STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525711	A. Building B. Wing	05/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pride Tlc Therapy and Living Campus	7805 Birch St Weston, WI 54476

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - 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. 30570 Based on observation, interview and record review, facility staff did not ensure adequate supervision and safety to prevent accidents from occurring by not using a gait belt when warranted for a resident transfer affecting 1 of 3 residents (R) reviewed for transfer and falls (R7). This is evidenced by: Facility policy titled Transfer and Body Mechanics Policy, dated as most recently revised on 12/03/23 was reviewed by Surveyor. The policy in part reads: Procedure: The intent of this policy is to ensure every resident receives specialized rehabilitive services as determined by their comprehensive plan of care to assist them to attain, maintain or restore their highest practicable level . Protocol: Guidelines and tips for using proper body Mechanics: ~Use a gait belt at all times. Surveyor reviewed R7's Admission Minimum Data Set (MDS) completed on 4/20/24 which noted R7 understands, is understood and is cognitively intact. R7's admission diagnoses included vertigo (a sensation of motion or spinning that is often described as dizziness) and displaced left hip fracture. R7 has a fall history prior to her admission. R7 requires partial to moderate assistance of one staff for transfers sitting to standing, toilet transfer, and shower transfer. Surveyor reviewed R7's care plan and noted the following: I have a mobility deficit with potential for falls R/T (related to) hip fracture s/p (status post) nailing and weakness. Goal: I will regain my prior level of function and will not have a fall with injury through the review date. Review Date: Overdue Interventions: (continued on next page)

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	My mobility devices are W/C (wheelchair), FWW (front wheeled walker) My weight bearing status is: WBAT LLE (weight bearing as tolerated, left lower extremity) I ambulate assist of one using FWW I transfer assist of one I need assist of one for toileting On 5/07/24 at 7:19 AM, Surveyor observed Certified Nursing Assistant (CNA) C assist R7 with morning care. CNA C offered R7 the toilet and took R7 to the bathroom via her wheelchair. CNA C assisted R7 to stand at the toilet, lowered R7's brief and assisted R7 to sit on the toilet. CNA C did not use a gait belt (transfer belt) when assisting R7 with her transfer. CNA took R7's wheelchair from the bathroom and brought in her walker. CNA C placed a gait belt around R7's waist and assisted her to stand and take a few steps with the walker to a shower chair in the shower in R7's bathroom. CNA C assisted R7 with the shower and told R7 the gait belt that had been removed from R7 had gotten wet from the shower spray. CNA C told R7 she needed to obtain a dry gait belt and proceeded to assist R7 in drying off from her shower. CNA C did not obtain a dry gait belt and proceeded to dry R7's feet. CNA C placed a towel on the shower floor and brought R7's walker closer to R7. CNA C assisted R7 to stand without the use of the gait belt. CNA C dried R7's back, applied lotion to R7's back and barrier cream to the buttocks as R7 stood with the walker. CNA C pulled up R7's brief/pants and transferred R7 to her wheelchair. No gait belt was used. On 5/07/24 at 9:55 AM, Surveyor interviewed Certified Nursing Assistant (CNA) C about the observation and expectation related to use of a gait belt with residents who need staff assistance to transfer. CNA C responded she should have used a gait belt as it is a facility expectation to not move residents without one as you would not want residents to fall when moving them. On 5/07/24 at 10:04 AM, Surveyor interviewed Physical Therapist (PT) D about R7's transfer abilities, the observation and the facility expectation related to gait belt use. PT D expressed the expectation is a resident would need a gait belt whenever it is indicated in a resident care plan that staff assistance is required for transfer. Physical Therapy does ongoing evaluation of resident transfer abilities and informs staff verbally as well as updated resident care plan. Staff should always use a gait belt when resident care plan specifies assist of one for transfers. It is important for both resident and staff safety. On 5/07/24 at 10:12 AM, Surveyor spoke with Nursing Home Administrator (NHA) A about the observation and the facility expectation regarding gait belt use. NHA A indicated gait belts are absolutely required for all resident transfers requiring one or two staff persons. All nursing staff are trained on this expectation including CNA C.

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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. 30570 Based on observations, record review and interview, the facility did not store and distribute foods in a sanitary manner. The facility practice has the potential to affect all 21 residents. This is evidenced by: Surveyor reviewed the facility policy titled Food Handling and Sanitation, most recently revised on 3/2024. The policy in part read: Policy: The food service department will comply with federal, state and county food codes to ensure food safety. Cover all equipment with a garbage bag when not in use and at the end of the business day: this includes but not limited to small and large equipment (utensils, can openers, mixers, blenders ect.) ~Hairnets shall cover 100% of the hairline, beards nets will be worn if not shaved. On 05/06/24 at 8:14 AM, Surveyor conducted the initial tour in the facility kitchen with Dietary Manager (DM) I. Surveyor observed a kitchen aide mixer with mixing bowl which was not inverted or covered on the food preparation counter. Surveyor observed a can opener and robo-coup food processor. The items were not in use or covered. Surveyor asked DM I if this is the normal way the equipment is stored and if the means of storage has a potential for contamination. DM I responded this was a normal means of storage and the means of storage is Pretty high potential for contamination. On 05/07/24 at 11:38 AM, Surveyor observed lunch service in the kitchen. Surveyor observed Cook F at the steam table plating foods for resident consumption. Cook F's hair was visibly hanging below the hair net at the back of the neck. Dietary Aide (DA) G was assisting with service by placing items on resident lunch trays. DA G had visible sideburns/beard with no beard net worn. DA G's hair net was only partially covering the hair in back. DA H was also observed in the kitchen assisting with tray line with hair hanging below the hair net at her ears and back of head. Surveyor asked DA G about hair restraint in the kitchen. DA G explained the facility has never provided him with a beard restraint stating, They are not used because they are not provided. Surveyor asked DM I about the expectation of hair restraint in the kitchen. DM I expressed all visible hair is to be covered in the kitchen. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 5/07/24 at 12:38 PM, Surveyor observed dishwashing and food preparation in the kitchen. Surveyor observed DA G loading dirty dishes to a rack, spraying the dishes and loading them to a tray which was loaded into the dish machine. DA G was wearing a hair net with visible hair at back of head and neckline and a surgical mask that was only partially covering the beard. DA H was observed unloading clean dishes with hair at sides of her face and back of head as DA H unloaded the clean dishes. DA H was observed walking throughout kitchen for various containers and lids and in and out of the walk in refrigerator. Surveyor observed Cook F taking clean shallow pans from rack at the 3 compartment sink. The pan was taken to the food preparation counter where Cook F scooped yogurt and coleslaw to individual containers. Cook F continued with visible hair at back of Cook F's head while completing food preparation.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 30570 Based on observation, interview and record review, the facility did not maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment. Staff did not perform hand hygiene when warranted while providing care to 1 of 3 residents (R) observed for care (R7). This is evidenced by: Surveyor requested and reviewed the facility policy titled Hand Hygiene Policy. The policy in part reads: This policy will provide staff for hand washing and hand hygiene techniques that will aid in the prevention of the transmission of infections. Hand washing with soap and water: Staff will perform hand hygiene by washing their hands .under the following conditions: Before moving from a contaminated body site to a clean site during resident care; for example: after providing peri care, before applying moisture barrier cream . After providing direct resident care. Using alcohol-based gel: If hands are not visibly soiled, use an alcohol-based hand rub for all the following: Before applying gloves and after removing gloves . Before moving from a contaminated body site to a clean body site during resident care; example: after providing peri care, before applying barrier cream After contact with inanimate objects in the immediate vicinity of the resident (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/07/24 at 7:19 AM, Surveyor observed Certified Nursing Assistant (CNA) C provide care to R7. CNA took R7 to the bathroom via her wheelchair and donned gloves in the bathroom. CNA C did not perform hand hygiene before donning the gloves. CNA assisted R7 to stand, lowered her brief and transferred R7 to the toilet. R7 urinated in the toilet and CNA C assisted R7 to stand and wiped her peri area with a wipe. With the same gloved hands CNA C assisted R7 to walk to shower chair in her shower and assisted R7 to sit in the chair. CNA C assisted R7 with removing her gown and slippers, adjusted the shower water and handed the shower hose to R7 to spray herself. CNA C wet R7's back and hair and proceeded to shampoo, apply conditioner and rinse R7's hair. CNA C applied soap to a cloth and washed and rinsed R7's back and underarms. CNA C proceeded to wash R7's body, legs and feet. CNA C dried her gloved hands and brought R7's walker closer to R7. CNA C placed a clean towel on floor and assisted R7 to stand. CNA C washed and rinsed R7's peri area and provided R7 a clean towel to dry her front. CNA C dried R7's back, legs and feet and assisted R7 back to shower chair. CNA C obtained lotion from counter, removed her gloves and donned clean gloves. CNA C did not perform hand hygiene. CNA C applied lotion to R7's back and gave R7 deodorant to apply. CNA C provided R7 with a clean shirt that she put on. CNA C applied clean tubi-grip stockings after lotion was applied to R7's legs. CNA C placed a clean brief, clean pants and slippers on R7. CNA C removed her gloves and donned clean gloves with no hand hygiene after drying water from R7's bathroom floor. CNA C assisted R7 to stand to apply barrier cream to her buttocks. CNA C pulled up R7's brief and pants and assisted R7 to transfer to her wheelchair. CNA C brought R7 into her room and provided her with a comb. CNA C returned to the bathroom to bag dirty linens. CNA C removed her gloves and performed hand hygiene. This is the first hand hygiene Surveyor observed during R7's care. On 05/07/24 at 9:55 AM, Surveyor interviewed CNA C about the facility expectation for hand hygiene and R7's morning care observation. CNA C expressed she should have performed hand hygiene prior to donning gloves, when removing gloves and when going from dirty to clean. Hand hygiene is important to not move germs from one place to another. On 5/08/24 at 9:15 AM, Surveyor spoke with Registered Nurse (RN) E about the observation. RN E is the facility's Infection Control Preventionist (ICP). RN E expressed RN E would expect hand hygiene before donning gloves. RN E would expect staff to perform hand hygiene after removing gloves and expect staff to remove gloves, do hand hygiene and don clean gloves every time when going from dirty to clean to prevent the spread of infection.