muskego Health and Rehabilitation Center | S77 W18690 Janesville Rd<br>Muskego, WI 53150 |

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 0559<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38829<br><br>Based on interview and record review the facility did not ensure that 1 (R1) of 1 Residents reviewed for a room change within the facility, were provided with prior written notice, including reason for the room change.<br><br>*R1 transferred to another room on an unknown date and there is no documentation R1 and/or guardian received prior written notice and gave consent for the reason for the transfer. On 2/14/25, R1 was transferred to yet another room and there is no documentation R1 and/or guardian received prior written notice and gave consent for the reason for the transfer.<br><br>Findings Include:<br><br>The facility's policy Change of Room or Roommate implemented 3/7/23 documents:<br><br>.Policy: It is the policy of this facility to conduct changes to room and/or roommate assignments when considered necessary and/or when requested by the Resident or Resident representative.<br><br>Policy Explanation and Compliance Guidelines:<br><br>4. Prior to making a room change or roommate assignment, all persons involved in the change/assignment, such as Residents and their representatives, will be given advance notice of such a change as is possible.<br><br>5. The notice of a change in room or roommate will be provided in writing, in a language and manner the Resident and representative understands and will include the reason(s) why the move or change is required.<br><br>6. The social service staff can assist the Resident to adjust to the new room or roommate by:<br><br>a. Informing the Resident and family as soon as possible of the room or roommate change<br><br>b. Involving the Resident in the decision and selection of a room or roommate when possible<br><br>c. Allowing the Resident to ask questions about the move<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0559<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | d. Showing the Resident where the room is located<br><br>e. Introducing the Resident to his/her new roommate and sharing information about the new roommate while maintaining confidentiality regarding medical information in order to help the Resident become acquainted<br><br>f. Introducing the Resident to employees who will be providing care<br><br>g. Explaining to the Resident why the change is necessary; reassuring the Resident his/her personal possessions will be safeguarded .<br><br>The facility's policy Notification of Changes implemented 10/24/25 and last revised 8/27/24 includes notice of room changes.<br><br>R1 was admitted to the facility on [DATE] with diagnoses of Cerebral Infarction due to Thrombosis of Right Middle Cerebral Artery, Hemiplegia and Hemiparesis Affecting Left Non-Dominant Side, Dysphagia, Anemia, Encephalopathy, Bipolar Disorder, Anxiety Disorder, and Schizophrenia. R1 has a legal guardian.<br><br>R1's Admission Minimum Data Set (MDS) completed on 1/23/25 documents R1 has a Brief Interview for Mental Status (BIMS) score of 13, indicating R1 is cognitively intact for daily decision making. R1's Patient Health Questionnaire (PHQ-9) is 10 indicating R1 has moderate depression. The only behavior documented on R1's MDS is verbal behaviors. R1 is always incontinent of bowel and bladder. R1 has range of motion (ROM) impairment on one side of both upper and lower extremity. R1 is dependent for showers, dressing, hygiene, mobility, and transfers.<br><br>R1's electronic medical record (EMR) documents R1 was admitted to room (100 range room number) and transferred to room (200 range room number) on 2/14/25. Surveyor reviewed R1's electronic medical record (EMR) and was not able to locate documentation of the room change.<br><br>On 2/19/25, at 10:29 AM, Surveyor left a message for R1's legal guardian with no return call.<br><br>On 2/19/25, at 1:50 PM, Surveyor interviewed Unit Manager/Social Services/Licensed Practical Nurse/Business Office Manager(UM/SS/LPN/BOM)-D. UM/SS/LPN/BOM-D informed Surveyor that R1 was transferred upstairs because R1 opened up the door downstairs and was found exiting through the door, out of the facility. UM/SS/LPN/BOM-D stated a room change form should have been completed and will look for it.<br><br>On 2/20/25, at 11:02 AM, Surveyor interviewed Licensed Practical Nurse (LPN)-E via telephone who informed Surveyor that R1 had been in room (different 200 range room number) but was transferred downstairs to room (100 range room number). People told them it wasn't a good idea to transfer R1 downstairs. LPN-E does not know why R1 was transferred downstairs.<br><br>On 2/20/25, at 11:10 AM, Surveyor interviewed Certified Nursing Assistant (CNA)-L via telephone regarding R1. CNA-L stated R1 was admitted to room (different 200 range room number) and transferred downstairs to room (100 range room number) and then transferred back upstairs to room (200 range room number). CNA-L is not sure why R1 was transferred to different rooms two times.<br><br>(continued on next page) |

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| F 0559<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 2/20/25, at 1:11 PM, Surveyor interviewed UM/SS/LPN/BOM-D again regarding R1's room transfers. UM/SS/LPN/BOM-D stated who ever is responsible for the room transfer completes the room change form and obtains consent. UM/SS/LPN/BOM-D recalls room (100 range room number) not being ready when R1 was admitted and so R1 was admitted to room [ROOM NUMBER]. UM/SS/LPN/BOM-D does not recall when R1 transferred from (different 200 range room number) to (100 range room number). UM/SS/LPN/BOM-D confirmed a room change form should be completed and contacting the responsible party to obtain consent should be done.<br><br>On 2/20/25, at 3:33 PM, Surveyor shared with Nursing Home Administrator (NHA)-A, Director of Nursing (DON)-B, and Director of Operations (DO)-C the concern that R1 was transferred to two different rooms with no documentation that R1 and R1's legal guardian were given advance notice and consented to the room transfer, and roommates were given notice. No further information was provided by the facility at this time. |

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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38829<br><br>Based on interview and record review the facility did not ensure 1 (R2) of 5 Residents reviewed sought consultation with the physician regarding significant weight loss, possible thrush, and the prescribed formula not being available for administration to R2.<br><br>Findings Include:<br><br>The facility's policy and procedure Notification of Changes implemented 10/24/23 and last revised 8/27/24 documents:<br><br>Policy:<br><br>.The purpose of this policy is to ensure the facility promptly informs the Resident, consults the Resident's physician; and notifies, consistent within his or her authority, the Resident's representative when there is a change requiring notification.<br><br>Changes of condition require an evaluation, using the situation, background, assessment, and recommendation (SBAR) Communication Form and Progress Note Evaluation ensures proper documentation and notification has been made.<br><br>Circumstances requiring notification include:<br><br>2. Significant change in Resident's physical, mental or psychosocial condition such as deterioration in health, mental or psychosocial status. This may include:<br><br>a. Life-threatening conditions<br><br>b. Clinical complications<br><br>3. Circumstances that require a need to alter treatment.<br><br>R2 was admitted to the facility on [DATE] with diagnoses of Other Nontraumatic Intracerebral Hemorrhage, Hemiplegia and Hemiparesis Affecting Right Dominant Side, Chronic Kidney Disease, Stage 4, and Depression. R2 has a legal guardian.<br><br>R2's Admission Minimum Data Set (MDS) completed 1/23/25 documents a Brief Interview for Mental Status (BIMS) score of 0, indicating R2 demonstrates severely impaired skills for daily decision making. R2's MDS documents R2's Patient Health Questionnaire (PHQ-9) score to be 12, indicating moderate depression. R2's MDS also documents R2 is always incontinent of bowel and bladder and has range of motion (ROM) impairment on both sides of upper and lower extremities. R2's MDS documents R2 is dependent for dressing, eating, transfers, mobility, hygiene, and showers. At the time of the MDS, R2 was nothing by mouth (NPO), and received complete nutrition through a gastrostomy tube (g-tube).<br><br>(continued on next page) |

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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | R2's electronic medical record (EMR) indicates that R2 understands yes and no questions and is able to nod head in answering yes and no questions with appropriate answers. R2 is also able to use cue cards.<br><br>R2 had a swallow study completed on 2/4/25 and was upgraded to a regular thin liquid diet. R2's bolus feedings of nepro 4 times a day was discontinued. The swallow study also documents that R2's tongue thrush needs to be treated. This recommendation is not documented it was communicated with R2's physician. R2's physician orders do not document a treatment was ordered.<br><br>-Licensed Practical Nurse (LPN)-P documents on 1/23/25 that LPN-P is awaiting pharmacy delivery of Bolus Feeding Formula Nepro 250 ml four times a day<br><br>-LPN-Q documents on 1/24/25 at 12:21 AM, 8:16 AM, and 9:11 AM that the Bolus Feeding Formula Nepro 250 ml is pending delivery.<br><br>-On 1/24/25, at 8:40 PM, LPN-E documents that LPN-E noticed in nursing documentation that R2 had missed times 4 bolus feedings due to Nepro not available. LPN-E informed Director of Nursing (DON)-B, Unit Manager and physician. LPN-E was informed Nepro was delivered today and was down in storage. LPN-E obtained vitals and administered feeding to R2 per order. Physician stated to continue current order. R2 is on by mouth (PO) diet as well.<br><br>Surveyor reviewed R2's electronic medical record (EMR) and notes the following documentation:<br><br>-On 1/28/25 Registered Dietitian (RD)-G documents that R2 had a significant weight loss times one week (-5.4%) (9 pounds)<br><br>-On 2/11/25 RD-G documents R2 has had a significant weight loss times 30 days(-6.9%) (11 pounds), Director of Nursing (DON)-B notified.<br><br>Surveyor was not able to locate documentation that R2's physician was notified and consulted with in regards to R2's significant weight loss.<br><br>On 2/11/25, R2's physician orders indicate that R2 was to receive nepro tube feeding times 8 hours, start at 10:00 PM and end at 6:00 AM. Registered Dietitian (RD)-G recommended this feeding due to R2 not eating enough calories at meals.<br><br>On 2/19/25, at 2:04 PM, Surveyor spoke with RD-G via telephone. Surveyor asked RD-G who notify's the physician when there is a significant weight loss. RD-G notify's Nursing Home Administrator (NHA)-A and DON-B of significant weight loss by email. RD-G does not have contact with the physician. RD-G explained that RD-G is in the facility one day a week.<br><br>On 2/19/25, at 3:25 PM, Surveyor interviewed DON-B in regards to a significant weight loss. DON-B stated that RD-G communicates to DON-B when there is a significant weight loss and it is the responsibility of the nurses to notify the physician.<br><br>(continued on next page) |

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|---|---|
| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 2/20/25, at 3:33 PM, Surveyor shared with NHA-A, DON-B, and Director of Operations (DO)-C the concern that RD-G documented R2 had a significant weight loss two different times and R2's EMR does not have documentation that R2's physician was notified and consulted with. NHA-A, DON-B, and DO-C understand the concern and provided no further information at this time. |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38829<br><br>Based on interview and record review, the facility did not protect 1 (R2) of 4 Residents by not implementing their written policies and procedures to prohibit and prevent the right to be free from verbal abuse from Certified Nursing Assistant (CNA)-H.<br><br>*Staff did not report allegations of verbal abuse immediately of a Resident by CNA-H, and consequently R2 was subjected to verbal abuse a couple of weeks later by CNA-H.<br><br>Findings Include:<br><br>The facility's Abuse, Neglect and Exploitation policy and procedure implemented 9/18/23 documents:<br><br>.It is the policy of this facility to provide protections for health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation, and misappropriation of resident property.<br><br>Policy Explanation and Compliance Guidelines:<br><br>1. The facility will develop and implement written policies and procedures that:<br><br>a. Prohibit and prevent abuse, neglect, and exploitation of Residents and Misappropriation of Resident property<br><br>b. Establish policies and procedures to investigate any such allegations<br><br>c. Include training for new and existing staff on activities that constitute abuse, neglect, exploitation, and misappropriate of Resident property, reporting procedures, and dementia management and Resident abuse prevention<br><br>2. The facility will designate an Abuse Prevention Coordinator in the facility who is responsible for reporting allegations or suspected abuse, neglect, or exploitation to the state survey agency and other officials in accordance with state law.<br><br>3. The facility will provide ongoing oversight and supervision of staff in order to assure that its policies are implemented as written.<br><br>II. Employee Training<br><br>A. New employees will be educated on abuse, neglect, exploitation and misappropriation of Resident property during initial orientation.<br><br>B. Existing staff will receive annual education through planned in-services and as needed.<br><br>C. Training topics will include:<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 1. Prohibiting and preventing all forms of abuse, neglect, misappropriation of Resident property and exploitation<br><br>2. Identifying what constitutes abuse, neglect, exploitation, and misappropriation of Resident property<br><br>3. Recognizing signs of abuse, neglect, exploitation and misappropriation of Resident property, such as physical or psychosocial indicators<br><br>4. Reporting process of abuse, neglect, exploitation, and misappropriation of Resident property including injuries of unknown sources<br><br>5. Understanding behavioral symptoms of Residents that may increase the risk of abuse and neglect.<br><br>III. Prevention of Abuse, Neglect, and Exploitation: The facility will implement policies and procedures to prevent and prohibit all types of abuse, neglect, misappropriation of resident property, and exploitation that achieves: .<br><br>B. Identifying, correcting, and intervening in situations in which abuse, neglect, exploitation, and/or misappropriation of resident property is more likely to occur with the deployment of trained and qualified registered, licensed, and certified staff on each shift in sufficient numbers to meet the needs of residents, and assure that the staff assigned have knowledge of the individual resident's care needs and behavioral symptoms.<br><br>C. Assuring an assessment of the resources needed to provide care and services to all Residents is included in the facility assessment.<br><br>D. The identification, ongoing assessment, care planning for appropriate interventions, and monitoring of residents with needs and behaviors which might lead to conflict or neglect.<br><br>H. Assigning responsibility for the supervision of staff on all shifts for identifying inappropriate staff behaviors.<br><br>B. Possible indicators of abuse include, but are not limited to:<br><br>5. Verbal abuse of a Resident overheard<br><br>VI. Protection of Resident<br><br>The facility will make efforts to ensure all Residents are protected from physical and psychosocial harm, as well as additional abuse, during and after the investigation.<br><br>A. Responding immediately to protect the alleged victim and integrity of the investigation<br><br>C. Increased supervision of the alleged victim and Residents<br><br>E. Protection from retaliation .<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | R2 was admitted to the facility on [DATE] with diagnoses of Other Nontraumatic Intracerebral Hemorrhage, Hemiplegia and Hemiparesis Affecting Right Dominant Side, Chronic Kidney Disease, Stage 4, and Depression.<br><br>R2's Admission Minimum Data Set (MDS) completed 1/23/25 documents a Brief Interview for Mental Status (BIMS) score of 0, indicating R2 demonstrates severely impaired skills for daily decision making. R2's MDS documents R2's Patient Health Questionnaire (PHQ-9) score to be 12, indicating moderate depression. R2's MDS also documents R2 is always incontinent of bowel and bladder and has range of motion(ROM) impairment on both sides of upper and lower extremities. R2's MDS documents R2 is dependent for dressing, eating, transfers, mobility, hygiene, and showers. At the time of the MDS, R2 was nothing by mouth(NPO), and received complete nutrition through a gastrostomy tube (g-tube).<br><br>R2's electronic medical record (EMR) indicates that R2 understands yes and no questions and is able to nod head in answering yes and no questions with appropriate answers. R2 is also able to use cue cards.<br><br>On 2/11/25, Licensed Practical Nurse (LPN)-E observed and heard R2 crying at approximately 9:30 AM. R2 could not articulate why R2 was crying and LPN-E (as documented in a written statement) provided comfort and safety. At approximately 9:45 AM, R2 was observed crying again and indicated R2 wanted assistance with using the telephone. R2 attempted to speak with R2's boyfriend on the phone, however, was crying so much that R2's boyfriend could not understand what was going on. R2's boyfriend informed LPN-E that he would have R2's daughter come to the facility to find out what was going on with R2. LPN-E documents in LPN-E's statement that LPN-E informed Unit Manager/Licensed Practical Nurse/Social Services/Business Office Manager (UM/LPN/SS/BOM)-D of R2 crying all morning and something didn't feel right about the situation. LPN-E stated this was about 11:00 AM.<br><br>CNA-H was assigned to R2. UM/LPN/SS/BOM-D and LPN-E both went and spoke with R2. R2 nodded yes that CNA-H was being mean and rough and requested another CNA to care for R2. LPN-E's statement documents about 11:40 AM, LPN-E witnessed CNA-H go into R2's room. Housekeeper (HKP)-F heard R2 crying and informed LPN-E that R2 was being changed by CNA-H. LPN-E immediately went to R2's room and asked if administration had spoke with CNA-H, and CNA-H stated no. At approximately noon, LPN-E observed Nursing Home Administrator (NHA)-A, UM/LPN/SS/BOM-D and CNA-H walk down and go into R2's room. LPN-E documents that CNA-H was allowed to work the entire shift. LPN-E indicates in LPN-E's statement that as LPN-E was in the car pulling in and CNA-H was pulling out and CNA-H started bobbing CNA-H's head and laughing at LPN-E. LPN-E felt humiliated. LPN-E was approached later in the afternoon at the nurse's station by NHA-A and UM/LPN/SS/BOM-D and was informed R2 was crying because R2 was in pain. Around 2:00 PM, R2's legal guardian came in, and after visiting with R2, went to NHA-A's office. According to LPN-E's statement that is when the investigation started.<br><br>Surveyor reviewed CNA-H's time punches for CNA-H's shift on 2/11/25. CNA-H was scheduled to work 5:00 AM-1:30 PM. CNA-H's time punch is 4:36 AM in and 1:30 PM out. CNA-H worked the entire shift increasing the chances other Residents could be vulnerable to abuse/neglect.<br><br>Documentation indicates the facility did not initiate an investigation until after CNA-H had left the building after CNA-H's shift. When gathering statements for the investigation, it was discovered that 2 facility CNAs and 1 hospice CNA had overheard verbal abuse from CNA-H towards another Resident(R6) a couple of weeks prior. All 3 staff confirmed they did not report the allegations of verbal abuse.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 2/19/25, at 1:50 PM, Surveyor interviewed UM/LPN/SS/BOM-D. UM/LPN/SS/BOM-D stated that LPN-E did report that R2 had been crying and confirmed both UM/LPN/SS/BOM-D and LPN-E went to interview R2 and R2 stated that CNA-H had been rough with R2. UM/LPN/SS/BOM-D confirmed UM/LPN/SS/BOM-D, NHA-A, and CNA-H went to speak with R2 later in the day. UM/LPN/SS/BOM-D does not recall what happened in between the time UM/LPN/SS/BOM-D initially informed NHA-A and when the 3 went to R2's room. According to UM/LPN/SS/BOM-D Upon investigation, more stuff came out.<br><br>On 2/20/25, at 10:03 AM, Surveyor interviewed HKP-F. HKP-F recalls hearing R2 crying loudly and witnessed LPN-E taking R2 into R2's room. HKP-F had no further information to provide.<br><br>On 2/20/25, at 10:43 AM, Surveyor interviewed LPN-E via telephone. LPN-E stated R2 grabbed LPN-E's arm to plead with LPN-E. R2 expressed that R2 wanted to use the phone. After being on the phone, LPN-E went and got UM/LPN/SS/BOM-D and both interviewed R2 and determined an allegation of abuse. LPN-E got UM/LPN/SS/BOM-D as a witness. LPN-E witnessed UM/LPN/SS/BOM-D go to NHA-A. LPN-E recalls NHA-A coming out to do a fire safety inservice about 12:00 PM. LPN-E spoke with NHA-A and said, what about (R2). LPN-E informed Surveyor that LPN-E observed NHA-A, UM/LPN/SS/BOM-D, and CNA-H go into R2's room and observed them in the room for about 5 minutes. LPN-E was approached by NHA-A and UM/LPN/SS/BOM-D at the nurse's station and told LPN-E, R2 has pain. LPN-E informed Surveyor that LPN-E had asked CNA-L to take care of R2 and informed CNA-H not to go into the room. LPN-E was very surprised to see CNA-H taking care of R2 and CNA-H was still in the facility.<br><br>On 2/20/25, at 11:05 AM, Surveyor spoke with CNA-L via telephone who confirmed that LPN-E asked CNA-L to take over providing cares to R2 for the rest of the shift.<br><br>On 2/20/25, at 3:33 PM, Surveyor interviewed NHA-A regarding the alleged verbal abuse of R2 by CNA-H. NHA-A never thought it was abuse when speaking to LPN-E and UM/LPN/SS/BOM-D. NHA-A confirmed that NHA-A discovered that staff had overheard alleged verbal abuse towards another Resident (R6) a couple of weeks ago by CNA-H and staff did not report immediately. NHA-A confirmed NHA-A is the abuse preventionist and does the abuse training in orientation. Abuse training is in a book for agency staff to review before working a shift and requires them to sign off they reviewed. NHA-A is upset with all the staff because they knew better and should have reported. NHA-A has gone over the abuse policy several times. Surveyor shared the concern with NHA-A, Director of Nursing (DON)-B, and Director of Operations (DO)-C that R2 was subjected to verbal abuse by CNA-H on 2/11/25. Staff had previously heard CNA-H verbally abusing R6 and did not report it, had staff reported, R2 being verbally abused by CNA-H would have been prevented. Surveyor also shared the concern that NHA-A and UM/LPN/SS/BOM-D brought CNA-H, the accused, into R2's room after the allegation of verbal abuse had been reported. DO-C informed Surveyor that DO-C had already re-educated NHA-A not to bring an accused staff member into a Resident's room.<br><br>On 2/25/25, at 9:22 AM, DO-C shared with Surveyor that this past weekend, DO-C inserviced staff on the abuse policy and warning signs of abuse.<br><br>On 2/25/25, at 1:21 PM, Surveyor shared the concern with DON-B, and DO-C that the facility did not prevent and protect R2 from verbal abuse by not implementing their policy and procedure to prohibit R2's right to be free from verbal abuse. DON-B and DO-C understand the concern. No further information was provided at this time. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 525686 | A. Building<br>B. Wing | 02/25/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Muskego Health and Rehabilitation Center | S77 W18690 Janesville Rd<br>Muskego, WI 53150 |

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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| F 0607<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Develop and implement policies and procedures to prevent abuse, neglect, and theft.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20483<br><br>Based on interview and record review the facility did not implement written policies and procedures to prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of residents property by having a system in place to ensure nurses have a current nursing license and allegations of verbal abuse are reported and investigated and/or investigated timely.<br><br>* The facility did not have a system in place to check licensed nurses to ensure their license remain valid. Licensed Practical Nurse (LPN)-Q held a multistate license from Texas. On [DATE] the Texas Board of Nursing revoked LPN-Q's license. LPN-Q worked at the facility on [DATE] & [DATE] after her license was revoked.<br><br>* R7 reported an allegation of verbal abuse by LPN-Q and the allegation of verbal abuse was not reported immediately to Nursing Home Administrator (NHA)-A and to the State Survey Agency. The allegation of verbal abuse was not investigated in a timely and thorough manner.<br><br>* 3 staff members reported to NHA-A allegations of Certified Nursing Assistant (CNA)-H being verbally abusive to R6. The allegation of verbal abuse was not reported immediately to Nursing Home Administrator (NHA)-A and to the State Survey Agency. The facility did not conduct an investigation of the allegation of verbal abuse.<br><br>* R8 reported to a CNA that R8 was missing money on [DATE]. The allegation of misappropriation was not reported immediately to Nursing Home Administrator (NHA)-A and to the State Survey Agency.<br><br>* R2's allegation of verbal abuse was not thoroughly investigated timely.<br><br>Findings include:<br><br>The facility's policy titled, Pre & Continuous Employment Background investigations and last reviewed [DATE] under procedure documents Licensure and Certification validation will be monitored through our payroll software. Reports will be run by the Human Resource Director bi-weekly reporting to the Administration any expired or expiring credentials and notifying the employee proactively.<br><br>The facility policy titled Abuse, Neglect, and Exploitation and dated [DATE] documents: It is the policy of this facility to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation, and misappropriation of resident property.<br><br>(continued on next page) |

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| F 0607<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Under section V Investigation of Alleged Abuse, Neglect an Exploitation documents A. An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur. B. Written procedures for investigations include: 1. Identifying staff responsible for the investigation; 2. Exercising caution in handling evidence that could be used in a criminal investigation (e.g. not tampering or destroying evidence); 3. Investigating different types of alleged violations; 4. Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and other who might have knowledge of the allegations; 5. Focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent, and cause; and 6. Providing completed and thorough documentation of the investigation.<br><br>Under Section VII Reporting/Response documents A. The facility will have written procedures that include:<br><br>1. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all required agencies within specified timeframe's:<br><br>a. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury<br><br>b. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury.<br><br>1.) On [DATE], at 8:22 a.m. Surveyor searched the DSPS (Department of Safety & Professional Services) for Licensed Practical Nurse (LPN)-Q's license. Surveyor received the following message No records to display.<br><br>On [DATE] Texas Board of Nursing revoked LPN-Q's license. LPN-Q worked at the facility through an agency on [DATE] and [DATE].<br><br>On [DATE], at 11:42 a.m., Surveyor asked Human Resource (HR)-K to explain the process for agency personnel. HR-K explained if they are a [Name] employee [agency name] HR will send everything over to them when on boarding is complete. Surveyor inquired what is sent to the facility. HR-K informed Surveyor their application, BID (background information disclosure), HR revolution, DOJ (Department of Justice), and their TB (tuberculosis) test if applicable. Surveyor inquired about references. HR-K informed [agency name] will send them. HR-K explained when they receive the paperwork they will print it and put it in a file. Surveyor inquired if the paper work is reviewed. HR-K informed Surveyor herself and Director of Nursing (DON) will take a look to see if they have any certifications & their background information. After this information is reviewed they are invited to pick up shifts. Surveyor asked if there are any charges listed on their DOJ what is the process. HR-K informed Surveyor for their employees they will review the charges and they talk about it and for [agency name] their HR will look at the charges. Surveyor inquired what if they indicate they have lived outside Wisconsin on the BID or their license is from another state. HR-K informed Surveyor [agency name] HR will look up the license.<br><br>(continued on next page) |

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| F 0607<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On [DATE], at 1:27 p.m., Surveyor spoke with Talent Acquisition Director [name] Agency (TAD)-AA on the telephone to inquire on their background process. TAD-AA informed Surveyor their onboarding process includes application, consent for background check & verification, license, CPR (cardiopulmonary resuscitation) and TB. They use HR revolution with prerequisites set up which gives them a green light, yellow light and red light. TAD-AA explained a green light means they met all requirements, yellow there are questions which their team reviews and red is a hard no. Surveyor inquired if the applicant completes a BID. TAD-AA replied yes. Surveyor inquired what occurs when the DOJ has charges listed. TAD-AA explained they will look at the BID to see if the applicant indicated this and then will review what the charges and dispositions were. Surveyor asked TAD-AA how they verify nurses licenses. TAD-AA informed Surveyor most of the nurses in Wisconsin have Wisconsin license, if they are from a compact state they will run their license as well. Surveyor asked TAD-AA how they become aware if a nurses licenses as been revoked. TAD-AA informed Surveyor they rely on the individual to let them know if their license is revoked.<br><br>On [DATE], at 8:35 a.m. Surveyor telephoned TAD-AA and inquired if LPN-Q is still a current employee. TAD-AA replied no. Surveyor inquired why LPN-Q is no longer an employee. TAD-AA explained the HR assistant was notified over the weekend her license was revoked. Surveyor verified with TAD-AA worked on [DATE] and [DATE] at the facility.<br><br>On [DATE], at 9:16 a.m., Surveyor asked HR-K how often they check the licenses for licensed nurses. HR-K informed Surveyor for their staff they do monthly license checks, explaining they have reports when their license is going to expire. HR-K informed Surveyor they are now checking license on a daily basis. Surveyor inquired when this started. HR-K informed Surveyor [DATE]. Surveyor asked HR-K why they started the daily checks. HR-K informed Surveyor its a new policy from Director of Operations-C. Surveyor asked HR-K prior to [DATE] were you checking agency nurses licenses. HR-K replied no not routinely. Surveyor asked HR-K what she meant by routinely. HR-K informed Surveyor when an agency nurse came on she would check their documents. Surveyor asked HR-K after the initial check did she check the licensed nurses license. HR-K replied after that, no.<br><br>On [DATE], at 9:23 a.m. Director of Operations-C and DON-B met with Surveyor. Surveyor was informed LPN-Q's license is no longer valid. Surveyor inquired how they found this out. Director of Operations-C informed Surveyor DON-B was notified on Sunday the 16th by another agency nurse her license was revoked. DON-B informed Surveyor she verified this happened and removed LPN-Q. She also notified HR, [name of] agency HR and removed LPN-Q from their system. DON-B informed Surveyor she reviewed in house resident's records for change of condition. On Monday ([DATE]) the medical director was notified , an ad hoc QAPI (quality assurance performance improvement) meeting was held. Every licensed nurses and CNA's license/certificates were checked as well as therapy. Director of Operations-C informed Surveyor she filed a complaint with the Texas Board of Nursing.<br><br>2.) The facility did not implement their abuse policy for R7. R7 reported an allegation of verbal abuse to HR-K and the allegation of verbal abuse was not reported immediately to Nursing Home Administrator (NHA)-A and to the State Survey Agency. The allegation of verbal abuse was not thoroughly investigated timely. Cross reference F609 & F610.<br><br>(continued on next page) |

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| F 0607<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 3.) The facility did not implement their abuse policy for R6. Three staff members reported to NHA-A allegations of Certified Nursing Assistant (CNA)-H being verbally abusive to R6. The allegation of verbal abuse was not reported immediately to Nursing Home Administrator (NHA)-A and to the State Survey Agency. The facility did not conduct an investigation of the allegation of verbal abuse. Cross reference F609 & F610.<br><br>4.) The facility did not implement their abuse policy for R8. R8 reported to a CNA that R8 was missing money on [DATE]. The allegation of misappropriation was not reported immediately to Nursing Home Administrator (NHA)-A and to the State Survey Agency. Cross reference F609.<br><br>5.) The facility did not implement their abuse policy for R2. R2's allegation of verbal abuse was not thoroughly investigated timely. Cross reference F600 and F610. |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38829<br><br>Based on record review and staff interviews, the facility did not ensure that 3 allegations of abuse/misappropriation involving 3 Residents (R6, R8 and R7) of 4 allegations of abuse/misappropriation were reported immediately to the Nursing Home Administrator (NHA)-A and to the State Survey Agency within the required reporting timeframe .<br><br>* 3 staff members reported late to Nursing Home Administrator (NHA)-A allegations of Certified Nursing Assistant (CNA)-H being verbally abusive to R6. The allegation of verbal abuse was not reported immediately to Nursing Home Administrator (NHA)-A and to the State Survey Agency.<br><br>* R8 reported to a CNA that R8 was missing money on 2/19/25. The allegation of misappropriation was not reported immediately to Nursing Home Administrator (NHA)-A and to the State Survey Agency.<br><br>* R7 reported an allegation of verbal abuse and the allegation of verbal abuse was not reported immediately to Nursing Home Administrator (NHA)-A and to the State Survey Agency.<br><br>Findings Include:<br><br>The facility's Abuse, Neglect and Exploitation policy and procedure implemented 9/18/23 documents:<br><br>.It is the policy of this facility to provide protections for health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation, and misappropriation of resident property.<br><br>Policy Explanation and Compliance Guidelines:<br><br>1. The facility will develop and implement written policies and procedures that:<br><br>a. Prohibit and prevent abuse, neglect, and exploitation of Residents and Misappropriation of Resident property<br><br>b. Establish policies and procedures to investigate any such allegations<br><br>c. Include training for new and existing staff on activities that constitute abuse, neglect, exploitation, and misappropriate of Resident property, reporting procedures, and dementia management and Resident abuse prevention<br><br>2. The facility will designate an Abuse Prevention Coordinator in the facility who is responsible for reporting allegations or suspected abuse, neglect, or exploitation to the state survey agency and other officials in accordance with state law.<br><br>3. The facility will provide ongoing oversight and supervision of staff in order to assure that its policies are implemented as written.<br><br>(continued on next page) |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | II. Employee Training<br><br>A. New employees will be educated on abuse, neglect, exploitation and misappropriation of Resident property during initial orientation.<br><br>B. Existing staff will receive annual education through planned in-services and as needed.<br><br>C. Training topics will include:<br><br>1. Prohibiting and preventing all forms of abuse, neglect, misappropriation of Resident property and exploitation<br><br>2. Identifying what constitutes abuse, neglect, exploitation, and misappropriation of Resident property<br><br>3. Recognizing signs of abuse, neglect, exploitation and misappropriation of Resident property, such as physical or psychosocial indicators<br><br>4. Reporting process of abuse, neglect, exploitation, and misappropriation of Resident property including injuries of unknown sources<br><br>5. Understanding behavioral symptoms of Residents that may increase the risk of abuse and neglect.<br><br>III. Prevention of Abuse, Neglect, and Exploitation: The facility will implement policies and procedures to prevent and prohibit all types of abuse, neglect, misappropriation of resident property, and exploitation that achieves: .<br><br>B. Identifying, correcting, and intervening in situations in which abuse, neglect, exploitation, and/or misappropriation of resident property is more likely to occur with the deployment of trained and qualified registered, licensed, and certified staff on each shift in sufficient numbers to meet the needs of residents, and assure that the staff assigned have knowledge of the individual resident's care needs and behavioral symptoms.<br><br>C. Assuring an assessment of the resources needed to provide care and services to all Residents is included in the facility assessment.<br><br>D. The identification, ongoing assessment, care planning for appropriate interventions, and monitoring of residents with needs and behaviors which might lead to conflict or neglect.<br><br>H. Assigning responsibility for the supervision of staff on all shifts for identifying inappropriate staff behaviors.<br><br>B. Possible indicators of abuse include, but are not limited to:<br><br>5. Verbal abuse of a Resident overheard<br><br>V. Investigation of Alleged Abuse, Neglect, and Exploitation<br><br>(continued on next page) |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A. An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect, or exploitation occur.<br><br>VII. Reporting/Response<br><br>A. The facility will have written procedures that include:<br><br>1. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all required agencies within specified timeframe's:<br><br>a. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury<br><br>b. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury.<br><br>1) R6 was admitted to the facility on [DATE] with diagnoses of Alzheimer's Disease, Type 2 Diabetes Mellitus, Essential Hypertension, Hyperlipidemia, and Hypothyroidism. R6 has an activated Health Care Power of Attorney (HCPOA).<br><br>R6's Significant Change Minimum Data Set (MDS) completed 1/20/25 documents R6's Brief Interview for Mental Status (BIMS) score of 3, indicating R6 demonstrates severely impaired skills for daily decision making. R6 requires supervision for eating. R6 is dependent on assistance for showers lower dressing and transfers. R6 requires substantial/maximum assistance for upper dressing, and mobility. R6 is incontinent of bowel and bladder. R6's MDS documents no mood or behavior issues.<br><br>In review of an abuse allegation of verbal abuse from CNA-H involving R2's investigation, Surveyor notes that staff reported allegations of verbal abuse involving CNA-H and R6. 2 CNAs gave a statement that they had heard CNA-H called R6 dumb in the dining room. The hospice CNA that comes in and provides cares to R6, heard CNA-H call R6 during a transfer, oh this bitch. All 3 staff admitted they did not report this immediately at the time of the abuse.<br><br>Surveyor notes the facility did not complete a thorough investigation of these allegations of verbal abuse involving R6.<br><br>On 2/20/25, at 3:33 PM, Surveyor interviewed NHA-A in regards to R6's allegation of verbal abuse. NHA-A confirmed that NHA-A discovered that staff had overheard alleged verbal abuse towards another Resident (R6) a couple of weeks ago by CNA-H and did not report immediately. NHA-A confirmed NHA-A is the abuse preventionist and does the abuse training in orientation. Abuse training is in a book for agency staff to review before working a shift and requires them to sign off they reviewed. Surveyor shared the concern with NHA-A, Director of Nursing (DON)-B, and Director of Operations (DO)-C that R6 was verbally abused by CNA-H. Staff had previously heard CNA-H verbally abusing R6 and did not report it.<br><br>2) R8 was admitted to the facility on [DATE] with diagnoses of Polyneuropathy, Chronic Respiratory Failure with Hypoxia, Chronic Obstructive Pulmonary Disease, Human Immunodeficiency Virus Disease, Malignant Neoplasm of Unspecified Site of Left Female Breast, Chronic Pain Syndrome. R8 discharged home on 2/22/25. R8 was R8's own person while at the facility.<br><br>(continued on next page) |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | R8's Quarterly MDS completed 2/4/25 documents R8's BIMS score of 15, which means R8 was cognitively intact for daily decision making. R8 has no range of motion issues. R8 required partial/moderate assistance for upper body dressing, hygiene, and mobility. R8 required substantial/maximum assistance for lower body dressing and transfers.<br><br>Surveyor reviewed a progress note documented in R8's electronic medical record (EMR):<br><br>On 2/19/25, at 5:43 AM, Registered Nurse (RN)-U documented:<br><br>(R8) told CNA money is missing. CNA asked (R8) if (R8) wanted to speak to nurse about missing money and (R8) stated (R8) was too upset at the moment to report it and will in the morning.<br><br>Surveyor notes that R8 reported to a CNA on 2/19/25 the missing money. The facility reported on 2/23/25 to the State Survey agency. Surveyor notes the police were notified.<br><br>On 2/25/25, at 8:58 AM, Surveyor interviewed Director of Nursing (DON)-B regarding the documentation. DON-B informed Surveyor that it was discovered on 2/22/25 after reviewing R8's progress notes. DON-B explained DON-B came in on the weekend to work on the investigation. DON-B stated that DON-B was able to get R8's statement before R8 discharged home.<br><br>On 2/25/25, at 9:22 AM, Director of Operations (DO)-C shared with Surveyor that this past weekend, DO-C inserviced staff on the abuse policy and warning signs of abuse. Surveyor again shared the concern that a thorough investigation was not initiated and completed involving R6 and the allegation of verbal abuse.<br><br>On 2/25/25, at 11:10 AM, DON-B provided Surveyor documentation of the investigation in progress.<br><br>On 2/25/25, at 1:21 PM, Surveyor shared the concern with DON-B, and DO-C that the facility did not immediately report the allegation of verbal abuse of R6 to Nursing Home Administrator (NHA)-A and to the State Survey Agency. Surveyor also shared that R8's allegation of misappropriation was not immediately reported to NHA-A and to State Survey Agency. DON-B and DO-C understand the concern. No further information was provided at this time.<br><br>20483<br><br>3.) R7's diagnoses include diabetes mellitus, hypertension, and morbid obesity.<br><br>The admission MDS (minimum data set) with an assessment reference date of 1/3/25 documents a BIMS (brief interview mental status) score of 15 which indicates cognitively intact.<br><br>(continued on next page) |

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Muskego Health and Rehabilitation Center | S77 W18690 Janesville Rd<br>Muskego, WI 53150 |

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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 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 2/20/25, at 10:30 a.m., Surveyor observed R7 in bed on her back. Surveyor inquired how everything is at the facility. R7 informed Surveyor she had a nurse come in when her son was here and was screaming at me and my son. The nurse was screaming at me, her name was [first name]. Surveyor asked when this was. R7 informed Surveyor she believes it was last Thursday. Surveyor asked what the nurse was yelling at her for. R7 informed Surveyor Certified Nursing Assistant (CNA)-Z asked her if she needed to be changed but her son was here so she told CNA-Z she could change her later. R7 informed Surveyor she thinks CNA-Z told the nurse I told her she couldn't feed her room mate until after her son left. [first name of LPN (Licensed Practical Nurse) LPN-Q] came in screaming at us. R7 informed Surveyor her son left and stated I wouldn't recommend this place to anyone if I could walk I would be out of here. Surveyor asked R7 if she reported LPN-Q yelling at her to anyone. R7 replied yes I did report it to the social worker who came in asking me questions if my life was in danger. She told me she was going to come back and she didn't. I asked that [first name of Nursing Home Administrator-A] come in and she didn't come in. Surveyor asked what the name of the social worker was. R7 informed Surveyor she didn't know but provided Surveyor with a description. Surveyor asked R7 if she told the social worker that [first name of LPN-Q] came in and was yelling at her. R7 replied Yes I did she was really yelling and my son just left.<br><br>On 2/20/25, at 11:35 a.m., Surveyor spoke to Human Resource (HR)-K, who is transitioning to Social Worker, and inquired if she had gone around the facility speaking with residents regarding another investigation. HR-K informed Surveyor she had spoken with multiple residents telling them who she was. She asked about abuse, if they felt safe, if something happened were to happen what would they do. Surveyor asked HR-K if any resident informed her they were yelled at during these conversations. HR-K replied no and informed Surveyor she doesn't have the papers in front of her.<br><br>On 2/20/25 at 1:04 p.m. Surveyor asked Unit Manager/Social Services/Licensed Practical Nurse/Business Office Manager (UM/SS/LPN/BOM)-D if she went around and spoke with residents recently when the facility was conducting an investigation. UM/SS/LPN/BOM-D replied no and explained she thinks HR-K did that.<br><br>On 2/20/25, at 1:46 p.m., Surveyor observed R7 sitting in a wheelchair in her room. R7 informed Surveyor she just got back from therapy. Surveyor asked R7 if she could tell Surveyor again what she told the social worker. R7 informed Surveyor she told her about the incident with [first name of LPN-Q], told her how it happened. R7 explained her son was here, the CNA asked if she could change me and told the CNA my son will be leaving soon. [First name of LPN-Q] came in started screaming at my son and me saying I said the aide couldn't feed [roommate's first name]. The social worker said she would come back the next day and she didn't.<br><br>(continued on next page) |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 2/20/25, at 2:40 p.m., Surveyor asked HR-K if she spoke with R7. HR-K replied yes. Surveyor asked if R7 spoke to her about [first name of LPN-Q] as this is what R7 told Surveyor. HR-K informed Surveyor R7 told her the nurse wasn't nice mentioned something about the roommate wanted to be fed and the nurse thought R7 told the CNA not to feed her. The nurse was telling R7 it is not just her room and the resident has the right to eat in there with the son present. HR-K informed Surveyor after she was finished talking to R7 she did call Director of Nursing (DON)-B and tell her. Surveyor asked HR-K if R7 said the nurse yelled at her. HR-K replied she said she raised her voice, not yelling, raised her voice, came back and raised her voice. HR-K informed Surveyor she called DON-B as she was not in the building and told her everything R7 had told her. Surveyor asked when this happened. HR-K informed Surveyor R7 told it was late last week. The nurse came in wasn't very nice, raised her voice and came back again. Surveyor asked HR-K if she wrote a statement. HR-K replied no. HR-K informed Surveyor when she spoke with DON-B, DON-B told her R7 is behavioral at times.<br><br>On 2/20/25, at approximately 4:00 p.m. during the end of the day meeting with NHA-A, DON-B and Director of Operations-C Surveyor asked DON-B if she remembers getting a telephone call from HR-K regarding R7. DON-B replied I guess and explained she gets multiple calls from multiple people. Surveyor asked NHA-A if she was informed of [first name of LPN-Q] yelling at R7. NHA-A replied I never heard about it until now. Surveyor asked DON-B if the allegation of [first name of LPN-Q] yelling at R7 was reported to the state agency. DON-B replied no. Surveyor asked why not. DON-B explained she had HR-K ask R7 if she had any ill effects and she said no so I didn't report it. Director of Operations-C asked when this happened. Surveyor informed Director of Operations-C the end of last week.<br><br>On 2/25/25 Surveyor was provided with Alleged Nursing Home Resident Mistreatment, Neglect, and Abuse Report F-62617 with a report submitted date 2/20/2025 7:26:06 PM. This report was submitted after the required timeframe.<br><br>On 2/25/25, at 9:08 a.m., Surveyor asked HR-K what date did she text DON-B regarding what R7 had told her. HR-K replied believe it was the 18th, it was the 17th or 18th when I called her. HR-K informed Surveyor she did start interviewing residents on Thursday and Friday (2/13 & 2/14). |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Respond appropriately to all alleged violations.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20483<br><br>Based on interview and record review the facility did not ensure 3 (R7, R6, & R2) of 4 allegations of abuse were investigated or thoroughly investigated timely.<br><br>* The facility did not conduct a thorough investigation timely for R7's allegation of verbal abuse.<br><br>* The facility did not conduct a thorough investigation timely for R2's allegation of verbal abuse.<br><br>* The facility did not conduct an investigation for R6's allegation of verbal abuse.<br><br>Findings include:<br><br>The facility policy titled Abuse, Neglect, and Exploitation and dated 9/18/2023 documents: It is the policy of this facility to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation, and misappropriation of resident property.<br><br>Under section V Investigation of Alleged Abuse, Neglect an Exploitation documents A. An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur. B. Written procedures for investigations include: 1. Identifying staff responsible for the investigation; 2. Exercising caution in handling evidence that could be used in a criminal investigation (e.g. not tampering or destroying evidence); 3. Investigating different types of alleged violations; 4. Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and other who might have knowledge of the allegations; 5. Focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent, and cause; and 6. Providing completed and thorough documentation of the investigation.<br><br>1.) R7's diagnoses which include diabetes mellitus, hypertension, and morbid obesity.<br><br>The admission MDS (minimum data set) with an assessment reference date of 1/3/25 documents a BIMS (brief interview mental status) score of 15 which indicates cognitively intact.<br><br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 2/20/25, at approximately 4:00 p.m. during the end of the day meeting with NHA-A, DON-B and Director of Operations-C Surveyor asked DON-B if she remembers getting a telephone call from HR-K regarding R7. DON-B replied I guess and explained she gets multiple calls from multiple people. Surveyor asked NHA-A if she was informed of [first name of LPN-Q] yelling at R7. NHA-A replied I never heard about it until now. Surveyor asked DON-B if the allegation of [first name of LPN-Q] yelling at R7 was reported to the state agency. DON-B replied no. Surveyor asked why not. DON-B explained she had HR-K ask R7 if she had any ill effects and she said no so I didn't report it. Director of Operations-C asked when this happened. Surveyor informed Director of Operations-C the end of last week.<br><br>On 2/25/25, at 11:06 a.m., Surveyor asked DON-B if she spoke to R7 about her allegation of verbal abuse involving LPN-Q. DON-B replied I did not.<br><br>The facility did not start to conduct their investigation of R7's allegation of verbal abuse until 2/20/24.<br><br>38829<br><br>2.) R2 was admitted to the facility on [DATE] with diagnoses of Other Nontraumatic Intracerebral Hemorrhage, Hemiplegia and Hemiparesis Affecting Right Dominant Side, Chronic Kidney Disease, Stage 4, and Depression.<br><br>R2's Admission Minimum Data Set (MDS) completed 1/23/25 documents a Brief Interview for Mental Status (BIMS) score of 0, indicating R2 demonstrates severely impaired skills for daily decision making. R2's MDS documents R2's Patient Health Questionnaire (PHQ-9) score to be 12, indicating moderate depression. R2's MDS also documents R2 is always incontinent of bowel and bladder and has range of motion(ROM) impairment on both sides of upper and lower extremities. R2's MDS documents R2 is dependent for dressing, eating, transfers, mobility, hygiene, and showers. At the time of the MDS, R2 was nothing by mouth (NPO), and received complete nutrition through a gastrostomy tube g-tube.<br><br>R2's electronic medical record (EMR) indicates that R2 understands yes and no questions and is able to nod head in answering yes and no questions with appropriate answers. R2 is also able to use cue cards.<br><br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 2/11/25, Licensed Practical Nurse (LPN)-E observed and heard R2 crying at approximately 9:30 AM. R2 could not articulate why R2 was crying and LPN-E as documented in a written statement provided comfort and safety. At approximately 9:45 AM, R2 was observed crying again and indicated R2 wanted assistance with using the telephone. R2 attempted to speak with R2's boyfriend on the phone, however, was crying so much that R2's boyfriend could not understand what was going on. R2's boyfriend informed LPN-E that he would have R2's daughter come to the facility to find out what was going on with R2. LPN-E documents in LPN-E's statement that LPN-E informed Unit Manager/Licensed Practical Nurse/Social Services/Business Office Manager (UM/LPN/SS/BOM)-D of (R2) crying all morning and something didn't feel right about the situation. This was at approximately 11:00 AM. CNA-H was assigned to R2. UM/LPN/SS/BOM-D and LPN-E both went and spoke with R2. R2 nodded yes that CNA-H was being mean and rough and requested another CNA to care for R2. LPN-E's statement documents about 11:40 AM, LPN-E witnessed CNA-H go into R2's room. Housekeeper (HKP)-F heard R2 crying and informed LPN-E that R2 was being changed by CNA-H. LPN-E immediately went to R2's room and asked if administration had spoke with CNA-H, and CNA-H stated no. At approximately noon, LPN-E observed Nursing Home Administrator (NHA)-A, UM/LPN/SS/BOM-D and CNA-H walk down and go into R2's room. LPN-E documents that CNA-H was allowed to work the entire shift. LPN-E indicates in LPN-E's statement that as LPN-E was in the car pulling in and CNA-H was pulling out and CNA-H started bobbing CNA-H's head and laughing at LPN-E. LPN-E felt humiliated. LPN-E was approached later in the afternoon at the nurse's station by NHA-A and (NHA)-A, UM/LPN/SS/BOM-D and was informed R2 was crying because R2 was in pain. Around 2:00 PM, R2's legal guardian came in and after visiting with R2, went to NHA-A's office. According to LPN-E's statement that is when the investigation started.<br><br>Surveyor reviewed CNA-H's time punches for CNA-H's shift on 2/11/25. CNA-H was scheduled to work 5:00 AM-1:30 PM. CNA-H's time punch is 4:36 AM in and 1:30 PM out. CNA-H worked the entire shift increasing the chances other Residents could be vulnerable to abuse/neglect.<br><br>Documentation indicates the facility did not initiate an investigation until after CNA-H had left the building after CNA-H's shift. When gathering statements for the investigation, it was discovered that 2 facility CNAs and 1 hospice CNA and overheard verbal abuse from CNA-H towards another Resident(R6) a couple of weeks prior. All 3 staff confirmed they did not report the allegations of verbal abuse.<br><br>On 2/19/25, at 1:50 PM, Surveyor interviewed UM/LPN/SS/BOM-D. UM/LPN/SS/BOM-D stated that LPN-E did report that R2 had been crying and confirmed both UM/LPN/SS/BOM-D and LPN-E went to interview R2 and R2 stated that CNA-H had been rough with R2. UM/LPN/SS/BOM-D confirmed UM/LPN/SS/BOM-D, NHA-A, and CNA-H went to speak with R2 later in the day. UM/LPN/SS/BOM-D does not recall what happened in between the time UM/LPN/SS/BOM-D initially informed NHA-A and when the 3 went to R2's room. Upon investigation, more stuff came out.<br><br>On 2/20/25, at 10:03 AM, Surveyor interviewed HKP-F. HKP-F recalls hearing R2 crying loudly and witnessed LPN-E taking R2 into R2's room. HKP-F had no further information to provide.<br><br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 2/20/25, at 10:43 AM, Surveyor interviewed LPN-E via telephone. LPN-E stated R2 grabbed LPN-E's arm to plead with LPN-E. R2 expressed that R2 wanted to use the phone. After being on the phone, LPN-E went and got UM/LPN/SS/BOM-D and interviewed R2 and determined an allegation of abuse. LPN-E got UM/LPN/SS/BOM-D as a witness. LPN-E witnessed UM/LPN/SS/BOM-D go to NHA-A. LPN-E recalls NHA-A coming out to do a fire safety inservice about 12:00 PM. LPN-E spoke with NHA-A and said, what about R2. LPN-E informed Surveyor that LPN-E observed NHA-A, UM/LPN/SS/BOM-D, and CNA-H go into R2's room and observed them in the room for about 5 minutes. LPN-E was approached by NHA-A and UM/LPN/SS/BOM-D at the nurse's station and told LPN-E R2 has pain. LPN-E informed Surveyor that LPN-E had asked CNA-L to take care of R2 and informed CNA-H not to go into the room. LPN-E was very surprised to see CNA-H taking care of R2 and CNA-H was still in the facility.<br><br>On 2/20/25, at 11:05 AM, Surveyor spoke with CNA-L via telephone who confirmed that LPN-E asked CNA-L to take over providing cares to R2 for the rest of the shift.<br><br>3.) R6 was admitted to the facility on [DATE] with diagnoses of Alzheimer's Disease, Type 2 Diabetes Mellitus, Essential Hypertension, Hyperlipidemia, and Hypothyroidism. R6 has an activated Health Care Power of Attorney(HCPOA).<br><br>R6's Significant Change MDS completed 1/20/25 documents R6's BIMS score of 3, indicating R6 demonstrates severely impaired skills for daily decision making. R6 requires supervision. R6 is dependent assistance for showers lower dressing and transfers. R6 requires substantial/maximum assistance for upper dressing, and mobility. R6 is incontinent of bowel and bladder. R6's MDS documents no mood or behavior issues.<br><br>In review of an abuse allegation of verbal abuse from CNA-H involving R2 investigation, Surveyor notes that staff reported allegations of verbal abuse involving CNA-H and R6. 2 CNAs gave a statement that they had heard CNA-H called R6 dumb in the dining room. The hospice CNA that comes in and provides cares to R6, heard CNA-H call R6 during a transfer, oh this bitch. All 3 staff admitted they did not report this immediately at the time of the abuse.<br><br>Surveyor notes the facility did not complete a thorough investigation of these allegations of verbal abuse involving R6.<br><br>On 2/20/25, at 3:33 PM, Surveyor interviewed NHA-A in regards to the alleged verbal abuse of R2 by CNA-H. NHA-A never thought it was abuse when speaking to LPN-E and UM/LPN/SS/BOM-D. NHA-A confirmed that NHA-A discovered that staff had overheard alleged verbal abuse towards another Resident(R6) a couple of weeks ago by CNA-H and did not report immediately. NHA-A confirmed NHA-A is the abuse preventionist and does the abuse training in orientation. Abuse training is in a book for agency staff to review before working a shift and requires them to sign off they reviewed. NHA-A is upset with all the staff because they knew better and should have reported. NHA-A has gone over the abuse policy several times. Surveyor shared the concern with NHA-A, Director of Nursing (DON)-B, and Director of Operations (DO)-C that R2 was subjected to verbal abuse by CNA-H on 2/11/25. Staff had previously heard CNA-H verbally abusing R6 and did not report it, had staff reported, R2 having been verbally abused by CNA-H would have been prevented. Surveyor also shared the concern that NHA-A and UM/LPN/SS/BOM-D brought CNA-H the accused into R2's room after the allegation of verbal abuse had been reported. DO-C informed Surveyor that DO-C had already re-educated NHA-A not to bring an accused staff member into a Resident's room.<br><br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Surveyor shared the concern that R2's allegation of verbal abuse was not investigated timely. Documentation indicates NHA-A was aware at around 11:00 AM of the allegation of verbal abuse, however, an investigation was not initiated until approximately 2:00 PM, after CNA-H had worked the entire shift. Surveyor also shared the concern that when NHA-A was made aware of the allegation of verbal abuse by CNA-H involving R6, a timely investigation was not initiated and completed. No further information was provided by the facility at this time.<br><br>On 2/25/25, at 9:22 AM., DO-C shared with Surveyor that this past weekend, DO-C inserviced staff on the abuse policy and warning signs of abuse. Surveyor again shared the concern that a thorough investigation was not initiated and completed involving R6 and the allegation of verbal abuse.<br><br>On 2/25/25, at 1:21 PM, Surveyor shared the concern with DON-B, and DO-C that the facility did not prevent and protect R2 from verbal abuse by not implementing their policy and procedure to prohibit R2's right to be free from verbal abuse. Surveyor shared that R2's alleged abuse investigation was not investigated timely and that a thorough investigation was not initiated and completed involving R6's allegation of verbal abuse. DON-B and DO-C understand the concern. No further information was provided at this time. |

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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 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20483<br><br>Based on interview and record review the facility did not ensure that based on the comprehensive assessment of a resident, residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan and the resident's choices for 2 (R3 & R4) of 2 residents.<br><br>* R3 was admitted to the facility on [DATE] with a left scrotum surgical wound and right fifth digit wound. The facility did not complete weekly assessments on these areas. On 2/20/25 R3's treatment to the right fifth digit was not completed and the left scrotum treatment was not completed according to physician orders.<br><br>* R4 was admitted to the facility on [DATE] with multiple non pressure areas. These non pressure areas were no assessed until 2/19/25, six days later by Wound Physician-T. Daily treatments to R4's bilateral buttocks, left 2nd toe, left medial foot, and right plantar foot were not initiated until 2/15/25, two days after admission.<br><br>Findings include:<br><br>The facility's policy titled, Wound Treatment Management and dated 2/14/23 under Policy Explanation and Compliance Guidelines documents 1. Wound treatments will be provided in accordance with physician orders, including the cleansing method, type of dressing and frequency of dressing change. 7. Treatments will be documented on the Treatment Administration Record or in the electronic health record. 8. The effectiveness of treatments will be monitored through ongoing assessment of the wound.<br><br>1.) R3's diagnoses includes end stage renal disease, peripheral vascular disease, morbid obesity, fournier gangrene, diabetes mellitus, and idiopathic aseptic necrosis of right finger.<br><br>R3's hospital discharge summary for date of discharge 1/17/25 under hospital course documents #Recent fournier gangrene s/p (status post) I&D (incision and drainage) of L (left) scrotum. admitted [DATE]-[DATE], numerous I&Ds managed by urology and ID (infectious disease), D/ced (discontinued) on doxycycline and completed on 12/22. Urology evaluated patient on 12/22. On 12/31, patient had increased pain in scrotum/surgical site with wound dehiscence and increased purulent drainage noted. Also with more erythematous scrotum, concern for recurrence of wound infection. Urology was consulted and patient started on Bactrim for 7 day course. No surgical intervention. Wound care recs (recommendation) ordered. No sepsis. -urology follow up. -BID (twice daily) wound care as below. -Started 7 day antibiotic course for skin pathogens; continued Bactrim SS BID x (times) 7 days eot (end of treatment) 1/8/25.<br><br>R3's physician order dated 1/17/25 documents Cleanse right 5th digit with soap and water, pat dry, apply betadine, and leave open to air daily. One time a day for wound care.<br><br>R3's physician order dated 1/17/25 documents cleanse scrotum wound with puracyn plus, skin prep peri area, apply 10 cm (centimeters) strip of Aquacel to wound bed, cover with kerlix sling under scrotum. Do not apply tape to the scrotum, apply kerlix to overlap and use tape on kerlix only. Two times a day for scrotum wound.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 525686 | A. Building<br>B. Wing | 02/25/2025 |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | R3's actual impairment to skin integrity care plan initiated 1/22/25 & revised 1/27/25 documents an intervention Weekly licensed nurse skin evaluation initiated 1/24/25.<br><br>R3's admission MDS (minimum data set) with an assessment reference date of 1/23/25 has a BIMS (brief interview mental status) score of 15 which indicates cognitively intact. Surgical wound is checked.<br><br>Wound Physician-T progress note dated 1/29/25 under note documents Signing off on patient who remains in the facility. not consult. Under category documents Sign off without visit in house.<br><br>Physician-S progress note dated 1/31/25 documents for skin assessment OA (open area) to groin, will be seen by [Wound Physician-T].<br><br>R3's Admission/Readmission/Routine Head-to toe Evaluation with an effective date of 2/3/25 under the skin integrity section is check for risk for skin alterations. Yes is answered for the question does the resident have any skin alterations. Under site documents Other (specify) and under description documents scrotum surgical site.<br><br>Physician-S progress note dated 2/6/25 documents for skin assessment OA (open area) to groin, will be seen by [Wound Physician-T].<br><br>R3's dialysis communication form dated 2/6/25 under the dialysis center information documents *Pt (patient) c/o (complained of) pain & odor r/t/ (related to) groin wound. Please change drsg (dressing) BID (twice daily).<br><br>On 2/19/25, at 9:32 a.m., Surveyor observed R3 in bed watching a video on his phone. Surveyor asked R3 if he has any wounds. R3 informed Surveyor it's suppose to be changed twice a day, referring to the scrotum, but always doesn't get changed. R3 informed Surveyor he thinks his wound is healing up. R3 also informed Surveyor he doesn't have a dressing on it right now. R3 informed Surveyor the morning nurse is back up and doesn't know if she will get around to it. Surveyor asked R3 if the nurse did his treatment yesterday. R3 replied no they did it the night before. Surveyor asked R3 why he doesn't have a dressing on the wound. R3 replied because they haven't put one on it. Sometimes they say the treatment is not showing up in the computer or something like that. I ask them to do it if they don't do it I ask the second shift. Surveyor asked R3 if he has reported his treatments not being completed. R3 informed Surveyor he doesn't want to get on anyone's nerves stating don't want them not to do me right. I just tell them and hope they help me. Surveyor asked R3 if the staff does the treatment on his fifth finger. R3 replied yeah. Surveyor asked if he has a treatment to his buttocks. R3 replied no because that closed.<br><br>Surveyor reviewed R3's February 2025 TAR (treatment administration record) and noted the treatment for R3's scrotum on 2/18/25 for the evening shift is not checked and initialed as being completed.<br><br>On 2/19/25, at 9:46 a.m., Surveyor asked Licensed Practical Nurse (LPN)-N if she will be doing treatments today. LPN-N informed Surveyor she thinks she does. Surveyor informed LPN-N Surveyor would like to accompany her when she does R3's treatments.<br><br>On 2/19/25, at 11:48 a.m., LPN-N informed Surveyor she is looking for Director of Nursing (DON)-B as they keep the Aquacel locked up and then she will be ready for R3's treatment.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 2/19/25, at 11:56 a.m. Surveyor observed LPN-N enter R3's room wearing a mask & gloves and placed the treatment supplies on the over bed table. LPN-N asked R3 if she could do his treatment, removed her gloves and washed her hands. LPN-N placed gloves on, lowered R3's pants and removed the incontinence product. LPN-N removed her gloves & placed gloves on. Surveyor asked LPN-N if there is a dressing over R3's surgical wound. LPN-N replied no stating this is a piece of tissue. LPN-N sprayed wound cleanser on four by four gauze and cleansed R3's left scrotum stitches, repeating this process three times. LPN-N removed her gloves, placed gloves on, and spray puracyn plus on abd pad, stated have to wipe up from bottom, and dabbed R3's stitches from the bottom of R3's scrotum up to the end of the suture line. LPN-N applied skin prep around the stitches and then informed Surveyor the facility doesn't have Aquacel, per DON-B using calcium alginate. LPN-N ripped the calcium alginate placing pieces of calcium alginate over the suture line. LPN-N asked R3 if there is any kerlix. R3 informed LPN-N there are treatment supplies in the dresser. LPN-N opened the drawer, stated she will go grab an abdominal pad and will be back in less than 2 seconds. LPN-N removed her gloves and left R3's room. LPN-N returned a few seconds later, cleansed her hands and placed gloves on. LPN-N folded the abdominal pad and placed this pad between R3's left thigh and scrotum. LPN-N taped the abdominal pad onto R3's scrotum at the top & bottom. LPN-N placed an incontinence product & pulled up R3's pants by having R3 roll himself on the left & right side. LPN-N removed her gloves and washed her hands.<br><br>On 2/19/25, at 12:06 p.m., after LPN-N finished R3's scrotum treatment Surveyor asked LPN-N if R3 has any other treatments that need to be completed. LPN-N replied he just has one.<br><br>Surveyor noted LPN-N did not do the treatment for R3's right fifth digit. LPN-N did not complete the scrotum treatment according to physician orders as LPN-N placed an abdominal pad between the left thigh & scrotum & taped the pad to the scrotum. LPN-N did not cover the dressing with kerlix sling under R3's scrotum and R3's physician orders document not to place tape on the scrotum.<br><br>On 2/20/25, at 7:31 a.m., Surveyor observed R3 in bed on the right side. Surveyor asked R3 if staff did his treatment yesterday evening. R3 replied no. Surveyor asked if they did the treatment for his finger. R3 replied no. Surveyor asked R3 if they have done his treatment this morning. R3 replied no.<br><br>On 2/20/25, at 10:23 a.m., Surveyor observed R3 in bed on his back. Surveyor informed R3 the nurse had told Surveyor he didn't want his treatment done until after dialysis. R3 replied yes because I have to get up. Surveyor informed R3 Surveyor would have observed his treatment if it was done before he left as Surveyor wanted to see if there was a dressing. R3 replied I don't think its on and then told Surveyor he could show Surveyor. R3 lowered his pants. Surveyor observed only one small piece of calcium alginate on the top portion of R3's suture line.<br><br>During R3's record review on 2/19/25 & 2/20/25 Surveyor was unable to locate any weekly assessment for R3's right 5th digit or the left scrotum surgical site.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 2/25/25, at 9:57 a.m., Surveyor met with DON-B and Director of Operations (DOO)-C. Surveyor asked if they complete skin assessment for surgical wounds. DON-B informed Surveyor any and all skin wounds we should be doing an evaluation. Surveyor asked if the assessment are completed weekly. DON-B informed Surveyor they should be per their evaluation guidelines. Surveyor informed DON-B and DOO-C Surveyor was unable to locate any skin assessments for R3's right 5th digit or the left scrotum site. Surveyor then informed DON-B and DOO-C Surveyor had observed R3's treatment for the scrotum and the nurse had informed Surveyor there was no Aquacel and used calcium alginate per DON-B directive. Surveyor asked DON-B if she had notified R3's physician. DON-B replied yes. Surveyor informed DON-B and DOO-C LPN-N did not do the treatment for R3's right 5th digit and LPN-N did not do the treatment according to physician orders as she did not use a kerlix sling but placed a folded abd pad between R3's left thigh & scrotum.<br><br>On 2/25/25, at 10:27 a.m., Surveyor asked Unit Manager/Social Services/Licensed Practical Nurse/Business Office Manager (UM/SS/LPN/BOM)-D if assessments of surgical wounds are completed. (UM/SS/LPN/BOM)-D informed Surveyor they should be unless told by the MD (medical doctor) to keep the dressing on until they have their appointment. If not there should be an assessment which goes along with a body check. Surveyor asked how often assessments are completed. (UM/SS/LPN/BOM)-D replied upon admission and then weekly.<br><br>On 2/25/25. at 11:05 a.m., DON-B provided Surveyor with a statement which documents Verbal received from [Physician-S] regarding Aquacel being unavailable and to exchange with calcium alginate for wound dressing on 2/19 for [R3's name]. DON-B informed Surveyor she did not transcribe the order and stated that is on me.<br><br>On 2/25/25, at 11:57 a.m., Surveyor asked DON-B if the treatment is blank on the TAR for a resident what does this mean. DON-B informed Surveyor if the treatment was not charted on or it wasn't done. Surveyor informed DON-B on 2/19/25 R3 informed Surveyor staff did not do his treatment the evening prior. Surveyor checked the TAR which was blank for the evening shift on 2/18/25.<br><br>2.) R4 was admitted to the facility on [DATE]. Diagnoses includes diabetes mellitus, atrial fibrillation, heart failure, fracture of lower end of left femur and fracture of lower end of right tibia. R4's POA (power of attorney) for healthcare was activated on 7/1/23.<br><br>R4's Admission/Readmission/Routine Head-to-toe Evaluation dated 2/13/25 under the skin integrity section is checked for risk for skin alterations. Yes is answered to the question does the resident have any skin alterations. Under Generic Body Diagram for site documents 14) abdomen & description trauma. Under site 22) left iliac crest (rear) and description trauma. Site 31) right buttock and description MASD (moisture-associated skin damage), Site 32) left buttocks and description MASD. Site 38) left knee (front) and description trauma. Site 46) left ankle (inner) description diabetic ulcer. Site 52) left toe(s) and description 2nd trauma. Site Other (specify) and description left dorsal foot trauma. Site Other (specify) and description left medial foot trauma. Site (specify) and description right plantar foot trauma. Surveyor noted there are no description of the wound beds and there are no measurements of these areas. R4's non pressure wounds were not assessed until 6 days later on 2/19/25 by Wound Physician-T.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Surveyor reviewed R4's February TAR (treatment administration record) and noted treatments which were ordered daily were not initiated until 2/15/25, two days after admission for the following: Bilateral Buttocks: Cleanse with soap and water, pat dry, apply nystatin powder to wounds, apply barrier cream cover with oil emulsion gauze daily and PRN (as needed). Left 2nd toe: Cleanse with soap and water, apply no sting barrier and leave open to air daily one time a day. Left Medial Foot: cleanse with soap and water, apply no sting barrier film and leave open to dry daily one time a day. Right Plantar Foot: Cleanse with soap and water, apply no sting barrier film and leave open to dry daily one time a day.<br><br>Wound Physician-T's wound assessments for R4 dated 2/19/25 are as follows:<br><br>Diabetic wound of the right foot resolved on 2/19/25.<br><br>Non pressure wound of the right knee. Etiology documents Trauma/injury. Wound size length 1.5, width 1.5, and depth 0.1 cm (centimeter). Exudate is moderate serious and granulation tissue is 100%.<br><br>Non pressure wound of the right shin. Etiology documents Trauma/injury. Wound size length 3, width 1, and depth 0.2 cm. Exudate is moderate serious and granulation tissue is 100%.<br><br>Post-Surgical wound of the right leg. Etiology post surgical. Wound size length 3, width 3, and depth 1 cm. Exudate is moderate serious. Thick adherent devitalized necrotic tissue is 100%.<br><br>Non Pressure wound of the right second toe. Etiology Trauma/injury. Wound size length 1, width 0.3, and width 0.2 cm. Exudate is moderate serious. Thick adherent devitalized necrotic tissue is 80% and granulation tissue is 20%.<br><br>Diabetic wound of the right first toe. Etiology diabetic. Wound size length 0.5, width 0.5, and depth 0.1 cm. Exudate is moderate serous. Granulation tissue is 100%.<br><br>Diabetic wound of the right distal foot. Etiology diabetic. Wound size length 1, width 1, and depth not measurable cm. Exudate is moderate serous. Scab is dried fibrinous exudate (scab).<br><br>Diabetic wound of the left second toe. Etiology diabetic. Wound size length 2, width 1, and depth 0.1 cm. Exudate is moderate serous. Thick adherent devitalized necrotic tissue is 90% and granulation tissue is 10%.<br><br>Non pressure wound of the left shin. Etiology trauma/injury. Wound size length 2, width 0.8, and depth 0.1 cm. Exudate is moderate serous. Granulation tissue is 100%.<br><br>Non pressure wound of the left heel. Etiology trauma/injury. Wound size length 1.5, width 1.5, and depth 0.1 cm. Exudate is moderate serous. Granulation tissue is 100%.<br><br>R4's admission MDS (minimum data set) with an assessment reference date of 2/19/25 has a BIMS (brief interview mental status) score of 13 which indicates cognitively intact. R4 is assessed as being at risk for pressure injuries, does not have any pressure injuries, and is marked yes for diabetic foot ulcer, surgical wounds, and skin tears.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 2/20/25, at 1:08 p.m., Surveyor asked Unit Manager/Social Service/Licensed Practical Nurse/Business Office Manager (UM/SS/LPN/BOM)-D when a resident is admitted does she do any skin assessments. UM/SS/LPN/BOM-D replied I don't and explained that would be the floor nurse.<br><br>On 2/20/25, at approximately 3:00 p.m. Surveyor asked Director of Nursing (DON)-B when a resident is admitted what does the skin assessment consist of. DON-B informed Surveyor it's built into the head to toe admission skin evaluation. They look head to toe and mark any impairments. Surveyor asked if there are any measurements. DON-B informed Surveyor if they are able to. Surveyor asked if the wound bed is assessed. DON-B informed Surveyor they don't until the wound evaluation. Surveyor informed DON-B R4 was admitted on [DATE] and there wasn't any comprehensive assessment for R4's multiple non pressure areas until 2/19/25, six days later by Wound Physician-T.<br><br>On 2/25/25, at 9:52 a.m. Director of Operations (DOO)-C informed Surveyor Director of Nursing (DON)-B went in and did a head to toe evaluation on 2/21/25 for R4. There is now a wound evaluation for every area R4 has including Wound Physician-T's notes. All orders for R4 were followed through from 2/19/25. DON-B did a skin sweep for all residents and no new concerns were found. They did educate nurses on the skin evaluation guidelines and change of condition.<br><br>On 2/25/25, at 10:27 a.m., Surveyor asked UM/SS/LPN/BOM-D when a resident is admitted what is the process for transcribing orders from the hospital. UM/SS/LPN/BOM-D informed Surveyor the nurses would put them into PCC (pointclickcare). Surveyor asked UM/SS/LPN/BOM-D if the floor nurses are responsible for putting the orders into PCC. UM/SS/LPN/BOM-D replied correct. Surveyor informed UM/SS/LPN/BOM-D R4 was admitted on [DATE], the orders weren't picked up until 2/14/25, and the treatments did not start until 2/15/25. |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20483<br><br>Based on observation, interview and record review, the Facility did not ensure that Residents with a pressure injury received necessary treatment and services, consistent with professional standards of practice, to prevent the development of pressure injuries and to promote healing for 1 (R7) of 1 Residents reviewed for pressure injuries.<br><br>On 2/6/25 the facility discontinued the treatment to R7's left fifth toe even though Wound Physician-T continued the treatment of skin prep. On 2/12/25 Wound Physician-T changed treatment orders for R7's left hip pressure injury, left lateral knee pressure injury, & right heel pressure injury. The facility did not pick up these orders until 2/20/25, 8 days later. On 2/20/25 R7's right heel treatment was not completed according to physician orders as the nurse informed R7 her treatment had been discontinued. R7's heels were observed not to be offloaded and R7's air mattress was set to the incorrect setting.<br><br>Findings include:<br><br>The facility's policy titled, Pressure Injury Prevention and Management and dated 2/14/23 under Policy documents This facility is committed to the prevention of avoidable pressure injuries, unless clinically unavoidable, and to provide treatment and services to heal the pressure ulcer/injury, prevent infection and the development of additional pressure ulcers/injuries. Under Policy Explanation and Compliance Guidelines documents 2. The facility shall establish and utilize a systematic approach for pressure injury prevention and management, including prompt assessment and treatment' intervening to stabilize, reduce or remove underlying risk factors; monitoring the impact of the interventions; and modifying the interventions as appropriate. 4d. documents Evidence-based treatments in accordance with current standards of practice will be provided for all resident who have a pressure injury present.<br><br>R7 was admitted to the facility on [DATE] with diagnoses which include diabetes mellitus, hypertension, and morbid obesity.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | R7's pressure ulcer and potential for pressure ulcer development care plan initiated & revised on 1/3/25 documents the following interventions: *Administer treatments as ordered and monitor for effectiveness. Initiated 1/3/25. *Assess/record/monitor wound healing. Measure length, width and depth where possible. Assess and document status of wound perimeter, wound bed and healing progress. Report improvements and declines to the MD (medical doctor). Initiated & revised 1/3/25. *Educate the resident/family/caregivers as to causes of skin breakdown; including transfer/positioning requirements; importance of taking care during ambulating/mobility, good nutrition and frequent repositioning. Initiated 1/3/25. *Enhanced Barrier Precautions r/t (related to) wound. Initiated 1/22/25. *Inform the resident/family/caregivers of any new area of skin breakdown. Initiated 1/3/25. *Monitor dressings with cares to ensure it is intact and adhering. Report loose dressing to treatment nurse. Initiated & revised 1/3/25. *Monitor/document/report PRN (as needed) any changes in skin status: appearance, color wound healing, s/sx (signs/symptoms) of infection, wound size (length x (times) width x depth), stage. Initiated 1/3/25. *Teach resident/family the importance of changing positions for prevention of pressure ulcers. Encourage small frequent position changes. Initiated 1/3/25. *The resident needs assistance to turn/reposition at least every 2 hours, more often as needed or requested. Initiated 1/3/25. *The resident requires pressure relief mattress and w/c (wheelchair) cushion. Initiated & revised 1/3/25.<br><br>The admission MDS (minimum data set) with an assessment reference date of 1/3/25 documents a BIMS (brief interview mental status) score of 15 which indicates cognitively intact. R7 is assessed as being dependent for toileting hygiene, roll left & right, and chair/bed to chair transfer. R7 is assessed as always incontinent of urine and bowel. R7 is at risk for pressure injury development and is assessed as having one stage 4 pressure injury which was present upon admission, three unstageable slough and/or eschar which were present on admission and one DTI (deep tissue injury) which was present on admission.<br><br>The pressure ulcer/injury CAA (care area assessment) dated 1/6/25 under analysis of findings for nature of the problem/condition documents According to documentation [R7's first name] triggered for pressure ulcers r/t (related to) currently having multiple pressure related wounds. She is being followed by wound care specialist. Treatments done as ordered. POC (plan of care) will be developed to promote healing and freedom from further breakdown.<br><br>On 2/20/25 Surveyor reviewed R7's physician orders and noted the following treatment orders:<br><br>*Left hip: Clean with Dakin's 1/2 strength, apply Dakin's wet to moist, cover with bordered gauze. Change twice daily. Two times a day for wound care with an order date of 1/13/25.<br><br>*Left lateral knee: Clean with Dakin's 1/2 strength, apply alginate calcium, f/b (followed by) ABD (abdominal) pad and wrap with gauze roll once daily. One time a day for wound care with an order date of 1/1/25.<br><br>*Right Heel: Cleanse with 1/2 strength for odor and infection prevention. Apply alginate calcium f/b gauze island with border once daily. One time a day for wound care with an order date of 1/1/25.<br><br>R7's Stage 4 left hip pressure injury:<br><br>(continued on next page) |

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|---|---|---|---|
| | 525686 | A. Building<br>B. Wing | 02/25/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Muskego Health and Rehabilitation Center | S77 W18690 Janesville Rd<br>Muskego, WI 53150 |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Wound Physician-T's wound evaluation & Management Summary dated 1/29/25 documents wound size for length 6, width 5, depth 5 cm (centimeters). Exudate is moderate serous. Thick adherent devitalized necrotic tissue is 40% and granulation is 60%.<br><br>Dressing treatment plan documents primary dressing(s) Sodium hypochlorite solution (Dakin's) apply twice daily for 30 days: 1/2 strength cleanse for infection prevention and odor; Alginate calcium apply twice daily for 30 days. Secondary dressing(s) Gauze island w/bdr (with border) apply twice daily for 30 days.<br><br>Wound Physician-T's wound evaluation & Management Summary dated 2/5/25 documents wound size for length 6, width 5, depth 5 cm (centimeters). Exudate is moderate serous. Thick adherent devitalized necrotic tissue is 40% and granulation is 60%.<br><br>Dressing treatment plan documents primary dressing(s) Sodium hypochlorite solution (Dakin's) apply twice daily for 23 days: 1/2 strength cleanse for infection prevention and odor; Alginate calcium apply twice daily for 23 days. Secondary dressing(s) Gauze island w/bdr (with border) apply twice daily for 23 days.<br><br>Wound Physician-T's wound evaluation & Management Summary dated 2/12/25 documents wound size for length 5, width 5, and depth 5 cm. Exudate is moderate serous. Thick adherent devitalized necrotic tissue is 30% and granulation tissue is 70%.<br><br>Dressing treatment plan documents Primary dressing(s) Sodium hypochlorite solution (Dakin's) apply once daily for 30 days: 1/2 strength cleanse for infection prevention and odor; Alginate calcium apply once daily for 30 days. Secondary dressing(s) Gauze island w/bdr apply once daily for 30 days<br><br>Surveyor noted Wound Physician-T changed the treatment for R7's left hip pressure injury on 2/12/25. The facility did not pick up this order until 2/20/25, 8 days later.<br><br>R7's Stage 4 left lateral knee pressure injury:<br><br>Wound Physician-T's wound evaluation & Management Summary dated 1/29/25 documents wound size for length 10, width 4, depth 0.1 cm. Exudate is moderate serous. Thick adherent devitalized necrotic tissue is 30% and granulation is 70%.<br><br>Dressing treatment plan documents Alginate calcium apply once daily for 30 days; Sodium hypochlorite solution (Dakin's) apply once daily for 30 days: 1/2 strength cleanse for odor and infection prevention. Secondary dressing(s) ABD pad apply once daily for 30 days; Gauze roll (kerlix) 4.5 (inch) apply once daily for 30 days.<br><br>Wound Physician-T's wound evaluation & Management Summary dated 2/5/25 documents wound size for length 10, width 3, depth 0.1 cm. Exudate is moderate serous. Thick adherent devitalized necrotic tissue is 20% and granulation is 80%.<br><br>Dressing treatment plan documents Alginate calcium apply once daily for 23 days; Sodium hypochlorite solution (Dakin's) apply once daily for 23 days: 1/2 strength cleanse for odor and infection prevention. Secondary dressing(s) ABD pad apply once daily for 23 days; Gauze roll (kerlix) 4.5 (inch) apply once daily for 23 days.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Wound Physician-T's wound evaluation & Management Summary dated 2/12/25 documents wound size length 7, width 1, depth 0.1 cm. Exudate is moderate serous. Thick adherent devitalized necrotic tissue 20% and granulation tissue 80%<br><br>Dressing treatment plan documents Alginate calcium, apply three times per week for 30 days; Sodium hypochlorite solution (Dakin's) apply three times per week for 30 days: 1/2 strength cleanse for odor and infection prevention. Second dressing(s) Gauze island w/bdr apply three times per week for 30 days.<br><br>Surveyor noted Wound Physician-T changed the treatment for R7's left lateral knee pressure injury on 2/12/25. The facility did not pick up this order until 2/20/25, 8 days later.<br><br>R7's unstageable DTI (deep tissue injury) left fifth toe pressure injury:<br><br>Wound Physician-T's wound evaluation & Management Summary dated 1/29/25 documents wound size length 0.8, width 0.3, depth non measurable cm. Exudate is none. Skin is intact with purple/maroon discoloration.<br><br>The dressing treatment plan documents primary dressing(s) Skin prep apply once daily for 30 days.<br><br>Wound Physician-T's wound evaluation & Management Summary dated 2/5/25 documents wound size length 0.8, width 0.3, depth non measurable cm. Exudate is none. Skin is intact with purple/maroon discoloration.<br><br>The dressing treatment plan documents primary dressing(s) Skin prep apply once daily for 23 days.<br><br>On 2/6/25 the facility discontinued the treatment for R7's left fifth toe.<br><br>Wound Physician-T's wound evaluation & Management Summary dated 2/12/25 documents wound size length 0.8, width 0.3, depth not measurable cm. Exudate is none. Skin is intact with purple/maroon discoloration.<br><br>The dressing treatment plan documents primary dressing(s) Skin prep apply once daily for 16 days.<br><br>The facility had discontinued this treatment on 2/6/25 and did not pick up the 2/12/25 order. The facility did not implement an order for skin prep daily to R7's left fifth toe until 2/22/25.<br><br>R7's unstageable right heel pressure injury:<br><br>Wound Physician-T's wound evaluation & Management Summary dated 1/29/25 documents wound size length 1.5, width 0.8, depth 0.1. Exudate is moderate serous. Thick adherent devitalized necrotic tissue is 100%.<br><br>The dressing treatment plan documents primary dressing(s) Alginate calcium apply once daily for 30 days. Sodium hypochlorite solution (Dakin's) apply once daily for 30 days: 1/2 strength cleanse for odor and infection prevention. Secondary dressing(s) Gauze island w/bdr apply once daily for 30 days.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Wound Physician-T's wound evaluation & Management Summary dated 2/5/25 documents wound size length 1.5, width 0.8, depth 0.1. Exudate is moderate serous. Thick adherent devitalized necrotic tissue is 20% and granulation tissue is 80%.<br><br>The dressing treatment plan documents primary dressing(s) Alginate calcium apply once daily for 23 days. Sodium hypochlorite solution (Dakin's) apply once daily for 23 days: 1/2 strength cleanse for odor and infection prevention. Secondary dressing(s) Gauze island w/bdr apply once daily for 23 days.<br><br>Wound Physician-T's wound evaluation & Management Summary dated 2/12/25 documents wound size length 1, width 0.8, depth 0.1. Exudate is moderate serous. Thick adherent devitalized necrotic tissue is 20% and granulation tissue is 80%.<br><br>The dressing treatment plan documents primary dressing(s) Alginate calcium apply three times per week for 30 days; Sodium hypochlorite solution (Dakin's) apply three times per week for 30 days: 1/2/strength cleanse for odor and infection prevention. Secondary dressing(s) Gauze island w/bdr apply three times per week for 30 days.<br><br>Surveyor noted Wound Physician-T changed the treatment for R7's unstageable right heel pressure injury on 2/12/25. The facility did not pick up this order until 2/20/25, 8 days later.<br><br>On 2/20/25, at 10:30 a.m., Surveyor observed R7 in bed on her back. Surveyor observed R7 is wearing blue pressure relieving boots. R7 informed Surveyor she doesn't like it here and they don't change her wounds like they are suppose to be changed, they are suppose to change them every day and they don't do it.<br><br>On 2/20/25, from 10:45 a.m. to 11:03 a.m. Surveyor observed morning cares for R7 with Certified Nursing Assistant (CNA)-V.<br><br>On 2/20/25, at 11:08 a.m. Physical Therapy Assistant (PTA)-W and CNA-V entered R7's room to transfer R7 into her wheelchair. PTA-W & CNA-V placed gown & gloves on and then placed shoes on R7. PTA-W removed the leg rests from under R7's wheelchair cushion and the head of the bed was raised up. R7 started yelling maintenance needs to come in and check this bed. There is a bar across and sticks in my back. Surveyor observed the Selectis mattress is set at firm.<br><br>On 2/20/25, at 1:02 p.m. Surveyor asked Unit Manager/Social Services/Licensed Practical Nurse/Business Office Manager (UM/SS/LPN/BOM)-D if she goes on wound rounds with Wound Physician-T. UM/SS/LPN/BOM-D replied no. Surveyor asked who goes on wound rounds. UM/SS/LPN/BOM-D replied first names of Director of Nursing (DON)-B or Registered Nurse (RN)-J. Surveyor asked UM/SS/LPN/BOM-D if she follows up on Wound Physician-T's assessments. UM/SS/LPN/BOM-D informed Surveyor it should be DON-B or RN-J.<br><br>On 2/20/25, at 1:22 p.m., Surveyor asked RN-J if she reviewed Wound Physician-T's assessments from the weekly wound rounds. RN-J informed Surveyor she has to review the ones Wound Physician-T did yesterday and she went on half of the rounds with Wound Physician-T. Surveyor asked if Wound Physician-T changes the treatment who changes the order. RN-J replied I would change the ones I'm responsible for and [first name of DON-B] would follow up on the others. RN-J informed Surveyor she is responsible for side she is working on.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 2/20/25, at 3:02 p.m., Surveyor observed CNA-X and RN-Y enter R7's room, wash their hands and place PPE (personal protective equipment) on. CNA-X and RN-Y transferred R7 from the wheelchair into bed using a Sara lift. CNA-X removed R7's shoes, asked R7 if she can turn to remove her clothes. R7 rolled on her left side & CNA-X lowered R7's pants. RN-Y asked CNA-X to stand by the side of the bed so she can move the bed away from the wall. CNA-X then removed her PPE, performed hand hygiene, and left R7's room. Surveyor observed the Selectis air mattress is set at firm.<br><br>At 3:10 p.m., RN-Y removed the dressings from R7's left hip and left lateral knee. RN-Y removed her gloves, brought the garbage can closer to the bed, washed her hands and placed gloves on.<br><br>At 3:11 p.m. RN-Y informed R7 she was going to do her hip first. RN-Y poured 1/2 strength Dakin's on gauze and cleansed the wound bed. RN-Y poured 1/2 strength Dakin's on gauze and packed the gauze into R7's left hip pressure injury. RN-Y then applied border foam dressing & dated the dressing.<br><br>At 3:16 p.m. RN-Y poured 1/2 strength Dakin's on gauze and cleansed the left lateral knee pressure injury. RN-Y removed her gloves and placed gloves on. RN-Y placed three pieces of calcium alginate on the wound bed, opened the dresser drawer to remove tape, covered the pressure injury with two ABD pads and taped the pads. Surveyor observed RN-Y did not wrap the left lateral knee with gauze according to physician orders. RN-Y asked if she still has no pain. R7 replied no I have a very high pain tolerance. RN-Y informed R7 she was all finished. R7 asked about her right heel. RN-Y asked R7 what's going on with your heel and then moved the bed back against the wall. RN-Y removed R7's sock and foam dressing. RN-Y removed her gloves and placed gloves on. RN-Y fastened R7's incontinence product and pulled up her pants.<br><br>At 3:16 p.m. RN-Y removed her gloves, stated to R7 let me see about your heel, will be right back, removed her PPE, washed her hands and went into the hall where the treatment cart was.<br><br>At 3:29 p.m. RN-Y entered R7's room informing R7 they discontinued the heel, is going to clean it and put border dressing back. RN-Y placed PPE on and placed a wash cloth under R7's right heel. RN-Y sprayed wound cleanser on the right heel wound bed, dabbed with gauze, and covered with a foam dressing. RN-Y placed the sock back on R7's right foot and informed R7 a CNA will help you get you up. RN-Y removed her PPE and washed her hands.<br><br>Surveyor noted R7's treatment to the right heel was not discontinued but the treatment was changed.<br><br>On 2/20/25, at 3:45 p.m. Surveyor met with Nursing Home Administrator (NHA)-A, DON-B, and Director of Operations-C. Surveyor asked who is responsible for reviewing Wound Physician-T's weekly wound assessments. DON-B replied I do and the nurses should. Surveyor informed DON-B Wound Physician-T changed the treatment to R7's left hip, left lateral knee and right heel on 2/12/25 which was not picked up.<br><br>On 2/25/25, at 7:51 a.m. Surveyor observed R7 in bed on her back with the head of the bed elevated and R7's breakfast on the over bed table in front of her. Surveyor observed R7 is wearing gripper socks with her heels resting directly on the mattress. R7 informed Surveyor she is suppose to be wearing boots but they lost them. Surveyor observed R7's Selectis air mattress is set at firm.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 2/25/25, at 10:51 a.m., Surveyor observed R7 continues to be in bed on her back. R7 continues to be wearing gripper socks on her feet with her heels resting directly on the mattress. R7 is not wearing pressure relieving boots and her heels are not being offloaded.<br><br>On 2/25/25, at 10:27 a.m. Surveyor asked UM/SS/LPN/BOM-D how the nurses on the floor know a treatment has been changed. UM/SS/LPN/BOM-D informed Surveyor the treatment is changed in PCC (pointclickcare).<br><br>On 2/25/25, at 11:39 a.m., Surveyor met with DON-B. DON-B informed Surveyor because R7's orders were not reviewed, she reviewed R7's orders on 2/20/25 and transcribed the orders to make sure they were updated. Surveyor asked DON-B why did the facility discontinue the treatment order for R7's left 5th toe when Wound Physician-T continued this treatment. DON-B replied I'm not sure. Surveyor asked DON-B what should R7's air mattress be set at. DON-B informed Surveyor it to be set according to their weight. Surveyor informed DON-B the air mattress has been set to firm and R7 complained she can feel the bar. Surveyor asked DON-B what are they doing to prevent R7's right heel pressure from declining. DON-B informed Surveyor they do a treatment, monitoring, ensuring the air mattress is on, and encouraging offloading. Surveyor asked DON-B if R7 wears pressure relieving boots. DON-B informed Surveyor she wasn't sure. Surveyor informed DON-B Surveyor observed pressure relieving boots on R7 on 2/20/25 but does not have them on today and her heels were not being offloaded. Surveyor informed DON-B R7's right heel treatment was not done according to physician orders on 2/20/25 as the nurse informed R7 the treatment had been discontinued. Surveyor asked DON-B how does the nurse know the treatment orders have been changed. DON-B informed Surveyor they should review the MD (medical doctor) orders prior to doing the treatment.<br><br>On 2/25/25, at 12:49 p.m., DON-B informed Surveyor R7's air mattress has been set to her weight and she took it off static. Surveyor asked DON-B if the mattress should have been set to static. DON-B replied to my knowledge no. DON-B informed Surveyor when R7 gets up she will have maintenance check her mattress.<br><br>No additional information was provided to Surveyor as to why the facility discontinued R7's treatment to the left fifth toe on 2/6/25 even though Wound Physician-T continued this treatment, treatment changes on 2/12/25 were not picked up until 2/20/25, the right heel treatment was not completed according to physician orders on 2/20/25, R7's heels were not being offloaded & the air mattress was set to an incorrect setting. |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38829<br><br>Based on observation, interview, and record review, the facility did not ensure 1 (R1) of 1 Residents reviewed received adequate supervision and assistance devices to prevent accidents.<br><br>* R1 has been assessed as a high risk for falls. R1 had unwitnessed falls on 1/17, 2/2, and 2/9/25 and a thorough investigation was not completed including a root/cause analysis.<br><br>R1 is nothing by mouth (NPO) and receives all nutrition through a Peg Tube. On 2/13/25, R1 was given a regular diet with thin liquids on a food tray in the dining room and the facility did not complete an investigation.<br><br>On 2/14/25, R1 attempted to exit the facility. The facility did not complete a thorough investigation. R1 was not re-evaluated for an elopement risk until 2/18/25 which determined R1 required a wanderguard to be placed. An elopement risk care plan was not implemented until 2/24/25.<br><br>Findings Include:<br><br>The facility's Accidents and Supervision policy and procedure implemented 12/29/22 documents:<br><br>Policy:<br><br>.The Resident environment will remain as free of accident hazards as is possible. Each resident will receive adequate supervision and assistive devices to prevent accidents. This includes:<br><br>1. Identifying hazard(s) and risk(s).<br><br>2. Evaluating and analyzing hazard(s) and risk(s)<br><br>3. Implementing interventions to reduce hazard(s) and risk(s)<br><br>4. Monitoring for effectiveness and modifying interventions when necessary.<br><br>Policy Explanation and Compliance Guidelines:<br><br>The facility shall establish and utilize a systematic approach to address Resident risk and environmental hazards to minimize the likelihood of accidents.<br><br>1. Identification of Hazards and Risks-the process through which the facility becomes aware of potential hazards in the environment and the risk of a Resident having an avoidable accident.<br><br>a. All staff are to be involved in observing and identifying potential hazards in the environment, while taking into consideration the unique characteristics and abilities of each Resident.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 2. Evaluation and Analysis- the process of examining data to identify specific hazards and risks to develop targeted interventions to reduce the potential for accidents. Interdisciplinary involvement is a critical component of this process.<br><br>a. Analysis may include, for example, considering the severity of hazards, the immediacy of risk, and trends such as time of day, location, etc.<br><br>b. Both the facility-centered and resident-directed approaches include evaluating hazard and accident risk data, which includes prior accidents/incidents, analyzing potential causes for each hazard and accident risk, and identifying or developing interventions based on the severity of the hazards and immediacy of risk.<br><br>c. Evaluations also look at trends such as time of day, location, etc.<br><br>3. Implementation of Interventions- using specific interventions to try to reduce a resident's risks from hazards in the environment. The process includes:<br><br>a. Communicating the interventions to all relevant staff.<br><br>b. Assigning responsibility.<br><br>c. Providing training as necessary.<br><br>d. Documenting interventions.<br><br>e. Ensuring interventions are put into action.<br><br>f. Interventions are based on the results of the evaluation and analysis of information about -hazards and risks and are consistent with relevant standards, including evidenced-based practice.<br><br>g. Development of interim safety measures may be necessary if interventions cannot immediately be implemented fully.<br><br>h. Facility-based interventions may include, but are not limited to- educating staff .<br><br>i. Resident-directed approaches may include- implementing specific interventions as part of the plan of care<br><br>4. Monitoring and Modification- Monitoring the process of evaluating the effectiveness of care plan interventions. Modification is the process of adjusting interventions as needed to make them more effective in addressing hazards and risks. Monitoring and modification processes include:<br><br>a. Ensuring that interventions are implemented correctly and consistently.<br><br>b. Evaluating the effectiveness of interventions.<br><br>c. Modifying or replacing interventions as needed.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | d. Evaluating the effectiveness of new interventions.<br><br>5. Supervision-Supervision is an intervention and a means of mitigating accident risk. The facility will provide adequate supervision to prevent accidents.<br><br>R1 was admitted to the facility on [DATE] with diagnoses of Cerebral Infarction due to Thrombosis of Right Middle Cerebral Artery, Hemiplegia and Hemiparesis Affecting Left Non-Dominant Side, Dysphagia, Anemia, Encephalopathy, Bipolar Disorder, Anxiety Disorder, and Schizophrenia. R1 has a legal guardian.<br><br>R1's Admission Minimum Data Set (MDS) completed on 1/23/25 documents R1 has a Brief Interview for Mental Status (BIMS) score of 13, indicating R1 is cognitively intact for daily decision making. R1's Patient Health Questionnaire (PHQ-9) is 10 indicating R1 has moderate depression. The only behavior documented on R1's MDS is verbal behaviors. R1 is always incontinent of bowel and bladder. R1 has range of motion (ROM) impairment on one side of both upper and lower extremity. R1 is dependent for showers, dressing, hygiene, mobility, and transfers.<br><br>Fall Risk Evaluations were completed on R1 determining R1 is a high risk for falls on the following dates:<br><br>-1/18/25<br><br>-2/2/25<br><br>-2/9/25<br><br>-2/23/25<br><br>R1's Care Plan documents:<br><br>(R1) is at risk for falls, accidents and incidents due to left hemiparesis, schizophrenia, bipolar<br><br>1/17/25<br><br>Interventions:<br><br>-Anticipate and meet R1's needs. 1/27/25<br><br>-Be sure (R1's) call light is within reach and encourage (R1) to use it for assistance as needed. R1 needs prompt response to all requests for assistance. 1/17/25<br><br>-Encourage (R1) to call for assistance with all transfers. 2/10/25<br><br>-Follow facility fall protocol. 1/17/25<br><br>-Monitor (R1) for increase restlessness while in dining room, if restlessness occurs offer (R1) to lie down. 2/10/25<br><br>(continued on next page) |

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| | 525686 | A. Building<br>B. Wing | 02/25/2025 |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | (R1) is an elopement risk/wanderer due to impaired cognition, behaviors, impulsive. 2/24/2025<br><br>-Distract (R1) from wandering by offering pleasant diversions, structured activities, food, conversation, television, book (R1) prefers: 2/24/2025<br><br>-WANDER ALERT: left ankle 2/24/2025<br><br>R1's initial admission assessment on 1/17/25 evaluated R1 to not be at risk for elopement.<br><br>R1 requires tube feeding due to dysphagia. 1/22/25<br><br>R1's baseline care plan developed 1/17/25 documents R1 is nothing by mouth (NPO) with a Peg Tube.<br><br>On 2/10/25, R1 had a swallow study conducted. Results document to continue G-Tube feedings to meet needs and for medication. Recommend trials of puree and nectar by teaspoon or honey thick liquids via cup under speech therapy supervision with advance to at least pleasure feeds with trained caregiver.<br><br>Falls:<br><br>1/17/25-R1 had an unwitnessed fall at 7:00 PM. R1 was observed lying on the floor next to the bed. R1 stated R1 wanted to get to Milwaukee. No root/cause analysis is documented. No staff statements documenting details of R1 prior to the fall.<br><br>2/2/25-R1 had an unwitnessed fall at 2:38 AM. R1 was observed on the floor close to the edge of the bed. R1 stated R1 rolled out of bed. No root/cause analysis is documented. No staff statements documenting details of R1 prior to the fall.<br><br>Surveyor notes no new person-centered intervention was implemented on R1's care plan.<br><br>2/9/25-R1 had an unwitnessed fall at 7:00 PM. R1 was found laying on the floor on right side. R1 stated R1 was trying to get up and walk so R1 could go home. No root/cause analysis is documented. No staff statements documenting details of R1 prior to the fall.<br><br>Surveyor notes that all 3 falls do not document what fall interventions were in place at the time of the fall. There is no documentation of a possible pattern given that 2 of the falls occurred at approximately 7:00 PM.<br><br>Attempted Elopement:<br><br>On 2/14/25, at 5:00 AM, R1 was found standing in the doorway attempting to exit the facility with door alarm sounding. R1 stated that R1 was going home. Interdisciplinary Team documented this was a new behavior. No root/cause analysis is documented. No staff statements documenting details of R1 prior to the attempted elopement.<br><br>Surveyor notes that it is documented on 2 of R1's falls that R1 fell because R1 was attempting to get home. There is no documentation of the facility correlating the pattern of trying to get home to the attempted elopement.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | R1 was transferred from downstairs to an upstairs room. R1 was not assessed for elopement risk until 2/18/25, determined to be high risk, and a wanderguard was placed on R1. An elopement care plan was not initiated for R1 until 2/24/25.<br><br>On 2/20/25, at 7:05 AM, Surveyor interviewed Certified Nursing Assistant (CNA)-I in regards to R1's attempted elopement from the facility. CNA-I stated CNA-I was doing rounds about 4:45 AM, and heard the door alarm going off. CNA-I went to the door and observed R1 half in and half out the door with R1's hand still on the door. R1 was wearing a gown, socks, and a brief at the time. CNA-I brought R1 back into the building and placed R1 in bed and R1 fell asleep. CNA-I stated CNA-I was working the community based residential facility and rounding on the 3 skilled nursing facility rooms downstairs that shift.<br><br>Provided Regular Diet with Thin Liquids:<br><br>R1 is NPO and receives all nutrition through a Peg Tube.<br><br>On 2/13/25, it is documented by Director of Nursing (DON)-B that R1 was mistakenly fed orally. Assessment noted no coughing and clear lung sounds present. Chest X-Ray documents no negative outcome.<br><br>The facility has no documented investigation of who or how R1 was given a food tray.<br><br>On 2/19/25, at 1:50 PM, Surveyor interviewed Licensed Practical Nurse (LPN)-D. LPN-D stated that the facility utilizes a 24 hour board and is not sure where the 24 hour board documentation would be for the month of February. I don't keep track of that stuff.<br><br>On 2/19/25, at 2:12 PM, Registered Dietitian (RD)-G via telephone informed Surveyor that RD-G was informed on 2/18/25 that R1 had been accidentally provided a tray from a staff member in the kitchen. RD-G has no further information.<br><br>On 2/19/25, at 3:15 PM, DON-B informed Surveyor that R1 was up in the wheelchair in the dining room on 2/13/25 and was provided another Resident's lunch tray. Does not recall if R1 ate the whole lunch tray. DON-B will need to look for the incident report. DON-B confirmed R1 attempted to leave the facility on 2/14/25, but a CNA heard the door alarm going off and was able to re-direct R1 back inside. DON-B is not able to locate the 24 hour report sheets.<br><br>On 2/20/25, at 9:23 AM, Surveyor interviewed Speech Therapist (SLP)-M via telephone. SLP-M was notified about R1 eating food off the tray from LPN-D. SLP-M stated that SLP-M evaluated R1 the day after the incident and found R1 not to be in any distress. No signs of silent aspiration. SLP-M was informed that it was unclear how much food R1 had consumed. R1 continues to be NPO and SLP-M continues to work with R1.<br><br>On 2/20/25, at 1:11 PM, Surveyor interviewed LPN-D again in regards to R1 getting the tray. LPN-D stated that Registered Nurse (RN)-J had informed LPN-D that R1 got a tray but does not know whose tray it was. LPN-D believes R1 ate half a sandwich.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 2/20/25, at 1:22 PM, Surveyor interviewed RN-J. RN-J stated that on 2/13/25, R1 was agitated and trying to get out of bed so the CNA brought R1 to the dining room. A staff member informed someone in the kitchen that R1 was another Resident (R2) and the kitchen provided R1 with R2's lunch tray. RN-J stated R1 ate the whole tray. RN-J stated that R1 has been begging for food for over a month. RN-J stated, If I've been begging for food, I would eat the whole tray. RN-J stated that R1 never went to the dining room for meals. R1 is always wanting to smoke, go home, and eat.<br><br>Surveyor reviewed the lunch menu for 2/13/25. R1 consumed roast turkey, gravy, stuffing, broccoli florets, dinner roll, pineapple upside down cake, and water.<br><br>On 2/20/25, at 3:33 PM, Surveyor met with Nursing Home Administrator (NHA)-A, DON-B, and Director of Operations (DO)-C. Surveyor shared the concern that R1's 3 falls, attempted elopement, and being provided a tray was not thoroughly investigated to determine root/cause, identify a pattern, and develop person-centered interventions. Surveyor shared without a thorough investigation, this increases the chances of further avoidable incidents in the future. No further information was provided by the facility at this time. |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide enough food/fluids to maintain a resident's health.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38829<br><br>Based on interview and record review, the facility did not ensure resident (R2) maintained acceptable parameters of nutritional status for 1 (R2) of 1 resident reviewed for weight loss.<br><br>On 1/24/25, Licensed Practical Nurse (LPN)-E documented in R2's electronic medical record (EMR) that R2 missed 4 bolus feedings due to Nepro not being available. Per R2's Medication Administration Record, there were 7 total missed feedings. R2 had a significant weight loss identified on 1/28/25 times one week of -5.4% (9 pounds). On 2/11/25, R2 was identified as having a significant weight loss times 30 days of -6.9% (11 pounds). The physician was not notified. Cross Reference (F580). On 1/25/25, weights 2 times a week on Tuesday and Saturday were initiated per physician's order. On 2/11/25, weights were recommended by Registered Dietitian (RD)-G to be obtained 3 times a week. No new physician order was obtained. 9 weights were not obtained. On 2/4/25, R2's swallow study recommended to treat R2's tongue thrush and a physician's order was not obtained. No new interventions were updated on R2's person-centered plan of care.<br><br>Findings Include:<br><br>The facility's policy and procedure Weight Monitoring implemented 1/4/24 and revised 6/4/24 documents:<br><br>Policy:<br><br>.Based on the Resident's comprehensive assessment, the facility will ensure that all Residents maintain acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the Resident's clinical condition demonstrates that this is not possible or Resident preferences indicate otherwise.<br><br>Compliance Guidelines:<br><br>Weight can be a useful indicator of nutritional status. Significant unintended changes in weight(loss of gain) or insidious weight loss(gradual unintended loss over a period of time) may indicate a nutritional problem.<br><br>1. The facility will utilize a systemic approach to optimize a Resident's nutritional status. This process includes:<br><br>a. Identifying and assessing each Resident's nutritional status and risk factors.<br><br>b. Evaluating/analyzing the assessment information.<br><br>c. Developing and consistently implementing pertinent approaches.<br><br>d. Monitoring the effectiveness of interventions and revising them as necessary.<br><br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 2. A comprehensive nutritional assessment will be completed upon admission on Residents to identify those at risk for unplanned weight loss/gain or compromised nutritional status.<br><br>3. Information gathered from the nutritional assessment and current dietary standards of practice are used to develop an individualized care plan to address the Resident's specific nutritional concerns and preferences. The care plan should address the following, to extent possible:<br><br>a. Identified causes of impaired nutritional status<br><br>b. Reflect the Resident's personal goals and preferences<br><br>c. Identify Resident-specific interventions<br><br>d. Time frame and parameters for monitoring<br><br>e. Updated as needed such as when the Resident's condition changes, goals are met, interventions are determined to be ineffective or a new causes of nutrition-related problems are identified<br><br>f. If nutritional goals are not achieved, care planned interventions will be re-evaluated for effectiveness and modified as appropriate<br><br>g. The Resident and/or representative will be involved in the development of the care plan to ensure it is individualized and meets personal goals and preferences.<br><br>4. Interventions will be identified, implemented, monitored and modified, consistent with the Resident's assessed needs, choices, preferences, goals and current professional standards to maintain acceptable parameters of nutritional status.<br><br>5. A weight monitoring schedule will be developed upon admission for all Residents:<br><br>d. If clinically indicated-monitor weights daily, weekly or per dietitian or provider requests<br><br>6. Weight Analysis: The newly recorded Resident weight should be compared to the previously recorder weight. A significant change in weight is defined as:<br><br>a. 5% change in weight in 1 month(30 days)<br><br>7. Documentation:<br><br>a. The physician should be informed of a significant change in weight and may order nutritional interventions.<br><br>b. The physician should be encouraged to document the diagnosis or clinical conditions that may be contributing to the weight loss.<br><br>c. Meal consumption information should be recorded.<br><br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | e. The Registered Dietitian of Dietary Manager should be consulted to assist with interventions; actions are recorded in the nutrition progress notes.<br><br>f. Observations pertinent to the Resident's weight status should be recorded in the medical record as appropriate .<br><br>R2 was admitted to the facility on [DATE] with diagnoses of Other Nontraumatic Intracerebral Hemorrhage, Hemiplegia and Hemiparesis Affecting Right Dominant Side, Chronic Kidney Disease, Stage 4, and Depression. R2 has a legal guardian.<br><br>R2's Admission Minimum Data Set (MDS) completed 1/23/25 documents a Brief Interview for Mental Status (BIMS) score of 0, indicating R2 demonstrates severely impaired skills for daily decision making. R2's MDS documents R2's Patient Health Questionnaire (PHQ-9) score to be 12, indicating moderate depression. R2's MDS also documents R2 is always incontinent of bowel and bladder and has range of motion (ROM) impairment on both sides of upper and lower extremities. R2's MDS documents R2 is dependent for dressing, eating, transfers, mobility, hygiene, and showers. At the time of the MDS, R2 was receiving nothing by mouth (NPO), and received complete nutrition through a gastrostomy (g-tube).<br><br>R2's electronic medical record (EMR) indicates that R2 understands yes and no questions and is able to nod head in answering yes and no questions with appropriate answers. R2 is also able to use cue cards.<br><br>Surveyor reviewed R2's EMR and noted the following documentation:<br><br>-Registered Dietitian (RD)-G documents on 1/20/25 to obtain a re-weigh and increase flush with 120 ml before and after each bolus feed<br><br>-Licensed Practical Nurse (LPN)-P documents on 1/23/25 that LPN-P is awaiting pharmacy delivery of Bolus Feeding Formula Nepro 250 ml four times a day<br><br>-LPN-Q documents on 1/24/25 at 12:21 AM, 8:16 AM, and 9:11 AM that the Bolus Feeding Formula Nepro 250 ml is pending delivery.<br><br>-On 1/24/25 at 8:40 PM, LPN-E documents that LPN-E noticed in nursing documentation that R2 had missed times 4 bolus feedings due to Nepro not available. LPN-E informed Director of Nursing (DON)-B, Unit Manager and physician. LPN-E was informed Nepro was delivered today and was down in storage. LPN-E obtained vitals and administered feeding to R2 per order. Physician stated to continue current order. R2 is on by mouth (PO) diet as well.<br><br>Surveyor reviewed R2's Medication Administration Record (MAR) and noted it is documented that R2 did not receive the following bolus feedings: (blank)<br><br>-1/22/25, 3 feedings on 1/23/25, 2 feedings on 1/24/25, and 1 feeding on 1/25/25 (7 total feedings)<br><br>-On 1/22/25 1 feeding is documented with an x with no corresponding documentation.<br><br>-Per physician orders, on 1/25/25, weight twice weekly in the morning every Tuesday, Saturday for weight control was initiated.<br><br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -On 1/28/25 RD-G documented that R2 had a significant weight loss times one week (-5.4%) (9 pounds). Weight loss likely due to poor meal intake due to R2 does not like current diet texture. Requested Speech Therapy evaluation.<br><br>-On 2/1/25, Registered Nurse (RN)-R documented weight twice weekly in the morning every Tuesday, Saturday for weight control to be obtained.<br><br>-On 2/4/25, tube feeding was discontinued due to diet upgrade.<br><br>R2 had a swallow study completed on 2/4/25 and was upgraded to a regular thin liquid diet. R2's bolus feedings of nepro 4 times a day was discontinued. The swallow study also documents that R2's tongue thrush needs to be treated. This recommendation is not documented it was communicated with R2's physician. R2's physician orders do not document a treatment was ordered.<br><br>-On 2/11/25, RD-G documented R2 has had a significant weight loss times 30 days (-6.9%) (11 pounds), Director of Nursing (DON)-B notified. Meal intake is poor per staff report and R2 is consuming 10-25% of meals per documentation. Receives magic cup 2 times a day-100% intake per documentation. Recommend to re-instate tube feeding due to inadequate meal intake (nighttime schedule to promote PO intake during the day) and continue magic cups. Recommend weekly weights times 3 due to significant weight loss and changes in texture/tube feeding order. DON-B notified of recommendation.<br><br>Surveyor was not able to locate documentation that R2's physician was notified and consulted with in regard to R2's significant weight loss.<br><br>Documented weights for R2:<br><br>1/22/25-167 pounds<br><br>1/28/25-158 pounds<br><br>2/11/25-155.5 pounds<br><br>Surveyor noted that per Medication Administration Record (MAR) and R2's EMR documentation, weights were not obtained per physician order as of 1/25/25 and per RD-G recommendation of weekly weights times 3 times on 2/11/25.<br><br>Surveyor reviewed R2's comprehensive care plan:<br><br>Inadequate oral intake due to history of cerebral vascular accident and or poor appetite as evidenced by need for tube feeding to cover 100% nutrition needs and BMI low for age/condition Initiated 1/22/25<br><br>Interventions:<br><br>-Provide and serve diet as ordered Initiated 1/22/25<br><br>-RD-G to evaluate and make diet change recommendations as needed Initiated 1/22/25<br><br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Surveyor noted there are no updated interventions updated on R2's person-centered plan of care based on the above documentation from R2's EMR.<br><br>Surveyor noted that R2 has a diagnosis of Depression and is on an antidepressant (Sertraline 75 mg one time a day).<br><br>R2's comprehensive care plan addresses R2's depression:<br><br>-(R2) has a psychosocial well-being due to dependent behavior, lack of motivation Initiated 1/27/23<br><br>-(R2) at risk for mood impairment due to little interest in doing things Initiated 1/27/23<br><br>On 2/3/25, R2 had an initial psychiatry evaluation that does not document R2's significant weight loss and how it may be correlated as a result of R2's depressive symptoms. Surveyor notes that R2's EMR documents multiple times that R2 is tearful.<br><br>On 2/19/25 at 2:04 PM, Surveyor spoke with RD-G via telephone in regards to R2's significant weight loss. Surveyor asked RD-G if Rd-G was aware that R2 had missed multiple R2's bolus tube feedings. RD-G informed Surveyor that RD-G was not aware of this . RD-G explained if RD-G was notified, RD-G would have an order written to change the formula temporarily until the facility could get the supply in. Surveyor asked RD-G who notifies the physician when there is a significant weight loss. RD-G notifies Nursing Home Administrator (NHA)-A and DON-B of significant weight loss by email. RD-G does not have contact with the physician. RD-G explained that RD-G is in the facility one day a week.<br><br>On 2/19/25 at 3:25 PM, Surveyor interviewed DON-B in regard to a significant weight loss. DON-B stated that RD-G communicates to DON-B when there is a significant weight loss and it is the responsibility of the nurses to notify the physician. DON-B stated it is the responsibility of DON-B to order tube feeding for the facility.<br><br>On 2/20/25 at 9:27 AM, Surveyor interviewed Speech Therapist (SLP)-M who stated that R2 has not been eating well. SLP-M continues to work with R2.<br><br>On 2/20/25 at 10:43 AM, LPN-E confirmed via telephone that R2 was not administered multiple bolus tube feedings.<br><br>On 2/20/25 at 3:33 PM, Surveyor shared with NHA-A, DON-B, and Director of Operations (DO)-C the concern that RD-G documented R2 had a significant weight loss two different times and R2's EMR does not have documentation that R2's physician was notified and consulted with. Shared concern of weights not being obtained per physician order and RD-G recommendations and no revisions to R2's care plan. Surveyor shared a root/cause analysis was not investigated as to R2's significant weight loss. NHA-A, DON-B, and DO-C understand the concern and provided no further information at this time.<br><br>On 2/22/25, RD-G completed an updated Nutritional Evaluation. R2 is currently on a hybrid diet: Regular (served on scoop/divided plate), thin liquids, magic cup two times a day, nighttime tube feeding times 8 hour to help meet nutritional needs. Goal is for gradual weight gain back to admission weight of 167 pounds.<br><br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 2/25/25 at 9:22 AM, DO-C provided additional information in regard to R2's significant weight loss. DO-C shared the facility obtained a re-weigh on R2 and completed a dehydration risk assessment. DON-B does not know why there was no Nepro in the facility for R2 as there had been a delivery. DON-B believes staff may have been using Nepro that was sent with R2 from the hospital. A re-education with nurses was completed on what to do when tube feeding is not available. RD-G updated physician orders to include alternative tube feedings if not available. Surveyor shared that R2's significant weight loss and the previous factors related is still a concern as R2 remains at significant risk for future weight loss |

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| | 525686 | A. Building<br>B. Wing | 02/25/2025 |

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| Muskego Health and Rehabilitation Center | S77 W18690 Janesville Rd<br>Muskego, WI 53150 |

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| F 0698<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe, appropriate dialysis care/services for a resident who requires such services.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20483<br><br>Based on interview and record review the facility did not ensure 1 (R3) of 1 residents have consistent pre and post dialysis communication for R3 who receives dialysis three times a week.<br><br>Findings include:<br><br>The facility's policy titled, Hemodialysis and dated 2/15/23 under under purpose documents The facility will assure that each resident receives care and services for the provision of hemodialysis and/or peritoneal dialysis consistent with professional standards of practice. This will include: The ongoing evaluation of the resident's condition and monitoring for complications before and after dialysis treatments received at a certified dialysis facility. Ongoing evaluation and oversight of the resident before, during and after dialysis treatments, including monitoring of the resident's condition during treatments, monitoring for complications, implementation of appropriate interventions, and using appropriate infection control practices and Ongoing communication and collaboration with the dialysis facility regarding dialysis care and services. Under compliance guidelines documents 4. The licensed nurse will communicate to the dialysis facility via telephonic communication or written format, such as a dialysis communication form or other form, that will include, but not limited itself to: a. Timely medication administration (initiated, held or discontinued) by the nursing home and/or dialysis facility; b. Physician/treatment orders, laboratory values, and vital signs; c. Advance Directives and code status; specific directives about treatment choices; and any changes or need for further discussion with the resident/representative, and practitioners; d. Nutritional/fluid management including documentation of weights, resident compliance with food/fluid restrictions or the provision of meals before, during and/or after dialysis and monitoring intake and output measurements as ordered; e. Dialysis treatment provided and resident's response, including declines in functional status, falls, and the identification of symptoms that may interfere with treatments; f. Dialysis adverse reactions/complications and/or recommendations for follow up observations and monitoring, and/or concerns related to the vascular access site. g. Changes and/or declines in condition unrelated to dialysis. h. The occurrence or risk of falls and any concerns related to transportation to and from the dialysis facility.<br><br>R3's diagnoses includes end stage renal disease.<br><br>R3's physician order dated 1/17/25 documents dialysis is on T/TH/SAT (Tuesday/Thursday/Saturday) [Name] chair time at 12:10 p.m.<br><br>R3's admission MDS (minimum data set) with an assessment reference date of 1/23/25 has a BIMS (brief interview mental status) score of 15 which indicates cognitively intact. Dialysis is check for while a resident.<br><br>On 2/20/25, at 10:23 a.m., Surveyor observed R3 in bed. R3 informed Surveyor he has to get up as he has dialysis today and they pick him up around 11:00 a.m. Surveyor asked R3 what time he returns from dialysis. R3 informed Surveyor about 4:00 p.m. R3 informed Surveyor he goes to dialysis three times a week.<br><br>(continued on next page) |

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| F 0698<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 2/21/25, at 7:30 a.m., Surveyor asked Director of Nursing (DON)-B where Surveyor would be able to locate dialysis communication sheets. DON-B informed Surveyor they are under the miscellaneous tab or she can check with medical records if there are any that have not been uploaded.<br><br>Surveyor reviewed R3's medical record for dialysis communication forms from 1/27/25 to present. Surveyor was able to locate only one dialysis communication form dated 2/6/25. Surveyor noted the pre dialysis information and dialysis center information has been completed. The post dialysis information section is blank. The date, time, shunt location status, bruit/thrill present, bleeding, vital signs, and general condition of resident has not been completed.<br><br>On 2/21/25, at 7:37 a.m., Surveyor informed DON-B Surveyor was only able to locate one dialysis form dated 2/6/25 in R3's electronic medical record and would like to see all R3's dialysis communication forms from 1/28/25 to present.<br><br>On 2/21/25, at 11:38 a.m., Surveyor asked Registered Nurse (RN)-J how they communicate with the dialysis center for R3. RN-J explained when a resident goes to dialysis they send the face sheet, MAR (medication administration record), and dialysis communication form. Surveyor asked RN-J how the dialysis communication form is completed. RN-J informed Surveyor the top section (pre dialysis information) is completed by the facility and the bottom sections are dialysis. RN-J informed Surveyor last week she didn't know R3 left early and the form was not sent. RN-J also informed Surveyor sometimes dialysis doesn't send back the papers. Surveyor asked RN-J if dialysis doesn't send back the communication form do you call them. RN-J replied honestly, no.<br><br>On 2/25/25, at 10:27 a.m., Surveyor asked Unit Manager/Social Services/Licensed Practical Nurse/Business Office Manager (UM/SS/LPN/BOM)-D if she could explain how the facility communicates with the dialysis center. (UM/SS/LPN/BOM)-D informed Surveyor she'd have to double check with DON-B.<br><br>On 2/21/25, at 12:02 p.m., Surveyor informed DON-B Surveyor has only received one dialysis communication form dated 2/6/25 since 1/28/25 and R3 goes to dialysis three times a week. DON-B indicated to Surveyor she doesn't have any other forms to provide to Surveyor.<br><br>No additional information was provided to Surveyor as to why there is not any further pre and post dialysis communication forms for R3 who has dialysis three times a week. |

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| F 0732<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Post nurse staffing information every day.<br><br>38829<br><br>Based on observation, interview, and record review, the facility did not ensure that the daily nursing staff posting contained accurate information for the skilled nursing facility (SNF). This deficient practice has the potential to affect a pattern of all 37 Residents residing in the facility.<br><br>The facility nursing staff posting included community based residential facility (CBRF) hours and the skilled nursing facility hours were either blank with no certified nursing assistants (CNAs) assigned on nights or the number of CNAs was inaccurate.<br><br>Findings include:<br><br>On 2/20/25, at 1:01 PM, Receptionist (RC)-O confirmed that RC-O is responsible for the daily nursing staff posting. Surveyor requested nursing schedules and nursing staff postings from 1/28/25-2/20/25.<br><br>On 2/25/25, at 9:52 AM, Surveyor conducted an interview with Director of Nursing (DON)-B. DON-B stated there is always 2 CNAs assigned on nights to work in the SNF. Surveyor and DON-B went over the nursing staff postings and DON-B confirmed that the CBRF hours are listed and should not be on the posting. Surveyor and DON-B reviewed the nursing staff postings which documented multiple times there was only 1 CNA listed as being assigned to the SNF. DON-B is confused why there is only 1 CNA listed for nights for SNF when there is always 2 CNAs. DON-B explained that if a CNA is assigned to the CBRF the CNA can also cover the 3 SNF rooms downstairs. Surveyor again requested the daily working schedules of the nursing staff and what assignment the staff had.<br><br>On 2/25/25, at 10:03 AM, RC-O explained that RC-O gets the daily schedule on a spreadsheet from DON-B and completes the nursing staff posting. RC-O confirmed RC-O includes the CBRF hours on the SNF posting. RC-O stated, maybe it needs to be clarified. I was following what the person did before me.<br><br>On 2/25/25, at 11:05 AM, DON-B informed Surveyor that the facility does not have daily nursing schedules of who worked and what their assignment was. DON-B stated that the practice has been to write it on the dry erase board by the nurse's station each day and then erased. DON-B does not have any documentation of assignments from the past. DON-B stated that going forward we will keep written schedules with assignments.<br><br>On 2/25/25, at 12:08 PM, DON-B informed Surveyor that the facility changed to writing the staff and assignments on the white board about a year ago. DON-B agreed that the CBRF hours should not be co-mingled with the SNF hours. Again, DON-B stated there is always 2 CNAs on nights, however, understands the concern that there are multiple days where it is documented on the nursing staff postings that there was no CNAs working nights in the SNF.<br><br>On 2/25/25, at 12:15 PM, Surveyor conducted a record review of the daily nursing postings from 1/18/25-2/25/25 and the actual time clock punches of staff working. Surveyor notes there are 14 days that there is inaccurate nursing staff hours that were documented on the daily nursing postings during that time period.<br><br>(continued on next page) |

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| F 0732<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | On 2/25/25, at 1:21 PM, Surveyor reviewed the concern with DON-B and Director of Operations (DO)-C that the daily nursing SNF postings were inaccurate based on actual staff time punches and that the postings included CBRF hours. DON-B and DO-C understands the concern and provided no further information at this time. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20483<br><br>Based on observation, interview, and record review the facility did not maintain an infection prevention and control program designed to reduce the transmission of disease and infection for 4 (R3, R4, R7, & R2) of 4 Residents.<br><br>* There was not an enhanced barrier precaution sign on R3's door, (Licensed Practical Nurse) (LPN)-N did not wear appropriate PPE (personal protective equipment) during a treatment observation and appropriate hand hygiene was not observed during the treatment observation.<br><br>* R4 was admitted to the facility on [DATE] with multiple non pressure areas. An enhanced barrier sign was not observed on R4's door on 2/20/25 until 2:56 p.m.<br><br>* Appropriate hand hygiene was not observed during treatment and incontinent cares for R7.<br><br>* The nurse did not wear appropriate PPE for R2 who is on enhanced barrier precautions when flushing R2's tube and did not perform hand hygiene prior to leaving R2's room.<br><br>Findings include:<br><br>The facility's policy titled, Enhanced Barrier Precautions and dated 12/23/22 under policy documents It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organism. Under definitions documents Enhanced barrier precautions: refer to the use of gown and gloves for use during high-contact resident care activities for residents known to be colonized or infected with a MDRO (multi drug resistant organism) as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices). Under Policy Explanation and Compliance Guidelines for 1. Prompt recognition of need: documents c. Clear signage will be posted on the door on wall outside of the resident room indicating the type of precautions, required personal protective equipment (PPE), and the high contact resident care activities that require the use of gowns and gloves.<br><br>The facility's policy titled, Hand Hygiene and dated 10/24/22 under policy documents All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents and visitors. This applies to all staff working in all locations within the facility. Under Policy Explanation and Compliance Guidelines for 6. Additional considerations: documents a. The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning (putting on) gloves, and immediately after removing gloves.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 2/25/25, at 11:48 a.m. Surveyor interviewed Director of Nursing (DON)-B regarding infection control. DON-B is the Infection Preventionist for the facility. Surveyor asked DON-B what is her expectation for when staff should perform hand hygiene. DON-B informed Surveyor when hands are visibly soiled, in & out of rooms, between cares and providing meals. Surveyor asked DON-B after removing their gloves? DON-B replied yes. Surveyor asked asked after performing incontinence cares and before going to a clean task should staff perform hand hygiene. DON-B replied yes. Surveyor asked if a resident has multiple wounds, after the nurse completes one area should she remove her gloves and perform hand hygiene before going to the next wound. DON-B replied that would be best practice. Surveyor asked if a resident has an order for enhanced barrier precautions should they be placed on EBP (enhanced barrier precautions). DON-B replied yes. Surveyor asked if a resident is admitted with non pressure skin impairments when would the EBP sign be placed on the door. DON-B informed Surveyor after the resident is admitted . Surveyor asked how would staff know a resident is on EBP. DON-B informed Surveyor there should be a sign on the door and an order in the chart.<br><br>1.) R3's diagnoses includes end stage renal disease, peripheral vascular disease, morbid obesity, fournier gangrene, diabetes mellitus, and idiopathic aseptic necrosis of right finger.<br><br>R3's physician orders dated 1/22/25 documents Enhanced Barrier Precautions r/t (related to) wounds.<br><br>On 2/19/25, at 9:32 a.m., Surveyor observed there is not an Enhanced Barrier Precaution sign outside R3's room.<br><br>On 2/19/25, at 11:56 a.m. Surveyor observed Licensed Practical Nurse (LPN)-N enter R3's room wearing a mask & gloves and placed the treatment supplies on the over bed table. LPN-N was not wearing the appropriate PPE as she was not wearing a gown. LPN-N asked R3 if she could do his treatment, removed her gloves and washed her hands. LPN-N placed gloves on, lowered R3's pants and removed the incontinence product. LPN-N removed her gloves & placed gloves on. LPN-N did not perform any hand hygiene. LPN-N sprayed wound cleanser on four by four gauze and cleansed R3's left scrotum stitches, repeating this process three times. LPN-N removed her gloves and placed gloves on. LPN-N did not perform any hand hygiene. LPN-N sprayed puracyn plus on abd pad, stated have to wipe up from bottom, and dabbed R3's stitches from the bottom of R3's scrotum up to the end of the suture line. LPN-N applied skin prep around the stitches. LPN-N ripped the calcium alginate placing pieces of calcium alginate over the suture line. LPN-N asked R3 if there is any kerlix. R3 informed LPN-N there are treatment supplies in the dresser. LPN-N opened the drawer, stated she will go grab an abdominal pad and will be back in less than 2 seconds. LPN-N removed her gloves and left R3's room. LPN-N did not perform any hand hygiene prior to leaving R3's room. LPN-N returned a few seconds later, cleansed her hands and placed gloves on. LPN-N folded the abdominal pad and placed this pad between R3's left thigh and scrotum. LPN-N taped the abdominal pad onto R3's scrotum at the top & bottom. LPN-N placed an incontinence product & pulled up R3's pants by having R3 roll himself on the left & right side. LPN-N removed her gloves and washed her hands.<br><br>On 2/19/25, at 1:57 p.m., Surveyor observed there is still not an EBP sign on or around R3's door.<br><br>On 2/19/25, at 2:08 p.m., Surveyor asked Registered Nurse (RN)-J how staff knows if a resident is on EBP (enhanced barrier precautions). RN-J informed Surveyor there would be a sign on the door and explained a resident is on EBP for wounds, catheter, etc. Surveyor asked RN-J where PPE (personal protective equipment) is kept. R-J replied in the room but there should be a cart outside.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 2/20/25, at 7:31 a.m. Surveyor observed there is still not an EBP sign on or around R3's door.<br><br>On 2/20/25, at 10:23 a.m. Surveyor observed there is still not an EBP sign on or around R3's door.<br><br>On 2/25/25, at 7:45 a.m., Surveyor observed there is not an EBP sign on R3's door. Surveyor noted R3 had been moved to a new room.<br><br>On 2/25/25, at 11:48 a.m., following the above interview with DON-B Surveyor informed DON-B of the observation of R3 not having an EBP sign on his room doors and concerns regarding hand hygiene during R3's treatment observation.<br><br>2.) R4 was admitted to the facility on [DATE] with multiple non pressure areas with treatments to R4's left knee, left ankle, abdomen, left iliac crest, left medial foot, and right plantar foot.<br><br>Surveyor reviewed R4's physician orders and was unable to locate an order for enhanced barrier precautions.<br><br>On 2/19/25, at 10:43 a.m., Surveyor did not observe an enhanced barrier sign on or around R4's door alerting staff R4 is on enhanced barrier precautions.<br><br>On 2/19/25, at 12:12 p.m., Surveyor did not observe an enhanced barrier sign on or around R4's door alerting staff R4 is on enhanced barrier precautions.<br><br>On 2/19/25, at 2:09 p.m., Surveyor did not observe an enhanced barrier sign on or around R4's door alerting staff R4 is on enhanced barrier precautions.<br><br>On 2/19/25, at 2:56 p.m., Surveyor observed there is now an enhanced barrier sign on R4's door.<br><br>3.) R7's diagnoses which include diabetes mellitus, hypertension, and morbid obesity. R7 has left hip pressure injury, left lateral knee pressure injury, right heel pressure injury, and left fifth toe pressure injury.<br><br>On 2/20/25, at 10:45 a.m., Surveyor observed Certified Nursing Assistant (CNA)-V place a gown & gloves on and asked R7 if she was ready to get up. CNA-V filled a wash basin and placed the basin & towels on the over bed table. CNA-V informed R7 she was going to wash her upper body, removed R7's gown and washed R7's upper body. CNA-V applied nystatin powder under R7's breasts, placed a shirt on R7, unfastened R7's incontinence product & removed R7's pressure relieving boots. CNA-V placed pants on R7 then using a disposable wipe, wiped under R7's abdomen and frontal perineal area. CNA-V removed the incontinence product which contained urine and placed the product in the garbage. CNA-V assisted R7 with positioning on her side, using a disposable wipe, washed R7's buttocks & rectal area. Surveyor observed BM (bowel movement) on the wipe. CNA-V did not remove her gloves or perform any hand hygiene. CNA-V placed an incontinence product under R7, informed R7 she can come back to her back and fastened the incontinence product. CNA-V placed the soiled linen in a clear bag, removed her gloves, removed gloves from a box, and placed gloves on. CNA-V informed R7 she was going to put the sling under her & then will get someone to help transfer her. Surveyor observed CNA-V did not perform any hand hygiene after removing her gloves. CNA-V stated to R7 let me pull up your pants and pulled up R7's pants. CNA-V removed her gown & gloves then stated to Surveyor make sure you tell them I washed my hands before and after. CNA-V then washed her hands.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 2/20/25, at 3:02 p.m., Surveyor observed CNA-X and RN-Y enter R7's room, wash their hands and place PPE (personal protective equipment) on. CNA-X and RN-Y transferred R7 from the wheelchair into bed using a Sara lift. CNA-X removed R7's shoes, asked R7 if she can turn to remove her clothes. R7 rolled on her left side & CNA-X lowered R7's pants. RN-Y asked CNA-X to stand by the side of the bed so she can move the bed away from the wall. CNA-X then removed her PPE, performed hand hygiene, and left R7's room. Surveyor observed the air mattress is set at firm.<br><br>At 3:10 p.m., RN-Y removed the dressings from R7's left hip and left lateral knee. RN-Y removed her gloves, brought the garbage can closer to the bed, washed her hands and placed gloves on.<br><br>At 3:11 p.m. RN-Y informed R7 she was going to do her hip first. RN-Y poured 1/2 strength Dakin's on gauze and cleansed the wound bed. RN-Y did not remove her gloves or perform any hand hygiene after cleansing the wound. RN-Y poured 1/2 strength Dakin's on gauze and packed the gauze into R7's left hip pressure injury. RN-Y then applied border foam dressing & dated the dressing. After completing the left hip pressure injury treatment, RN-Y did not remove her gloves or perform hand hygiene.<br><br>At 3:16 p.m. RN-Y poured 1/2 strength Dakin's on gauze and cleansed the left lateral knee pressure injury. RN-Y removed her gloves and placed gloves on. RN-Y did not perform any hand hygiene. RN-Y placed three pieces of calcium alginate on the wound bed, opened the dresser drawer to remove tape, covered the pressure injury with two ABD pads and taped the pads. Surveyor observed RN-Y did not wrap the left lateral knee with gauze according to physician orders. RN-Y asked if she still has no pain. R7 replied no I have a very high pain tolerance. RN-Y informed R7 she was all finished. R7 asked about her right heel. RN-Y asked R7 what's going on with your heel and then moved the bed back against the wall. RN-Y removed R7's sock and foam dressing. RN-Y removed her gloves and placed gloves on. RN-Y did not perform any hand hygiene. RN-Y fastened R7's incontinence product and pulled up her pants. RN-Y removed her PPE and washed her hands.<br><br>38829<br><br>2.) R2 was admitted to the facility on [DATE] with diagnoses of Other Nontraumatic Intracerebral Hemorrhage, Hemiplegia and Hemiparesis Affecting Right Dominant Side, Chronic Kidney Disease, Stage 4, and Depression.<br><br>R2's Admission Minimum Data Set (MDS) completed 1/23/25 documents a Brief Interview for Mental Status (BIMS) score of 0, indicating R2 demonstrates severely impaired skills for daily decision making. R2's MDS documents R2's Patient Health Questionnaire (PHQ-9) score to be 12, indicating moderate depression. R2's MDS also documents R2 is always incontinent of bowel and bladder and has range of motion (ROM) impairment on both sides of upper and lower extremities. R2's MDS documents R2 is dependent for dressing, eating, transfers, mobility, hygiene, and showers. At the time of the MDS, R2 was nothing by mouth (NPO), and received complete nutrition through a gastrostomy g-tube.<br><br>R2 currently has a G-Tube still in place and should be on Enhanced Barrier Precautions(EBP).<br><br>R2's care plan documents:<br><br>R2 requires tube feeding due to low body mass index(BMI). Initiated 1/22/25<br><br>Intervention-Enhanced Barrier Precautions due to Peg Tube. Initiated 1/22/25<br><br>(continued on next page) |

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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 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 2/19/25, at 10:50 AM, Surveyor observed Licensed Practical Nurse (LPN)-N with a surgical mask on, and gloves. LPN-N is not wearing a gown. LPN-N came out of R2's room with a syringe and container. Surveyor asked LPN-N what LPN-N had done for R2, and LPN-N stated that LPN-N had been flushing R2's G-Tube. Surveyor then observed LPN-N walk down the hallway with the syringe and container. Surveyor observed LPN-N with the same gloves on and did not take the gloves off upon exiting R2's room and perform hand hygiene. Surveyor notes there is no indication that R2 requires EBP.<br><br>On 2/20/25, at 7:16 AM, Surveyor observes no indication that R2 requires EBP.<br><br>On 2/25/25, at 7:22 AM, Surveyor observed Certified Nursing Assistant (CNA)-L in R2's room and was assisting roommate with breakfast. Surveyor asked CNA-L if anyone in the room required EBP. CNA-L stated, Oh I don't know. Surveyor asked CNA-L where is the personal protective equipment(PPE) kept. CNA-L was able to locate 2 gowns in R2's closet. CNA-L confirmed that CNA-L was not aware any of the Residents in R2's room required EBP. CNA-L and Surveyor then were able to locate an EBP sign that was placed on the opposite side of R2's room door which only would be visible to anyone entering the room when the door is closed. Surveyor has only observed R2's room door to be open. CNA-L informed Surveyor, I guess (R2) would be with the tube.<br><br>On 2/25/25, at 11:47 AM, Surveyors interviewed Director of Nursing (DON)-B in regards to EBP. DON-B confirmed that DON-B is also the Infection Control Preventionist. DON-B explained that there should be a physician's order when a Resident is on EBP and a sign on the door. DON-B confirmed that if someone has a G-Tube, EBP should be initiated. DON-B stated that PPE are kept in the Resident closets if on EBP and gloves are always in the room. Surveyor shared the observation of LPN-N not wearing a gown, and not completing hand hygiene after flushing R2's G-Tube. DON-B confirmed that LPN-N should have been wearing a gown when flushing R2's G-Tube.<br><br>On 2/25/25, at 1:21 PM, Surveyor shared the EBP concerns of not wearing a gown when flushing R2's G-Tube and not completing hand hygiene when done flushing with DON-B and Director of Operations (DO)-C. Both DON-B and DO-C understands the concern and provided no further information at this time. |