STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525706	A. Building B. Wing	04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Christian Community Home of Osceola, Inc	2650 65th Ave Osceola, WI 54020

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47657 Based on record review, observation and interview, the facility did not develop and implement a comprehensive individualized care plan to meet the needs of 3 of 12 residents (R). R4, R17 and R180. This is evidenced by: The facility policy, entitled Nursing Policies and Procedures, states in part: Will complete a comprehensive assessment and develop a comprehensive care plan for each resident. The assessment will include the resident's medical, nursing, mental and psychosocial needs as well as well as set measurable objectives and timetables to meet these needs. Example 1 R4 was admitted to the facility on [DATE] for end-of-life hospice care for a terminal prognosis of stage 4 chronic kidney disease and multiple sclerosis. On 09/16/23, the facility conducted a fall risk assessment which indicated a score of 19 indicating R4 was at high risk for falls. R4's Minimum Data Set (MDS) assessment, dated 09/21/23, Section J: Fall history on Admission, indicated no falls any time in the last month prior to admission. On 04/03/24 at 9:18 AM, Surveyor reviewed R4's record and noted R4 had 25 falls between the period of 10/12/23 through 12/23/23. Surveyor was unable to locate a comprehensive care plan that included problem, goals, and interventions put into place to prevent falls. On 04/04/24 at 10:56 AM, Surveyor interviewed Director of Nursing (DON) B, who confirmed there was no care plan with interventions noted in R4's chart. DON B handed Surveyor documents entitled Nursing Assistant Assignment Sheet/Care plan that listed Laser alarm in bed/recliner. Tabs in w/c recliner in room or day room, body pillow on floor next to bed, low bed, perimeter mattress. On 04/02/24 through 04/04/24, Surveyor observed R4 walking with staff, no use of a wheelchair, and no use of alarms in bed. 47284 (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Example 2 R17 was admitted to the facility on [DATE] with diagnoses that included in part cognitive communication deficit, vascular dementia, abdominal pain, colitis and gastroenteritis, diverticulosis, GERD (gastroesophageal reflux disease), zoster (shingles), long term (current) use of anticoagulant, and atrial fibrillation. R17's MDS assessment, dated 2/13/24, indicated that R17 had frequent pain that was moderate and use of anticoagulant. R17's pain assessments were done quarterly with noted nonpharmacological interventions, pain scale, location, and use of PRN (as needed) Tylenol that helped with R17's pain. R17's pain interviews were completed quarterly with detailed information on R17's pain. Current pain control works for R17. R17's provider orders: *Warm foot soak PRN for foot/joint discomfort as needed. *Aqua K pad/moist heat for joint discomfort on 20-minute intervals, as needed. *Complete pain interview (3.0) in assessment tab every day shift every 91 day(s). *Complete pain assessment in assessment tab every evening shift every 91 day(s). *Bio Freeze Gel 4 % (Menthol (topical analgesic)) apply to neck topically as needed for pain. *Lidocaine Patch: apply to right midback topically one time a day for pain related to zoster without complications 4% patch and remove per schedule. *Acetaminophen oral tablet give 650 mg by mouth every 6 hours as needed for mild to moderate pain related to pelvic fracture. *Warfarin Sodium tablet give 4.5 mg by mouth at bedtime related to long term (current) use of anticoagulants. Next INR 4/11/24 @ 1000. Review of R17's care plan did not include anything concerning R17's pain nor anticoagulant use. On 4/04/24, Surveyor asked Nursing Home Administrator (NHA) A for these care plans. NHA A later provided R17's care plan that included: The resident has chronic pain related to history of shingles and The resident is on anticoagulant therapy Warfarin for atrial fib and CVA (stroke) both added 4/04/24, after Surveyor asked for the care plans. On 4/02/24 at 3:50 PM, Surveyor interviewed R17 about pain. R17 said she had arthritis pain to her legs mostly. R17 said the facility provides Tylenol for the pain and that helps. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/04/24 at 11:15 AM, Surveyor interviewed Licensed Practical Nurse (LPN) E and asked if they monitor R17 for bleeding/bruising due to anticoagulant use. LPN E said daily they look during skin checks and cares. Surveyor asked LPN E if they have any concerns with this. LPN E said no concerns with R17 bleeding/bruising. Surveyor asked LPN E how R17's pain was. LPN E said R17's pain does okay with Tylenol at night that she asks for. R17's pain was mostly to her legs. LPN E said Tylenol helps R17 with the pain. On 4/04/24 at 3:50 PM, Surveyor interviewed DON B and asked if R17 should have a care plan for pain and anticoagulant use. DON B said yes, we entered that into R17's care plan today, but it should have been there before today. 47807 Example 3 The facility policy, entitled, Fall/Injury Reporting, revised July 2023, states: Policy: Falls and injuries to residents, whether known or suspected, will be documented in the resident medical records . 12. The IDT will then evaluate the fall and recommend intervention. The change in plan will then be documented in the resident care plan and CNA care plan. Fall tracking tools will be tabulated quarterly and results reviewed by the Quality Assurance Committee. On 04/02/24 at 10:52 AM, Surveyor interviewed R180 regarding their time at the facility. R180 said R180 had a fall and believed it was due to the medications. R180 was not exactly sure how the fall happened. R180 indicated feeling much better now and did not have any fear of falling at this time. Record review revealed that R180 did have a fall on 03/21/24 at 1:00 AM. R180 was found on the floor screaming and confused. R180 was sent to the emergency room for evaluation. The discharge papers from the hospital reported there was no injury sustained from the fall. On 04/04/24 at 1:16 PM, Surveyor asked for IDT review and current care plan. Surveyor was given an IDT review stating that resident was to get a perimeter mattress from hospice. On 04/04/24 at 2:06 PM, Surveyor received current comprehensive care plans and found no evidence of a care plan related to falls. The updated interventions that were noted from the IDT review were not found in the comprehensive care plan. No other care plans were provided to Surveyor.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47807 Based on observation, interview and record review, the facility did not provide care consistent with professional standards to prevent development of a pressure injury and does not develop pressure injuries unless the individual's clinical condition demonstrates that they were unavoidable for one of one resident reviewed for pressure injuries. Resident (R)12 developed an unavoidable stage 2 pressure injury while at the facility. Observations of poor infection control occurred during wound care. This has the potential to effect 1 of 1 resident observed for pressure injuries. Findings include: The facility policy, entitled Dressing Change Clean Technique, revision date June 2023, states: Policy: Licensed Nursing Staff will provide for a clean technique when changing dressings . procedure: . 9. Remove soiled dressings. 10. Place soiled dressings in a plastic Bag. Use red biohazard bag if necessary. 11. Remove soiled gloves and place gloves with soiled dressings. 12. Perform hand hygiene. 13. Put on new gloves. R12 had diagnoses that include in part: pressure ulcer of other site, unspecified stage, unspecified dementia, without behavioral disturbances, multiple sclerosis, other neuromuscular dysfunction of bladder, neurogenic bowel, quadriplegia. R12's Minimum Data Set (MDS) assessment, dated 03/19/24, indicated that R12 had limited mobility to both arms and legs. R12's Brief Interview for Mental Status (BIMS) score of 03 indicated severe impairment. R12's care plan, dated 03/05/24, states: Open area/wound will resolve/heal without complications Interventions include: - Assess/record/monitor wound healing weekly. 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. - Daily skin observation with cares. Report new or worsening concerns to nurse immediately. - Pressure reducing/relieving cushion in WC/chair. - Pressure reducing/relieving mattress. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Provide wound care per MD orders. - Turn and reposition q 2-3 hours Upon entrance to the facility on [DATE], Surveyor observed R12 to have air mattress, cushion for Broda chair. R12's Braden assessments on 10/13/23 admission and the most recent assessment on 03/15/24 indicated R12 was high at risk for skin breakdown. R12 was not admitted to the facility with a pressure injury; the first indication of a stage 2 pressure injury in the ischial area was on 03/15/24 and it was indicated to be a stage 2 pressure injury. The wound measured (in cm's)length/width/depth: 1.5 cm x 1.4 cm x 0.3 cm. The most recent measurement was on 04/03/24 and the wound was staged at a stage 2 by the facility. The wound measured (in cm's) length/width/depth: 1cm x 0.9cm x 0.5cm. Weekly assessments, and physician notification with wound care order changes have been done. 04/04/24 7:12 AM R12 Wound Care Observation: Surveyor observed Director of Nursing (DON) B perform wound care to R12's right ischial pressure injury. DON B indicated this was a stage 2 with Moisture Associated Skin Damage (MASD) around the buttock region. DON B washed hands, donned gown, mask and gloves. R12 is on enhanced barrier precautions. DON B removed the old dressing that had brown/yellow drainage on it, no odor, and threw the dressing away in the garbage. DON B did not remove gloves, measured the right ischial pressure injury that was circular, dark purple in color, no slough present. DON B's measurements were 1.5 x 1 cm x 0.7 cm. No other measurements taken. R12 does have an area just to the right of the circular area that is open, beefy red in color - macerated, no slough present and does not appear to have depth to it. R12 also had a large red MASD area around the entire buttock that was not measured either. DON B removed gloves and applied new gloves. No hand hygiene between glove change. DON B sprayed wound cleanser to entire open area and MASD, cleaned with gauze and threw the gauze away. DON B did not change gloves. DON B continued with the contaminated gloves, to get the scissors and cut Aquacel AG then placed Aquacel AG into the circular wound and over the beefy red area. DON B placed island tegaderm over the Aquacel AG. DON B did not change gloves. DON B then opened R12's bedside cabinet to get nystatin to apply to the MASD area. DON B applied an abdominal (ABD) pad to the coccyx area. Note Miconazole cream was ordered, but had not come in yet. DON B removed gloves and gown and washed hands with soap and water. On 4/04/24 at 4:25 PM, Surveyor interviewed DON B concerning the expectation of glove use and hand hygiene during wound care. DON B said before start of the wound care, wash hands with soap and water then dry and apply gloves. Remove old dressing, remove gloves, hand hygiene, and apply new gloves to complete the dressing change. Surveyor asked DON B if she performed hand hygiene between glove change when Surveyor observed the wound care to R12. DON B stated she did not use hand hygiene between glove changes. Surveyor asked DON B if glove change and hand hygiene should have been performed after the wound was cleaned with wound cleanser and gauze. DON B said, Yes, gloves should have been removed and hand hygiene performed.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47657 Based on interviews and record reviews, the facility did not ensure that the resident's environment remained as free of accident hazards as possible for 2 of 4 residents (R4, R5). This is evidenced by: Example 1 The facility policy, entitled Fall/Injury Reporting, states in part: 5. Provide immediate safety interventions and document interventions. Utilize fall template for documentation in progress note. 6. Complete Falls Report forms 7. Initiate Fall Investigation 10. A Resident Fall Tracking log will be completed at the Interdisciplinary Team (IDT) meeting to assess trends for each resident and continue with implementation for a plan of prevention. 11. The IDT will audit the medical record for appropriate documentation and conduct a post fall review. 12. The IDT will then evaluate the fall and recommend intervention. The change in plan will then be documented in the resident Care Plan and Certified Nursing Assistant (CNA) care plan. Fall tracking tools will be tabulated quarterly and results reviewed by the Quality Assurance Committee (QA). R4 was admitted to the facility on [DATE] for end-of-life hospice care for a terminal prognosis of stage 4 chronic kidney disease and multiple sclerosis. R4's Admission Minimum Data Set (MDS), completed on 09/21/23 indicated a Brief Interview for Mental Status (BIMS) score of 08 (moderately impaired). R4's quarterly MDS with a target date of 12/19/23 indicated a BIMS score of 99 unable to complete interview. The facility conducted 4 fall risk assessments since admission of 09/15/23: 09/16/23 indicated a score of 19 indicating R4 was at high risk for falls. 10/14/23 indicated a score of 22. 01/13/24 indicated a score of 28. 03/14/24 indicated a score of 17. R4's Minimum Data Set (MDS) assessment, dated 09/21/23, Section J: Fall history on Admission, indicated no falls any time in the last month prior to admission. On 04/03/24 at 9:18 AM, Surveyor reviewed R4's record and noted documentation of R4 having 25 falls between the period of 10/12/23 through 12/23/23. Dates of falls and intervention documentation: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10/12/23 at 12:20 PM: grippy socks instituted. Not noted in plan of care 10/14/23 at 2:03 AM: increased visual checks for rest of shift. Not noted in plan of care 10/19/23 at 12:30 AM: ensure laser alarm was appropriately placed. R4 was given lorazepam saying that she felt uneasy. 10/21/23 at 12:00 PM: (sent to ER no fracture). 10/25/23 at 4:50 PM: remind R4 to use call light, fall mat and body pillow removed from floor next to bed as she continues with self-transfer attempts. Called St. Croix Hospice and requested raised perimeter mattress, 10/28/23 at 5:35 PM: Continue with laser alarm and low bed. 10/30/23 at 10:05 AM: Not in Nurses progress notes IDT reviewed on 11/02/23. States R4 was 1:1 until medication took effect. 11/18/23 at 3:00 PM. Continue with laser alarm and low bed. Resident brought to great room for closer observation. 11/21/23 at 3:10 AM. Not in Nurses progress notes. IDT reviewed on 11/30/23. No intervention noted at time of fall. 11/21/23 at 8:00 AM. Frequent checks. 11/21/23 at 10:00 AM. Increase checks. Move to great room for greater visibility. 11/24/23 at 7:30 AM. Assessed for pain/ROM indicated terminal agitation. 11/26/23 at 9:05 AM. Keep resident in a visible area when up in her chair. 11/26/23 at 9:00 PM. Bed was placed back into low position and dim light. 11/27/23 at 12:25 PM. No new interventions 11/28/23 at 19:30 PM. Continue with use of alarms in room. 11/30/23 at 12:25 PM. Not in Nurses progress notes and no IDT review provided. No interventions documented. 12/05/23 at 11:45 AM. 1:1 instituted. 12/08/23 at 14:30 PM. No new interventions stated. 12/17/23 at 5:45 AM. Peri care done, washed, and dressed for the day and brought out to great room. 12/17/23 at 11:00 AM. Pain addressed. 12/19/23 at 6:20 AM. 1:1 attention until hospice staff arrived. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	12/22/23 at 8:05 AM. Updated hospice and requested medication changes. 12/23/23 at 2:45 AM. Pillow repositioned closer to bed. On 04/04/24 at 10:56 AM, Surveyor interviewed Director of Nursing (DON) B, who provided a document entitled: Nursing Assistant Assignment Sheet/Care plan that listed 5 interventions. Laser alarm in bed/recliner. Tabs in w/c recliner in room or day room, body pillow on floor next to bed, low bed, perimeter mattress. The other fall interventions to prevent falls were not included on the assignment sheet. On 04/02/24 through 04/04/24, Surveyor observed R4 walking with staff, no use of a wheelchair, and no use of alarms in bed. On 04/04/24 at 8:31 AM, Surveyor interviewed DON B regarding R4's falls states that 25 falls between 10/12/23 through 12/23/23 sounds correct. DON B stated that during the week the facility has a meeting where falls in past 24 hours are discussed and then weekly the facility has an interdisciplinary team meeting where they have more in-depth discussion of falls. DON B stated that R4 is at high risk for falls especially with being on the lorazepam. Surveyor shared observations of the fall interventions not being followed during the 3 day survey. Surveyor asked DON B if there is any documentation supporting that the psychotropic medication was considered a potential cause of falls prior to the lorazepam being discontinued on 11/27/23. DON B confirmed it was not and that fall interventions to prevent future falls had not been added to R4's plan of care. 47284 Example 2 R5 was admitted to the facility on [DATE] and had diagnoses that included in part cognitive communication deficit, other abnormalities of gait and mobility, dependence on wheelchair, peripheral vascular disease, vascular dementia, other symptoms and signs involving cognitive functions following unspecified cerebrovascular disease, muscle weakness (generalized), hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting left non-dominant side, repeated falls, major depressive disorder, and anxiety disorder. R5's fall risk assessments completed upon admit and quarterly all state R5 was high risk for falls. R5's care plan, dated 7/07/20, revision 11/30/22, with a target date of 5/22/24, states: Focus: The resident is high risk for falls related to gait/balance and weakness due to post CVA (stroke) with poor safety awareness. Goal: The resident will not sustain serious injury through the review date. R5's care plan fall interventions include: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*Anticipate and meet the resident's needs. Has refused to allow any type of alarms. Date Initiated: 2/02/22, Revision on: 4/03/24. *Note this revision was completed after survey team entered the facility. *Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance. Has refused offer of wrist or pendent call light for added safety measures. Date Initiated: 7/07/20, Revision on: 3/06/23. *Educate the resident/family/caregivers about safety reminders and what to do if a fall occurs. Date Initiated: 2/02/22. *Encourage the resident to participate in activities that promote exercise, physical activity for strengthening and improved mobility such as: ambulating and using nu step with restorative nursing. Date Initiated: 7/07/20, Revision on: 1/15/21. *Ensure that the resident is wearing appropriate footwear non-skid socks as does not wear shoes when ambulating or mobilizing in wheelchair. Resident has signed waiver to not have alarms in place. Risks of falling have been explained to him with no understanding of his physical limitations. Date Initiated: 7/07/20, Revision on: 3/06/23. *Follow facility fall protocol. Date Initiated: 2/02/22. *Review information on past falls and attempt to determine cause of falls. Record possible root causes. Alter remove any potential causes if possible. Educate resident/family/caregivers/IDT (interdisciplinary team) as to causes. Date Initiated: 7/07/20. *The resident needs a safe environment with even floors free from spills and/or clutter, adequate, glare-free light, a working and reachable call light, personal items within reach. Date Initiated: 2/02/22, Revision on: 5/24/22. Note R5 had falls on 11/01/23, 12/15/23, 1/16/24, 1/19/24, and 2/21/24 with no revision to R5's care plan interventions post falls. R5's post fall assessments: *11/01/2023 Fall Note: Time: At 20:45 [8:45 PM] this nurse was notified that patient [R5] was laying on the floor. Upon entering the room patient laying flat on back with wheelchair next to him. Patient grinning and stating I did not fall Patient denies hitting head, no bumps or abrasions to scalp. When asked what he was doing patient stated I slipped out onto the floor. Non-skid socks in place. Pupils equal and reactive to light and accommodation. Respirations even and unlabored, no signs/symptoms of SOB [shortness of breath]. No complaints of pain or discomfort noted. Patient assisted back into wheelchair X2 [2 person] assist. Gait WNL [within normal limits] for patient. Skin intact. Neuro checks initiated. Vitals WNL 169/83, 18, 78, 97.9, 97% RA [room air]. Plan of care ongoing. Location: Room (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Position resident found in: Laying flat Environmental Factors: crowding Range of Motion: WNL Pain: 0 complaints of pain Visible injury describe: 0 signs of injury Describe extremity appearance: crowding, poor lighting Vital Signs: 169/83, 78, 18, 97.9, 97% RA Assistance required to change positions: Assisted X2 back into wheelchair Resident description of fall: I just slipped out onto floor Witness description of fall: N/A Fall prevention interventions instituted: Reminder to use call light for help Immediate interventions provided: Neuro checks initiated DR/NP Notification: Alert left for [provider] Family/responsible party notification: voicemail left *12/15/2023 Fall Note: Time: 1100 [AM] Location: Resident [R5] room Position resident found in: sitting on bottom, legs out in front, wheelchair directly behind him Environmental Factors: none Range of Motion: WNL Pain: denies Visible injury describe: none observed Describe extremity appearance: WNL Vital Signs: 97.7, 95% RA, 76, 18, 133/79 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assistance required to change positions: A2 [assist of 2] using gait belt Resident description of fall: I didn't fall Witness description of fall: unwitnessed Fall prevention interventions instituted: education, frequent checks Immediate interventions provided: education, frequent checks (resident has a signed risk agreement stating he will not allow staff to use alarms) DR/NP Notification: via fax Family/responsible party notification: yes *1/16/2024 Fall Note: Time: 0930 [AM] Location: resident [R5] room Position resident found in: lying on left side, legs tangles in blankets, wheelchair centered in front of tv, resident to the left and in front of the wheelchair Environmental Factors: blankets tangled in legs. Range of Motion: WNL Pain: denies Visible injury describe: none observed Describe extremity appearance: WNL Vital Signs: b/p [blood pressure] low at 90/30. t: 98.5, r: 18 p: 62, O2sats: 93% RA. Assistance required to change positions: A2 and gait belt. Resident description of fall: I was trying to get to the BR [bathroom] Witness description of fall: not witnessed. Fall prevention interventions instituted: assisted to BR and then back to wheelchair. Resident then later self-transferred into his bed. Immediate interventions provided: removed blankets. reminded to call for assist. DR/NP Notification: yes (continued on next page)

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	525706	A. Building B. Wing	04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Christian Community Home of Osceola, Inc	2650 65th Ave Osceola, WI 54020

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Family/responsible party notification: resident refused - didn't want family notified. *1/18/2024 Fall/incident follow-up: Note Text: Fall from 1/16 reviewed by IDT at this time and deemed that fall could have been prevented if resident had called for assist. However, he is resistive to using call light and will not consent to any type of alarm to alert staff. Will continue to educate resident on use of call light. Will educate staff to be sure resident is checked on and toileted every 2 hours and to offer assist if noted to be attempting to self-transfer. *1/19/2024 Fall Note Time: 2340 [11:40 PM] Location: room [ROOM NUMBER] Position resident found in: On all fours Environmental Factors: None noted Range of Motion: WNL all extremities Pain: only old pain in right wrist Visible injury describe: Some reddened areas on back due to being lifted back into bed Describe extremity appearance: Normal Vital Signs: 110/54, 18, 98.6, 94% 02 Sat, 54 Pulse Assistance required to change positions: 2 plus gait belt Resident description of fall: Could not explain fall. Confused. Didn't know where he was going. Kept saying I didn't fall. Witness description of fall: None Fall prevention interventions instituted: Floor Alarm placed 2nd [secondary to] fall Immediate interventions provided: Helped to bed, covered. Made comfortable in bed. DR/NP Notification: VIA Text message Family/responsible party notification: Doesn't want family notified. *2/21/2024 Fall Note: Time: 1715 [5:15 PM] (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Location: room [ROOM NUMBER] in front of recliner Position resident found in: sitting on the floor leaning on right side Environmental Factors: none Range of Motion: per usual Pain: denies pain Visible injury describe: none Describe extremity appearance: no rotation or deformity. Vital Signs: 169/79, T 98.3, P 62, R 18, O2 96% RA Assistance required to change positions: assisted off of the floor with Hoyer lift and assist of two. Resident description of fall: Resident per his usual denied that he fell . He first stated, I wanted to lay down when writer asked if he wanted to lay on the floor, he said I'm just sitting on the floor when asked how he got to the floor he stated, I took the bus. Witness description of fall: no witness told CNA that he fell while attempting to self-transfer into his recliner. Fall prevention interventions instituted: Note left for therapy to evaluate for positioning and possibly pommel cushion. Immediate interventions provided: Resident was placed on 30-minute checks for the rest of the shift DR/NP Notification: [provider] Family/responsible party notification: daughter *2/21/24 Follow up interventions note: Requested therapy eval, 30 min checks till end of shift done. Resident fell self-transferring. How could the fall have been prevented: he could use his call light. Resident refuses alarms. Root cause forgetful poor safety awareness refuses alarms. Note, R5 did not have any injury from these falls. On 4/04/24 at 11:11 AM, Surveyor interviewed Licensed Practical Nurse (LPN) E and asked who updates the care plan interventions for falls. LPN E said any nurse can update the care plan. (continued on next page)

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	525706	A. Building B. Wing	04/04/2024

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/04/24 at 11:15 AM, Surveyor interviewed Certified Nursing Assistant (CNA) M and asked if a resident was at risk for falls how would you know what fall interventions were in place. CNA M said the care plan we carry does not have if the resident was a fall risk, I believe they have a fall risk bracelet on them. If a resident was a fall risk, CNA M said she would get another staff member to help with transfers, use of gait belt. Surveyor asked CNA M what interventions you would know specific to the resident. CNA M showed Surveyor the CNA care plan. On 4/04/24 at 4:00PM, Surveyor interviewed DON B and asked what the expectation was of when care plans should be updated with interventions for post falls. DON B said they should be updated immediately after the fall intervention was determined. Surveyor asked DON B if R5's care plan was updated after the five falls from November 2023 until February 2024. DON B said no, R5's care plan was not updated, but it should have been updated.

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	525706	A. Building B. Wing	04/04/2024

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47284 Based on observations, interviews and record review, the facility did not ensure pain management orders were followed for 1 of 2 residents (R) reviewed for pain (R183). R183 was prescribed a pain medication with dosage to be given based on the pain scale. The facility did not provide the appropriate amount of pain medication based on R183's pain scale, giving less medication than prescribed. Findings include: R183 was admitted to the facility on [DATE] with diagnoses that included in part left knee joint replacement surgery, migraine, Parkinson's disease, dementia, cognitive communication deficit, diabetes, poly-osteoarthritis, chronic pain, and low back pain. R183's care plan stated: Pain/Comfort: Alteration in/Potential for alteration in comfort. Interventions included: *Resident will experience relief of pain as evidenced by: verbal report of relief of pain. *Resident will be kept as comfortable as possible. *Alter environment for comfort: Provide comfortable room temperature or remove/add blanket, sweater as needed. *Combine non-pharmacological interventions with Pharmacological interventions. *Encourage to report discomfort promptly. *Monitor effectiveness of new or changed interventions using electronic health record documentation. *Observe for side effects of medications. *Offer: warm blanket, back massage, cold pack, repositioning, rest/relaxation, warm bath/whirlpool &/or diversional activities for comfort. R183's pain assessment completed on 4/1/24 to include non-pharmacological interventions of therapy, heat cold, distraction. Use of narcotics. Pain level, location, severity. R183's provider orders: Oxycodone oral tablet 5mg: Give 2.5 mg by mouth every 4 hours as needed (PRN) for acute pain (pain rating 1-5) and Give 5 mg by mouth every 4 hours as needed for acute pain (pain rating 6-10) started 3/27/24. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R183's Medication Administration Record (MAR): PRN Oxycodone 2.5mg every 4 hours as needed for acute pain rating 1-5: *3/27/24 at 2027 pain 8 - Incorrect amount given, should have been 5mg Oxycodone dose. Follow up: 3/27/2024 22:18 Pain 2 *3/28/24 at 0719 pain 7 - Incorrect amount given, should have been 5mg Oxycodone dose. Follow up: 3/28/2024 11:59 Pain 2 *3/28/24 at 1432 pain 9 - Incorrect amount given, should have been 5mg Oxycodone dose. Follow up: 3/28/2024 16:39 Pain 0 *3/29/24 at 0837 pain 10 - Incorrect amount given, should have been 5mg Oxycodone dose. Follow up: 3/29/2024 11:03 Pain 3 *3/30/24 at 0543 pain 5 - correct dose. Follow up: 3/30/2024 10:15 Pain 8 *3/30/24 at 1023 pain 10 - Incorrect amount given, should have been 5mg Oxycodone dose. Follow up: 3/30/2024 11:20 Pain 0 *3/31/24 at 0816 pain 9 - Incorrect amount given, should have been 5mg Oxycodone dose. Follow up: 3/31/2024 09:36 Pain 2 *3/31/24 at 1216 pain 7 - Incorrect amount given, should have been 5mg Oxycodone dose. Follow up: 3/31/2024 13:58 Pain 0 *4/2/24 at 0547 pain 5 - correct dose. Follow up: 4/2/2024 09:34 Pain 4 *4/2/24 at 1129 pain 6 - Incorrect amount given, should have been 5mg Oxycodone dose. Follow up: 4/2/2024 13:46 Pain 2 *4/2/24 at 1926 pain 7 - Incorrect amount given, should have been 5mg Oxycodone dose. Follow up: 4/2/2024 20:40 Pain 0 (continued on next page)

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	525706	A. Building B. Wing	04/04/2024

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Note 9 out of 11 doses given were the incorrect dose of 2.5mg when it should have been 5mg based on the order for pain scale given greater than or equal to 6. On 4/02/24 at 4:28 PM, Surveyor interviewed R183 concerning pain. R183 said R183 had pain to her left knee due to recent surgery for total knee replacement and had arthritis pain too. Surveyor asked if the facility was providing pain management. R183 said, Yes, they were providing pain medication along with ice packs and elevation of the knee. R183 was observed with ice pack over left knee and legs elevated in the recliner. On 4/04/24 at 10:54 AM, Surveyor interviewed Licensed Practical Nurse (LPN) E and asked to look at Oxycodone MAR order/documentation for R183. LPN E pulled up R183's April MAR that had the 3 times filled in with pain rate of 5, 6, and 7 with the dosage of 2.5mg given. Surveyor asked LPN E based on order of pain scale of 6-10, give 5mg, what should R183 have received. LPN E said R183 should have received the 5mg dose for the pain scale 6 and 7. Surveyor asked LPN E how R183's pain had been. LPN E said R183's pain was controlled and R183 had not asked for PRN medication yesterday or yet today. LPN E said R183 said her pain had little discomfort and was being controlled with current treatment. On 4/04/24 at 4:00 PM, Surveyor interviewed Director of Nursing (DON) B concerning R183's PRN Oxycodone order. Surveyor showed R183's MAR for Oxycodone to DON B for the months of March and April 2024. After review, DON B said R183 should have received the 5mg dose instead of the 2.5mg dose when her pain scale was 6 or higher. DON B said staff should have looked at the order and given the proper amount of medication.

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	525706	A. Building B. Wing	04/04/2024

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 48793 Based on observation, interview and policy review, the facility did not ensure that a resident was provided pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 1 of 1 resident (R9) reviewed. The facility did not ensure R9 was administered insulin appropriately based on the observation of the Licensed Practical Nurse (LPN) not priming the insulin pen before administration. This is evidenced by: The facility policy, entitled Insulin pens, dated 08/23, states: .-#8. Turn the dial to 2, push the plunger, and waste 2 units. -#9. Turn the dial to an appropriate number of units . On 04/03/24 at 7:25 AM, Surveyor observed LPN E draw 7 units of insulin glargine from R9's insulin glargine pen. Surveyor did not observe LPN E prime the insulin glargine pen with 2 units first before drawing the 7 units of insulin glargine. On 04/03/24 at 8:24 AM, Surveyor observed LPN E administer the 7 units of insulin glargine to R9's abdomen. Surveyor did not observe LPN E prime the insulin glargine pen with 2 units before prepping and administering the insulin glargine pen. On 04/03/24 at 8:25 AM, Surveyor interviewed LPN E and asked normal process for drawing up insulin pens. LPN E indicated that usually LPN E primes pen with 2 units, to make sure bubbles are out, then draws up insulin and administers it to residents. LPN E indicated that she did not prime the insulin pen before giving it to R9. On 04/03/24 at 10:03 AM, Surveyor interviewed Director of Nursing (DON) B and asked what the expectation is for priming, drawing, and administering insulin pens. DON B indicated that all insulin pens should be primed with 2 units, then clear and draw up the units of insulin needed thereafter. DON B indicated that LPN E should have primed the pen before administering the insulin glargine pen to R9.

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	525706	A. Building B. Wing	04/04/2024

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47657 Based on observation, interview and record review, the facility did not ensure residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record. The facility did not ensure PRN (as needed) orders for psychotropic drugs are limited to 14 days. The facility did not ensure adverse consequence such as unwanted, uncomfortable, or dangerous effects that a drug may have, such as impairment or decline in an individual's mental or physical condition or functional or psychosocial status. This occurred for 1 of 5 residents (R) reviewed for unnecessary medications. (R4). This is evidenced by: The facility's policy entitled Psychotropic Use developed 01/21/14 and last revised August 2023 states: Purpose: To provide a standard means of monitoring residents that receive psychotropic medications to ensure that psychotropic use is necessary and that the resident does not have adverse reactions to the medication. Under the section entitled Procedure states in part: 1. Any resident that is admitted with antipsychotic medication is assessed for diagnosis for the use of the medication. 3. All PRN psychotropics will have an automatic stop date after 14-days unless other duration length is ordered, with the exception of PRN antipsychotics which will always have a stop date after 14-days. 5. Residents with psychotropic medications will be discussed at BIMPS Program. See BIMP policy and procedure. The facility's policy entitled Behavior tracking developed July 2023 states: It is the policy of this facility to consistently monitor occurrences of behavioral problems for each resident identified by the Behavioral Intervention and Management Team. (BIMPS). Under the section titled Procedure, states in part . 1. BIMP members initiate a Targeted Behavior Monitoring (TBM) when a resident is a receiving medication intended to treat behavioral problems. 2. Assigned staff complete the TBM as follows: a) Record frequency of targeted behaviors observed or as reported to them on each shift if interventions were used, what and if successful, b) Initial the box for the shift they are recording c) total and record the number of occurrences per day d) Write progress notes containing information regarding frequency and patterns of behavior occurrences (continued on next page)

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	525706	A. Building B. Wing	04/04/2024

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	e) total and record the number of behavior occurrences at the end of each month. 3. Tracking information is included on the BIMP review. R4 was admitted to the facility on [DATE] for end-of-life hospice care for a terminal prognosis of stage 4 chronic kidney disease and multiple sclerosis. R4's admission Minimum Data Set (MDS) with a target date of 09/21/23 indicated a Brief Interview for Mental Status (BIMS) score of 08 (moderately impaired). Section J1900A indicated 0 falls with no injury; J1900B indicated 0 falls with injury (except major) R4's quarterly MDS with a target date of 12/19/23 indicated a BIMS score of 99 unable to complete interview. Section J1900A indicated 2 or more falls with no injury; J1900B indicated 1 falls with injury (except major). R4's current plan of care states: The resident is at risk for altered mood status r/t DX [diagnosis] of Depression disorder and anxiety disorder. o The resident will remain free of s/sx [signs and symptoms] of distress, symptoms of depression, anxiety, or sad mood by/through review date. o Administer medications as ordered. Monitor/document for side effects and effectiveness. o Arrange for the resident's clergy or spiritual leader of choice if requested. o Assist the resident in developing/Provide the resident with a program of activities that is meaningful and of interest. Encourage and provide opportunities for exercise, physical activity. o Monitor/document/report to MD s/sx of depression, including hopelessness, anxiety, sadness, insomnia, anorexia, verbalizing, negative statements, repetitive anxious or health-related complaints, tearfulness. o Pharmacy review monthly or per protocol. On 04/02/24 at 10:49 AM, Surveyor reviewed R4's orders for an antipsychotic medication without having a specific condition diagnosed nor targeted behavior documentation or assessments regarding effectiveness nor potential adverse consequences. On 09/15/23, R4 was ordered: Quetiapine Fumarate Oral Tablet. Give 100 mg by mouth two times a day for Anxiety and increased on 11/21/23 to Quetiapine Fumarate Oral Tablet 100 MG. Give 100 mg by mouth three times a day for anxiety. On 04/03/24 at 2:59 PM, Surveyor asked (Director of Nursing) DON B the diagnosis for the antipsychotic medications. DON B confirmed anxiety is not an appropriate diagnosis and confirmed that it is the facility's responsibility to assure psychotropic medications are ordered appropriately and followed even if a R4 is on hospice. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R4 was prescribed an antipsychotic medication. The medication was administered since admission with no stop date ordered. There is no targeted behavior documentation or assessments regarding effectiveness nor potential adverse consequences. On 09/15/23, R4 was admitted with an order for lorazepam oral concentrate 2 MG/ML. Give 1 ml by mouth every 2 hours as needed for anxiety, sedation, nausea or vomiting which was discontinued on 11/27/2023. On 10/04/23, an order to routinely schedule the lorazepam was received for lorazepam oral concentrate 2 MG/ML (Lorazepam) Give 0.5 mg by mouth 3x day for anxiety/agitation. On 11/22/23, record review of R4's order for lorazepam oral concentrate 2 MG/ML was changed to: Give 1.0 mg by mouth 3x day for anxiety/agitation and was changed on 12/21/23 to lorazepam oral concentrate 2 MG/ML. Give 0.5mg mg by mouth 6x day for anxiety/agitation which was discontinued on 12/22/23. R4 received the PRN lorazepam 32 times in September, 51 times in October (in addition to the scheduled dose) and 11 times in November (in addition to the scheduled dose). On 12/23/23, R4 received an order for an antipsychotic haloperidol oral tablet. Give 2.5 mg by mouth three times a day for anxiety/agitation. R4 received this medication 14 times before being discontinued on 12/27/2023. On 04/02/24 at 10:49 AM, Surveyor reviewed a current physician order dated 12/22/23 haloperidol oral tablet. Give 5 mg by mouth every 6 hours as needed for anxiety/agitation without a stop date or rationale for continued use. R4 received as needed haloperidol (3 times in December 2023, 2 times in January 2024, and none in the months of February 2024 and March 2024. On 04/02/24 at 10:49 AM, Surveyor reviewed a pharmacy note dated 01/11/24 sent to attending physician/prescriber regarding PRN use of Haldol to evaluate the medication for appropriateness and continuation, indicating evaluation must occur every 14 days to meet CMS Guidelines. Physician response dated 1/12/24 stated, Pt is hospice, hospice is evaluating. On 02/8/24, provider signed GDR contraindicated for PRN use of Haldol Multiple Sclerosis (MS), Hospice. Consent signed on 12/24/23. No stop date order noted. On 04/02/24, record review noted a social services note dated 3/26/2024 13:32 Plan of Care Note which in states in part, Since the discontinuation of Lorazepam cognitive and physical functions have improved greatly, to the point where [R4] is able to communicate with staff appropriately and assist with her ADL's [activities of daily living]. [R4] recently was evaluated by therapy to be set up with a restorative program and is making progress in mobility and has not had any falls since d/c [discontinuation] of Ativan. Is able to make needs known and using the call light for assist. On 04/03/24 at 2:13 PM, Surveyor interviewed Certified Nursing Assistant (CNA) J and CNA K regarding behaviors. Both aides stated that resident used to be combative at times but now has no behaviors. CNAs stated they know R4 had a medication change that made her normal. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/03/24 at 2:21 PM, Surveyor interviewed Licensed Practical Nurse (LPN) L regarding R4's behaviors and monitoring. LPN L stated that R4 does not have any behaviors since being removed off of lorazepam and is not aware of any target behaviors required to document specific to R4. On 04/03/24 at 2:59 PM, Surveyor interviewed DON B regarding process of psychotropic medication and behaviors monitoring. DON B stated the facility has a meeting called Behavioral Intervention and Management Program (BIMPS) that was just restarted in January 2024. The meetings are conducted monthly. Surveyor asked DON B what prompted the restarting of the meetings. DON B stated, Because we knew we weren't in compliance. Surveyor asked DON B when the last meeting was done prior to restarting the BIMPS meetings. DON B stated not since 2022. On 04/03/24 at 2:59 PM, DON B confirmed that R4's PRN use of Haldol without stop date is not appropriate. DON B confirmed R4 was placed on the PRN Haldol when the scheduled lorazepam was discontinued and had not been administered since ordered and should have been reevaluated or discontinued after 14 days. On 04/03/24 at 2:59 PM, DON B was asked to provide supporting documentation of targeted behavior documentation monitoring to determine if behaviors are continuing, worsening, or improving to determine if adjustments or discontinuing of medications are warranted. DON B was unable to provide documentation to support the continued use of the antipsychotic medication, including dosage changes. On 04/04/24 at 8:31 AM, Surveyor interviewed DON B regarding R4's 25 falls during the period 10/12/23 through 12/23/23. DON B stated that resident is at high risk for falls especially with being on the lorazepam. Surveyor asked DON B if there is any documentation supporting that the psychotropic medication was considered a cause of falls prior to one of the medications being discontinued on 11/27/23. DON B confirmed there was not.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 48793 Based on observation, interview and policy review, the facility did not ensure all drugs and biologicals were stored and labeled in accordance with currently accepted professional principles, did not ensure only authorized personnel had access to medication carts and did not ensure expired medications were removed from stock supply. This occurred for 2 of the 3 medication carts/storage rooms observed. During the three-day survey, 3 of 4 observations were made of medication carts left unlocked when unattended and out of view of staff. One observation was made of a lorazepam liquid bottle opened and not labeled with an open or expiration date stored in the E-hall medication storage room. One observation was made of an opened bottle of liquid Humalog vial not labeled with resident identification, nor with an open or expiration date label. Findings include: The facility policy, entitled Medication Administration, dated 08/23, states: .-When opening a new medication that is not in a card, mark medication with an open date and use-by date per pharmacy recommendation. -Medication carts must never be left unattended unless locked with medications secured . Surveyor reviewed medication storage pharmacy reviews, which stated in part: .-09/28/23: E-Hall has 3 undated insulin pens, and one bottle of lorazepam brought from a resident's home that is unlabeled and difficult to read with no open date on the bottle. -10/25/23: E-Hall has 1 undated vial of tuberculin solution. -11/27/23: E-Hall has 1 bottle of nystatin powder no resident information label, and d1 undated vial of TB solution. -01/02/24: E-Hall has 1 undated foil neb packet, 1 expired novolog pen, and 1 undated eye drop bottle. -02/15/24: E-Hall has unlocked the medication cart and unattended, 1 undated foil of nebulizer pack. -03/03/24: E-Hall has 1 undated foil nebulizer packed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525706	A. Building B. Wing	04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Christian Community Home of Osceola, Inc	2650 65th Ave Osceola, WI 54020

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-04/01/24: E-Hall has 1 vial of Humalog with no open date or resident/RX info, 1 undated foil of nebulizer pack, and 1 bottle of Systane with no open date or resident/RX info. E-Hall fridge as 2 expired vials of insulin and 1 expired spike vaccination . Example 1 On 04/03/24 at 7:45 AM, Surveyor observed Licensed Practical Nurse (LPN) E walk away from medication cart unlocked, down the hallway to administer medications. Surveyor observed the medication cart to be unlocked. On 04/03/24 at 7:50 AM, Surveyor observed LPN E walk back to the medication cart. Surveyor observed the medication cart to still be unlocked. On 04/03/24 at 7:52 AM, Surveyor interviewed LPN E and asked normal process for locking medication carts during medication administration. LPN E indicated that it is not LPN E's normal routine to leave the medication cart unlocked. On 04/03/24 at 7:53 AM, Surveyor observed LPN E walk away from the medication cart and stated LPN E needed to use the restroom as there was something in LPN E's eye. Surveyor observed the medication cart to be left unlocked. On 04/03/24 at 7:54 AM, Surveyor observed LPN E walk back to the medication cart and prep more medications for the next administration. Surveyor observed the medication cart to be unlocked. On 04/03/24 at 7:55 AM, Surveyor observed LPN E walk away from medication cart unlocked, down the hallway to administer medications. Surveyor observed the medication cart to be unlocked. On 04/03/24 at 8:00 AM, Surveyor observed LPN E walk back to the medication cart. Surveyor observed the medication cart was unlocked. On 04/03/24 at 10:03 AM, Surveyor interviewed Director of Nursing (DON) B and asked what the expectation is for locking the medication cart when administering medications or leaving the cart. DON B indicated that all nurses are to lock the medication cart before leaving the medication cart alone to administer medications or complete a task. DON B indicated that carts are to never be left unlocked for any reason. Example 2 On 04/03/24 at 8:01 AM, Surveyor observed the E-hall medication storage room with LPN E. Surveyor observed an open liquid vial of lorazepam in the refrigerator. Surveyor did not observe an open or use-by date label on the lorazepam bottle. Surveyor observed that a pharmacy review form hanging on the door stated a review was completed on 04/01/24 with pharmacy recommendations stating the facility was recommended to correct the liquid bottle of lorazepam that has no open or use-by date label on the bottle. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/03/24 at 8:04 AM, Surveyor interviewed LPN E and asked LPN E the expectations for storing opened lorazepam in the refrigerator. LPN E indicated the opened vial of lorazepam is supposed to be labeled when it was opened or have a use-by date. LPN E indicated the vial of lorazepam does not have an open date or use-by date. On 04/03/24 at 10:03 AM, Surveyor interviewed DON B and asked what the expectation is for labeling used liquid lorazepam. DON B indicated that once the bottle is opened the bottle should be labeled when it was opened and have a use-by date on the bottle. DON B confirmed the vial of lorazepam on E-Hall did not have a label and that the pharmacy checks the storage rooms monthly. DON B indicated the pharmacy just reviewed the storage room refrigerator on 04/01/24 and suggested that the lorazepam bottle should be labeled. Surveyor asked DON B who completes the task of correcting any recommendations from the pharmacy every month. DON B indicated it should be the nurse on duty to correct pharmacy recommendations when the review is completed. Example 3 On 04/03/24 at 11:49 AM, Surveyor observed a 100-unit vial of Humalog insulin opened on the top shelf of the medication cart on E-Hall. Surveyor did not observe any resident information or open date label on the vial of Humalog insulin. On 04/03/24 at 11:50 AM, Surveyor interviewed Registered Nurse (RN) D and asked who oversees checking medication carts and correcting any errors in open dates or expired medications. RN D indicated that when the pharmacy came to review the medication cart on 04/01/24 the charge nurse on that shift should have corrected the deficiencies/recommendations that the pharmacy suggested. RN D indicated that RN D would dispose of the Humalog bottle. Surveyor observed RN D dispose of the Humalog bottle. On 04/03/24 at 1:25 PM, Surveyor interviewed DON B and asked what the expectation is for labeling the used Humalog bottle. DON B indicated that once opened the bottle should be labeled when opened and have a use-by date on the bottle. DON B indicated the bottle should also have residents' information labeled on the bottle. DON B indicated the pharmacy just reviewed the storage room and medication carts on 04/01/24 and suggested that all suggestions/recommendations from the pharmacy be completed by a nurse on the shift the pharmacy came and reviewed the medication storage room.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 48793 Based on observation, interview, and record review, the facility did not prepare, distribute, and serve food in a manner that prevents foodborne illness to 33 out of 33 residents reviewed. Cook touched ready-to-eat foods with contaminated gloves when serving meals. The facility did not ensure the foods were served at safe temperatures in accordance with professional standards for food safety. Staff identified the temperature of the pork tenderloin on the hot steam table at 132. 6 degrees Fahrenheit when serving the lunch meal. The facility did not ensure dishes had proper sanitization completed by observations of low-temperature wash cycles and incomplete chemical solution testing. The kitchen cooler contained a variety of foods in cups not labeled with open or use-by dates. Dietary Aide (DA) laid personal belongings on the food prep table. Findings include: Surveyor reviewed the policy titled, Employee Sanitary Practices, which stated in part, - .#6: Use utensils to handle food, avoiding bare-hand contact with food. Surveyor reviewed the policy titled, Hand Washing, which stated in part, - .#1. When to wash hands: - f. After handling soiled equipment or utensils. - g. During food preparation, as often as necessary to remove soil or contamination and to prevent cross-contamination when changing tasks. -j. After engaging in other activities that contaminate the hands . Surveyor reviewed the policy titled, Food Temperatures, which stated in part, - .#1. All hot foods must be cooked to appropriate internal temperatures, held, and served at a temperature of at least 135 degrees Fahrenheit. -b. Hot food items may not fall below 135 degrees Fahrenheit after cooking. -#5. Tray line and alternative meal preparations and service areas will avoid the following methods: Holding foods in the temperature danger zone (41 degrees to 135 degrees Fahrenheit) . (continued on next page)

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	525706	A. Building B. Wing	04/04/2024

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Surveyor reviewed the policy titled, Cleaning Dishes/Dish Machine, which stated in part, - .#1. Prior to use, proper temperatures and/or chemical concentrations and machine function should be verified . Surveyor reviewed the policy titled, Sanitation of Dishes/Dish Machine, which stated in part, - .#1. Staff will monitor dish machine temperatures throughout the dishwashing process. For low temperature Dishwasher sanitization washing cycle temperature is 120 degrees Fahrenheit with 50 PPM Hypochlorite . Surveyor reviewed the policy titled, Food Safety and Sanitation, which stated in part, - .#4: All time and temperature control for safety (TSC) foods (including leftovers) should be labeled, covered, and dated when stored. -When a food package is opened, the food item should be marked to indicate the open date. This date is used within 72 hours (or discarded) . Surveyor reviewed the reference index titled, Food storage chart for food storage guidelines, which stated in part, - .All items need to be dated when pulled from the cooler or freezer. -muffins/pastries are to be refrigerated for 5 days and then discarded. -Butter is to be refrigerated for 3 months and then discarded. -Cookies baked and/or zip lock bagged are to be refrigerated for 7 days and then discarded. -Fruit canned opened are to be refrigerated for 1 week then discarded . Surveyor reviewed the policy titled, Personal Hygiene and Health Reporting, which stated in part, - .#1: Street clothing, coats, purses, packages, and other personal effects will be stored in employee lockers or designated storage areas and not in the kitchen . Example 1 (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 04/02/24 at 11:50 AM, Surveyor observed Cook G grab a plate and plate cover with gloved hands. Cook G picked the bread bag up and untied it with gloved hands. Cook G took the lid to the cold ham meat with Cook G's gloved right hand and set the lid on the counter. Cook G took Cook G's dirty gloved right hand and grabbed bread out of the bag. Cook G grabbed ham lunch meat with a dirty gloved right hand and placed it on the bread. Cook G took dirty right-gloved hand and put the lid back on the ham container. Cook G grabbed the lid of the cheese container with a dirty right-gloved hand and set the lid on the counter. Cook G grabbed cheese with both dirty gloved hands and spread it on bread making a sandwich. Cook G took a knife with a dirty right hand and then grabbed bread with a dirty left gloved hand and held the sandwich so Cook G could cut the bread. Cook G placed the plate on the counter to be served. On 04/02/24 at 12:07 PM, Surveyor observed Cook G take the plate and plate cover with gloved hands. Cook G grabbed the fried basket with the right gloved hand and shook the cod onto the plate. Cook G took the knife with the right-gloved hand and then grabbed cod fish with dirty left-gloved hand and cut the cod on a plate. Cook G took both dirty gloved hands, rearranged the cod on the plate and placed tartar sauce on the plate. Cook G placed the plate on the counter to be served. On 04/02/24 at 12:14 PM, Surveyor observed Cook G grab the plate and plate cover with gloved hands. Cook G rearranged the plate on a tray. Cook G opened the cooler and grabbed the ham salad container. Cook G took the lid off and laid it on the counter. Cook G took 2 pieces of bread out of the bread bag with both dirty gloved hands and laid them on the plate. Cook G used a spatula and scooped ham salad. Cook G took a piece of bread with a dirty left-gloved hand and spread ham salad with right-gloved hand. Cook G set the spatula down. Cook G took another piece of bread with a dirty right-gloved hand and placed both pieces together and placed on the plate. Cook G grabbed a potato chip container on the shelf and popped the top off with both dirty gloved hands. Cook G shook the container over the plate and dropped potato chips onto the plate. Cook G took the dirty left-gloved hand and rearranged the chips on the plate. Cook G placed the plate on the counter to be served. On 04/02/24 at 12:22 PM, Surveyor observed Cook G grab a ham salad container with both gloved hands, open the cooler door, and place the container back in the cooler. Cook G picked up a piece of bread sitting on the counter with a dirty left-gloved hand and placed the piece of bread back in the bread bag. On 04/02/24 at 12:25 PM, Surveyor observed Cook G take a gloved left hand and lift the top of the pork tenderloin on the hot steam table. Cook G picked the pork tenderloin up with tongs on the right gloved hand and placed it on the cutting board. Cook G took a knife with a gloved right hand and grabbed the pork tenderloin with a dirty left gloved hand to hold the pork tenderloin in place. Cook G cut the pork tenderloin, then took both dirty gloved hands and scooped the pork tenderloin and scattered it on a plate. Cook G placed the plate on the counter to be served. On 04/02/24 at 12:36 PM, Surveyor observed Cook G take a gloved left hand and lift the top to the pork tenderloin on the hot steam table. Cook G picked the pork tenderloin up with tongs on the right gloved hand and placed it on the cutting board. Cook G took a knife with a gloved right hand and grabbed the pork tenderloin with a dirty left gloved hand to hold the pork tenderloin in place. Cook G cut the pork tenderloin, then took both dirty gloved hands and scooped the pork tenderloin and scattered it on a plate. Cook G placed the plate on the counter to be served. Example 2 (continued on next page)

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	525706	A. Building B. Wing	04/04/2024

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 04/02/24 at 11:40 AM, Surveyor observed Cook I temp pork tenderloin on the hot steam table. Cook I indicated that the temperature of the pork tenderloin was 132.6 degrees Fahrenheit. Surveyor interviewed Cook I and asked what the normal temperature range is for holding pork on the hot steam table before serving. Cook I indicated that she was unsure and believed it was ok. Surveyor observed Cook I serve pork tenderloin to residents. On 04/02/24 at 1:52 PM, Surveyor interviewed Dietary Manager (DM) F and asked about proper temperatures for pork tenderloin before serving meat to residents. DM F indicated that all food on the hot steam table should be held above 135 degrees Fahrenheit. DM F indicated that the pork tenderloin should not have been served with temperatures in the danger zone. On 04/02/24 at 1:55 PM, Surveyor requested temperature logs. On 04/02/24 at 2:36 PM, Surveyor received cooked verification temperature logs. DM F indicated that the temperature logs were documented for temperatures when the kitchen staff checked the post-cooked food temperatures, not the temperatures at the point of service. Surveyor did not receive temperature logs for temps checked at the point of service. Example 3 On 04/02/24 at 1:30 PM, Surveyor observed Cook I start washing 1st cycle of dishes. Surveyor observed a temperature gauge that read 90 degrees Fahrenheit. Surveyor did not observe Cook I check the temperature, or chemical strips for proper sanitization of the dishwasher. On 04/02/24 at 1:31 PM, Surveyor observed Cook I start washing 2nd cycle of dishes. Surveyor observed a temperature gauge that read 93 degrees Fahrenheit. Surveyor did not observe Cook I check temperature, or chemical strips for proper sanitization of the dishwasher. On 04/02/24 at 1:32 PM, Surveyor observed Cook I start washing 3rd cycle of dishes. Surveyor observed a temperature gauge that read 97 degrees Fahrenheit. Surveyor did not observe Cook I check the temperature, or chemical strips for proper sanitization of the dishwasher. On 04/02/24 at 1:33 PM, Surveyor observed Cook I start washing the 4th cycle of dishes. Surveyor observed a temperature gauge that read 100 degrees Fahrenheit. Surveyor did not observe Cook I check the temperature, or chemical strips for proper sanitization of the dishwasher. On 04/02/24 at 1:38 PM, Surveyor interviewed Cook I and asked what kind of dishwashing system the kitchen operates and what are the expectations of checking to make sure the kitchen dishes are being sanitized correctly. Cook I indicated the dishwasher is considered a chemical sanitization dishwasher. Cook I indicated that Cook I usually runs a strip through on the first cycle of dishes and will use the stick to check the inside chemical ratio when dishes are completed after 1st cycle. Surveyor asked about the temperature on the gauge. Cook I indicated that each cycle should at least be at a minimum of 120 degrees Fahrenheit before washing dishes. Cook I indicated that she did not do this for the first 4 cycles. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 04/02/24 at 1:50 PM, Surveyor interviewed DM F and asked what kind of dishwashing system the kitchen operates and what are expectations of staff to check and make sure the kitchen dishes are being sanitized correctly. DM F indicated the dishwasher is considered a low-temperature (chemical sanitization) dishwasher. DM F indicated that a temperature strip was to be run through the first cycle to make sure the temperature was above 120 degrees Fahrenheit. DM F indicated that Cook I should have checked temperatures before completing the 1st cycle of dishes and if temperatures were not above 120 degrees Fahrenheit then Cook I should have re-cycled the dishes through until the desired temperature of a minimum of 120 degrees Fahrenheit. Example 4 On 04/02/24 at 9:56 AM, Surveyor observed in cooler #9 at the back of the cooler a Ziplock bag of butter. Surveyor did not observe an open or use-by date. Surveyor interviewed DM F and asked when the butter had been opened or when was the butter expected to be used. DM F indicated that since no one labeled the butter it should be discarded now. DM F picked the butter up and then laid it back down on a shelf at the front of the cooler. On 04/02/24 at 9:57 AM, Surveyor observed in cooler #9 vanilla pudding in pre-made bowls labeled 03/30/24. Surveyor asked DM F about the date of 03/30/24 on the vanilla pudding and what the date indicates. DM F indicated that 03/30/24 was when the pudding was prepped. Surveyor asked if the vanilla pudding had a use-by date and how do staff know when to use the vanilla pudding. DM F indicated the vanilla pudding did not have a use-by date and the facility policy use-by date indicates that all foods should be discarded after 3 days of being prepped. DM F indicated the vanilla pudding should be discarded now. On 04/02/24 at 9:58 AM, Surveyor observed a zip lock bag of leftover meatloaf cooked, sitting on the shelf with the date of 03/30/24. Surveyor interviewed DM F about the used meatloaf and when the meatloaf is to be discarded. DM F indicated the meatloaf is waiting to be frozen. Surveyor asked DM F what the policy for freezing leftovers is. DM F indicated the expectation to freeze leftovers should be within 2 days. DM F indicated that the meatloaf is past the time frame to be frozen now. On 04/02/24 at 10:00 AM, Surveyor observed cooler #1 up front in the cooking area to have a blue Gatorade opened and a quarter full sitting on a shelf in the facility food prepped cooler. DM F stated that the blue Gatorade is an employee's drink and should not be in the kitchen prepped food cooler, but it should be kept in the employee cooler in the back. On 04/02/24 at 10:01 AM, Surveyor observed cooler #1 with a container full of cooked bran muffins labeled with a use-by date of 03/27/24. Surveyor interviewed DM F and asked to explain the bran muffins in the container labeled with a use-by date of 03/27/24. DM F indicated that even though they wrote use by date it was the prepped date. Surveyor asked DM F if the date of 03/27/24 is still acceptable to be used or offered to residents. DM F indicated the bran muffins are past their use-by date of 3 days and should be discarded. (continued on next page)

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	525706	A. Building B. Wing	04/04/2024

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 04/02/24 at 10:04 AM, Surveyor observed another cooler in the kitchen entry area to have a tray of prepped mandarin oranges in bowls. Surveyor did not observe a prep date or use-by date. Surveyor interviewed DM F and asked about mandarin orange bowls and if the mandarin orange bowls were acceptable to serve to residents with no dates labeled. DM F indicated the mandarin oranges should be tossed as employees will not know when the mandarin orange bowls were prepped or when to use the mandarin orange bowls. Surveyor observed DM F take mandarin oranges out of the cooler and toss them in the trash. Example 5 On 04/02/24 at 9:54 AM, Surveyor toured the kitchen with DM F. Surveyor entered the kitchen. Surveyor immediately observed a blue sweatshirt and car keys lying on the meal prep table. Surveyor interviewed DM F and asked about the personal belongings found on the prep table. DM F indicated the personal belongings belonged to Dietary Aide (DA) H. DM F indicated that personal belongings are to be kept in the employee break room behind the kitchen and not supposed to be lying on the kitchen prep table. Surveyor observed DA H grab personal belongings and walk to the back of the kitchen. Surveyor did not observe staff wipe down the food prep table before using the prep table.

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	525706	A. Building B. Wing	04/04/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47807 Based on observation, interview and record review, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. The facility did not establish a water management program with measures to monitor the control measures in place. The facility did not ensure the standard of practice for infection surveillance and treatment and McGeer's criteria were being utilized in the facility's infection control program. This has the potential to affect all 33 of 33 residents (R) residing in the facility. Findings include: The facility policy, entitled, Water Management Policy for Legionnaires' disease, which is not dated, states in part: Infection Control - . Risk Assessment - . B. Implement general strategies for detecting and preventing Legionnaires disease: . c. Keep adequate records of infection control measures, including communication with maintenance, maintenance procedures and environmental test results. The Center for Disease Control and Prevention (CDC) guidelines, entitled Controlling Legionella in potable water systems, last reviewed February 3, 2021, states in part: Flush low-flow piping runs and dead legs at least weekly and flush infrequently used fixtures (e.g., eye wash stations, emergency showers) regularly as-needed to maintain water quality parameters within control limits. On 04/03/24 at 1:30 PM, Surveyor reviewed the facility's Water Management Plan (WMP) and did not find a record of maintenance, inspections, or flushing of areas of concerns that required flushing. On 04/03/24 at 3:42 PM Surveyor interviewed Nursing Home Administrator (NHA) A and Director of Maintenance (DM) N regarding the flow chart and hot spots. NHA A and DM N stated they do have a flow chart that shows where water is flowing and have talked about flushing hot spots every two weeks, but don't think the facility has any stagnate rooms in the building. NHA A did say they do not document any of the flushings. NHA A indicated the maintenance program knows this is a concern. The sheet for documenting has been created, but not yet filled out or used. Surveyor was presented with a document named Christian Community Homes and Services Water Management Program - Water Flushing. This document had no records of any flushing in the facility. On 04/04/24, Surveyor was given room occupancy records for the months of February, March, and April of the [AGE] year from NHA A. The records showed there are 13 instances where rooms were left vacant for over seven days, four instances where one rooms was left vacant for over 14 days, and instance where room [ROOM NUMBER] was left vacant for 38 days. 48793 The Facility Policy entitled Nosocomial Infection Surveillance/Antibiotic Stewardship Program, states in part: The infection Preventionist is responsible for monitoring; investigating and setting forth a control plan to prevent unnecessary infections. The IP is responsible for monitoring and trending the facility infection incidence rates and this information is reviewed quarterly assurance committee with the interdisciplinary team and medical director each at least quarterly . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	.Procedure: - #1. An infection Control Log sheet/daily surveillance will be kept for each hallway/unit and updated by nursing staff when suspected/actual infections occur. See Infection Criteria list-reference McGeer's infection Criteria. -#2. The IP will confer with the licensed nurse/nurse manager/DON for each resident group and maintain an updated list of suspected/actual residents exhibiting signs and symptoms of an infection. -#3. The interdisciplinary team will review infections weekly. -#4. The list of residents with infections will be reviewed at the Quality Assurance meeting with the interdisciplinary team and Medical Director each quarter. -#5. The IP verifies the signs and symptoms/dx are documented in the resident medical record. -#6. The IP will evaluate each resident for: a. Adequate/inadequate antibiotic use -monitor for urine analysis/urine culture results and if lab results are negative or mixed will notify MD to DC antibiotics if ordered. b. Proper follow-up care. c. Lab/Xray results. d. Causative agent. e. Improvement in resident signs and symptoms. f. Determination if infection is pre-existing of nosocomial. g. Risk factors for infection. h. Need for hospitalization . i. Preventative measures for residents' risk of future infection. -#7. The IP is responsible for keeping a monthly list of infections and completing the cumulative nosocomial infection data. -#8. Infection incident rates are calculated monthly and compared to the previous month and trended over the year. -#10. On-going audits/real-time surveillance will be completed . Example 1: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525706	A. Building B. Wing	04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Christian Community Home of Osceola, Inc	2650 65th Ave Osceola, WI 54020

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 04/02/24 at 10:42 AM, Surveyor interviewed Director of Nursing (DON)/Infection Control (IC) B and asked about infection surveillance and documentation that infection surveillance processes were being completed. DON B indicated that DON B would need to gather the monthly line lists, but DON B is unsure where these are located at the moment. Surveyor asked DON B if there was a binder on the computer in which DON B kept the monthly line lists. DON B indicated to Surveyor that DON/IC B would find them and give them to Surveyor once found. On 04/02/24 at 10:47 AM, Surveyor entered DON B's office and observed DON B creating monthly line lists. DON/IC B apologized and stated, I will get these to you soon. On 04/02/24 at 1:45 PM, Surveyor received January 2024 to March 2024 monthly resident line lists for infection surveillance from DON B. Surveyor reviewed the resident infection line lists from January 2024 to March 2024, titled, Infection/Antibiotic use Quality Assurance Weekly Review Week/Year, which included in part, .categories labeled resident name, date, room #, type of infection, signs and symptoms that only stated facility acquired or community-acquired, and antibiotic . Surveyor did not observe resident surveillance logs for tracking and trending infections for the last 12 months of logs since the last recertification survey. Example 2 On 04/02/24 at 1:50 PM, Surveyor received January 2024 to April 2024 staff infection surveillance line lists from DON/IC B. Surveyor reviewed January 2024 to April 2024 staff infection surveillance line lists: -On 03/03/24, surveillance indicated Staff Member P had vomiting and returned to work on 03/05/24. -On 03/04/24, surveillance indicated Certified Nurse Assistant (CNA) K had diarrhea and returned to work on 03/05/24. -On 03/05/24, surveillance indicated Medication Aide (MA) Q had diarrhea and returned to work on 03/06/24. The staff surveillance log for RSA P, CNA K, and MA Q did not include the well date, any testing, and what department/location all last worked. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 04/03/24 at 9:45 AM, Surveyor interviewed DON B and asked DON B what the process was for infection surveillance for residents and staff. Surveyor requested the last 6 months to a year of infection surveillance. DON B stated that DON B could not give Surveyor the last 6 months to a year of infection surveillance line lists as they are not being completed correctly. DON B indicated that DON B made January 2024-March 2024's resident infection line lists yesterday 04/02/24 because DON B hasn't had time to complete infection surveillance. DON B indicated DON B pulled information on what resident was on antibiotics from the electronic health record (EHR) and wrote information on papers provided to Surveyor. DON B stated, I am a one-man show here and receive no help, this has fallen through the cracks. Surveyor asked DON B what source or criteria is used to track infections. DON B indicated that DON B cannot think of the name of the source used to track and treat infections throughout the facility. DON B indicated she cannot explain when precautions were started for residents on the line list but may give a rough estimate of the time frame for previous infections as DON B's process is not the best. DON B indicated that DON B's process is lacking tremendously. DON B indicated that she completed the course of IC training and became IC nurse around November/December of 2023 and the old person in the position left in the middle of COVID-19 and IC has fallen through the cracks. Surveyor asked DON B who tracks staff infection surveillance. DON B indicated that Human Resources (HR) C tracks infection surveillance throughout the staff. DON B indicated DON B only receives notice of when staff calls in and then DON B decides if staff needs to be tested and when they can come back to work. DON B indicated that DON B does not complete any documentation on staff infection surveillance. Surveyor asked DON B what process DON B follows for residents' onset of symptoms and determining who is placed on antibiotics and precautions. DON B indicated that nurses on the floor just let the Physician Assistant (PA) know when a resident is sick, and the PA determines tests or antibiotics. On 04/03/24 at 10:47 AM, Surveyor interviewed HR C and asked HR C what the process is for infection surveillance for staff. HR C indicated that she receives the call-ins and logs the information on a line list. HR C lets DON B know who is sick and their symptoms. HR C indicated that DON B decides who needs to be tested and when staff is allowed to come back to work. HR C indicated that DON B does not keep documentation of staff call-ins or plan of action for preventing further spread of infection.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48793 Based on the interview and record review, the facility did not establish an Infection Prevention and Control Program (IPCP) that must include, at a minimum, the following elements: An Antibiotic Stewardship Program that includes antibiotic use protocols and a system to monitor antibiotic use. This has the potential to affect all 33 residents in the building who may utilize antibiotics. The facility did not ensure the standard of practice for infection surveillance and treatment, and McGeer's criteria were being utilized in the facility's antibiotic stewardship program. The facility did not follow Standards of Practice (SOP) for Antibiotic Stewardship for antibiotic use for residents on the line list logs from [DATE] through [DATE] line lists. This is evidenced by: The Facility Policy entitled Nosocomial Infection Surveillance/Antibiotic Stewardship Program, dated , d+[DATE], states in part: The infection Preventionist is responsible for monitoring; investigating and setting forth a control plan to prevent unnecessary infections. The IP is responsible for monitoring and trending the facility infection incidence rates and this information is reviewed quarterly assurance committee with the interdisciplinary team and medical director each at least quarterly . .Procedure: - #1. An infection Control Log sheet/daily surveillance will be kept for each hallway/unit and updated by nursing staff when suspected/actual infections occur. See Infection Criteria list-reference McGeer's infection Criteria. -#2. The IP will confer with the licensed nurse/nurse manager/DON for each resident group and maintain an updated list of suspected/actual residents exhibiting signs and symptoms of an infection. -#3. The interdisciplinary team will review infections weekly. -#4. The list of residents with infections will be reviewed at the Quality Assurance meeting with the interdisciplinary team and Medical Director each quarter. -#5. The IP verifies the signs and symptoms/dx are documented in the resident medical record. -#6. The IP will evaluate each resident for: a. Adequate/inadequate antibiotic use -monitor for urine analysis/urine culture results and if lab results are negative or mixed will notify MD to DC antibiotics if ordered. b. Proper follow-up care. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	c. Lab/Xray results. d. Causative agent. e. Improvement in resident signs and symptoms. f. Determination if the infection is pre-existing or nosocomial. g. Risk factors for infection. h. Need for hospitalization . i. Preventative measures for residents' risk of future infection. -#7. The IP is responsible for keeping a monthly list of infections and completing the cumulative nosocomial infection data. -#8. Infection incident rates are calculated monthly and compared to the previous month and trended over the year. -#10. On-going audits/real-time surveillance will be completed . Surveyor reviewed the resident infection surveillance line lists from [DATE] to [DATE], titled, Infection/Antibiotic use Quality Assurance Weekly Review Week/Year, which included in part, .categories labeled resident name, date, room #, type of infection, signs and symptoms that only stated facility acquired or community-acquired, and antibiotic . Surveyor reviewed 3 sampled residents (R) from [DATE] to [DATE] on the resident (R) infection surveillance list. (R13, R22, and R230). Surveyor reviewed resident infection surveillance log for the month of February 2024: -On [DATE], surveillance indicated R13 had a Urinary Tract Infection (UTI), facility acquired, and antibiotic Cephalexin. -On [DATE], surveillance indicated R22 had respiratory infection, facility acquired, and antibiotic Doxycycline. -On [DATE], surveillance indicated R230 had a UTI and antibiotic Ciprofloxacin. R13, R22, and R230's infection surveillance logs did not have signs and symptoms of infection, the start date of infection, the start date of isolation, the start date of antibiotics, appropriate lab culture results, hospital/death, or well date. Surveyor did not observe the monthly rate of infections on surveillance logs. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On [DATE] at 9:45 AM, Surveyor interviewed Director of Nursing (DON) B and asked DON B how DON B keeps track of how long residents are on antibiotics and if a resident needs a different antibiotic or adjustment. DON B indicated the facility just listens to the Physician Assistant (PA)'s orders. Surveyor asked DON B for any documentation such as any diagnostic tests, lab cultures, signs and symptoms, and criteria that the facility determines residents with infections to be placed on antibiotics from DON B's [DATE]-[DATE] line lists. Surveyor received no further reports or notes. On [DATE] at 3:40 PM, Surveyor interviewed DON B and asked about the antibiotic stewardship process. DON B indicated that the antibiotic stewardship committee meets annually for antibiotic stewardship to go over policies and update antibiotic use at the facility. Surveyor asked DON B when policies were updated. DON B indicated that policies are updated annually. Surveyor pointed out that IC policies were last updated in 2022. DON B indicated the policies were not up to date. Surveyor received no further documentation addressing the expired policies.