STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525712	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/13/2024
NAME OF PROVIDER OR SUPPLIER Care and Rehab - Cumberland		STREET ADDRESS, CITY, STATE, ZIP CODE 1100 7th Ave Cumberland, WI 54829	

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47807 Based on interview and record review, the facility did not ensure that based on the comprehensive assessment of a resident, that residents receive treatment and care in accordance with professional standards of practice. The facility did not ensure that a Registered Nurse (RN) assessed a resident after a fall occurred. This had the potential to effect 2 of 7 residents (R) (R29, R193) investigated for accidents. Findings include: Wisconsin state statue Chapter N 6 titled Standards Of Practice For Registered Nurses And Licensed Practical Nurses dated December 2018, states, In the performance of acts in basic patient situations, the L.P. N. shall, under the general supervision of an R.N. or the direction of a provider: (a) Accept only patient care assignments which the L.P.N. is competent to perform. (b) Provide basic nursing care. N 6.04(1)(c)(c) Record nursing care given and report to the appropriate person changes in the condition of a patient. (d) Consult with a provider in cases where an L.P.N. knows or should know a delegated act may harm a patient. (e) Perform the following other acts when applicable: 1. Assist with the collection of data. 2. Assist with the development and revision of a nursing care plan. 3. Reinforce the teaching provided by an R.N. provider and provide basic health care instruction. 4. Participate with other health team members in meeting basic patient needs . (1m)?Basic nursing care means care that can be performed following a defined nursing procedure with minimal modification in which the responses of the patient to the nursing care are predictable. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy, entitled Fall/Incident Assessment updated on 05/28/24, states, Procedure: resident fall. 1. Do not move the resident until a nurse assess the resident for potential injury 2. Notify the nurse. Example 1 R193 was admitted to the facility on [DATE] at 12:20 PM. Diagnoses included Alzheimer's disease, unspecified intracapsular fracture of right femur related to a fall at home. R193 entered the facility with an activated power of attorney, and the facility did not have time to complete Minimum Data Set (MDS) assessment or baseline care plan. On 11/12/24 at 2:45 PM, Surveyor completed record review of R193's recent fall. Surveyor found that R193 fell and fractured their left hip on 11/07/24 at 3:50 PM, a few hours after entering the facility. Surveyor looked for assessment of the fall and found an interdisciplinary report of the fall and review of the fall by the Director of Nursing (DON), but no initial fall report or assessment from staff member on duty at the time of the fall. On 11/13/24 at 8:38 AM, Surveyor interviewed DON B regarding the fall and initial fall report. DON B said R193 was assessed by a Licensed Practical Nurse (LPN). Initially there were no issues and R193 was assisted into their recliner by the LPN. DON B assessed R193 when R193 began having complaints of pain in left leg. DON B indicated the LPN who assessed R193 has not charted on the incident yet. R193 was transferred to the hospital, having a fractured hip. DON B indicated she has asked staff to chart the assessment. Surveyor asked DON B if an LPN can assess a resident after a fall, and DON B stated an LPN can. Surveyor did request evidence of this. Surveyor did note LPN had assessed R193 and moved them to the recliner prior to an RN assessment. On 11/13/24 at 12:52 PM, LPN E was interviewed regarding scope of practice. LPN E said as it refers to a fall, I can inspect a fall and report my findings. I'm always working with a Registered Nurse. I cannot assess the resident. No evidence was received from facility regarding LPNs being able to assess or move residents after a fall. 44863 Example 2 According to the Nurse Practice Act, an LPN can provide basic nursing care under the supervision of an RN. Basic nursing care includes monitoring vital signs, administering medications, and changing bandages. R29 was admitted to the facility on [DATE]. Diagnoses included dementia with agitation, history of stroke, repeated falls, weakness, unsteadiness on feet, and difficulty walking. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R29's MDS assessment dated [DATE] confirmed the following: -Scored 02/15 during Brief Interview for Mental Status (BIMS), indicating severe cognitive impairment. On 11/13/24, Surveyor reviewed R29's falls, and noted the following: On 07/29/24, R29's progress notes indicated a Certified Nursing Assistant (CNA) notified an LPN that R29 sustained a fall. Documentation indicated an assessment was completed by LPN C, with no RN assessment. On 09/04/24, R29 sustained a fall. Documentation indicated an assessment was completed by LPN D, with no RN assessment. Surveyor was unable to locate evidence an RN assessment was completed for R29's falls to ensure R29 did not have an injury or change in condition.

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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** 44863 Based on interview and record review, the facility did not ensure new care planned fall interventions were implemented post falls to prevent accidents for 1 of 7 residents (R) R29, reviewed for falls. The facility did not implement fall interventions or identify root cause for ten fall incidents, of which R29 sustained minor injury. Findings: The facility's policy titled, Fall/Incident Assessment, read in part .PURPOSE: To assure appropriate follow-through on all accidents and incidents; and to give guidance on preventive/corrective action. 8. The nurse will assess/evaluate the need for any changes in safety precautions and update the plan of care. 9. Document .Corrective action taken to resolve or minimize fall risk. 11. The fall team and DON reviews incidents weekly and make a final interdisciplinary note. R29 was admitted to the facility on [DATE]. Diagnoses included dementia with agitation, history of stroke, repeated falls, weakness, unsteadiness on feet, and difficulty walking. R29's Minimum Data Set (MDS) assessment dated [DATE] confirmed the following: -Scored 02/15 during Brief Interview for Mental Status (BIMS), indicating severe cognitive impairment. -Demonstrated verbal, physical, and wandering behaviors. -Required staff assistance with transfers and was able to independently propel his wheelchair. -Incontinent of bowel and bladder, requiring staff assistance with personal hygiene. R29's physician orders included the following: -Furosemide (diuretic), 20 mg daily. -Lorazepam (anti-anxiety), 0.5 mg twice daily, and as needed. R29's care plan included, The Resident is at risk for falls related to history of falls, pain, impaired vision, poor safety awareness, and dementia. Dated 01/04/24, Revised 04/24/24. Interventions: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-01/12/24, Encourage participation in activities that will increase strength and mobility. -01/12/24, revised 08/27/24, Sensor alarms in wheelchair, recliner, and bed. Pressure sensing floor alarm by bed. -04/03/24, Therapy to evaluate and treat due to falls. -05/15/24, Remind resident to lift his feet up when in wheelchair without foot pedals. -06/10/24, Walk with resident with walker and assist of one, wheelchair to follow. -07/03/24, Anti-rollback device to wheelchair. -08/15/24, Bathroom visits. -10/24/24, Trial prompted every two hours toileting schedule. R29's fall risk assessments confirmed R29 is at high risk for falls. On 11/13/24, Surveyor reviewed R29's falls investigations for the previous three months and noted the following falls: -07/20/24, un-witnessed fall in bathroom. R29 sustained skin tear to right upper arm. Interdisciplinary team (IDT) review of fall; Root cause of fall was dementia with poor safety awareness. Remains a high fall risk. Care plan reviewed and remained appropriate. Surveyor noted no new intervention implemented. -07/29/24, R29 was ambulating with staff from the bathroom, R29 became weak, and staff lowered him to the floor. No injury. IDT review of fall; Care plan reviewed and remains appropriate. Surveyor noted there was no root cause identified. -08/15/24, R29 found on floor in room. R29 stated he needed to use the bathroom. IDT review of fall; Root cause of fall remains poor safety awareness and overestimation of abilities. Remains high fall risk. Care plan reviewed and remains appropriate. Surveyor noted R29's care plan was updated on 08/15/24, with a new intervention, Bathroom Visits, Surveyor was not able to verify the details of this intervention. -08/24/24, un-witnessed fall in bathroom. R29 sustained laceration to his right ear. -08/25/24, un-witnessed fall in bathroom. Sustained laceration to his right hand. IDT review of both falls occurring on 08/24/24 and 08/25/24; Root cause of falls is responding to toilet need. Will address with MD if he thinks resident might have BPH that could be causing frequent need to toilet. Pressure sensing mat placed on floor in front of bed. Care plan reviewed and updated. Fall risk remains high. Surveyor noted R29 does not have a diagnosis of benign prostatic hyperplasia (BPH), or other urinary tract diagnoses. Surveyor noted R29 is not prescribed medications to treat bladder, prostate, or urinary tract. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The care plan was not updated with interventions to address the toileting need for R29 that was identified as the root cause for the 8/24 or 8/25 fall. -09/04/24, fall in facility hallway, no injury. Surveyor noted no root cause or new interventions on the care plan after this fall. -09/09/24, un-witnessed fall in dining room, no injury. IDT review of both falls occurring on 09/04/24 and 09/09/24; Root cause remains dementia with impaired safety awareness. Resident continues to be encouraged to attend activities to keep self busy. Fall risk remains high. Care plan reviewed and remains appropriate. Surveyor noted the same intervention was implemented on 01/12/24. -10/09/24, R29 fell in bathroom, hitting right rib area on toilet. IDT review of fall; Root cause of fall is dementia with poor safety awareness, inability to make needs known, and toileting need. Fall risk remains high. Care plan reviewed. Surveyor noted no new intervention was implemented. -10/11/24, R29 fell in the lobby area and sustained a skin tear to his left hand. IDT review of fall: Root cause of fall remains dementia with poor safety awareness. Fall risk remains high. Care plan reviewed and remains appropriate. Surveyor noted no new intervention was implemented. -10/16/24, Request for physical therapy (PT) and occupation therapy (OT) evaluation and treatment. -10/20/24, un-witnessed fall in bathroom, with no injury. R29 stated toileting need. IDT review of fall; Root cause is dementia with impaired safety awareness. Remains fall risk. Care plan reviewed. Orders received for PT/OT. Surveyor noted this is not a new intervention as PT/OT was requested on 10/16/24. -On 10/24/24, four days after the fall, the facility added an intervention to trial R29 on a two-hour prompted toileting schedule. On 11/13/24 at 10:32 AM, Surveyor interviewed Director of Nursing (DON) B. Surveyor asked why new interventions were not implemented after each incident. DON B stated, There is not always an intervention that will reduce the risk. Surveyor asked DON B how she would know that and if she could provide an example. DON B did not respond. On 11/13/24 at 11:52 AM, Surveyor interviewed DON B. DON B stated R29's two-hour toileting schedule has been effective since being implemented on 10/24/24. DON B stated, We should have implemented it sooner. DON B acknowledged the facility could improve their falls policy and procedures, as they are not always identifying a root cause and adding interventions to prevent future falls in a timely manner.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51095 Based on interview and record review, the facility did not have documentation included in resident's medical record that the residents and/or the resident's responsible party received education regarding the benefits and potential side effects of the influenza vaccine, and the resident (R), either received the influenza immunization or did not receive the influenza immunization for 3 out 5 (R3, R13, R15) residents sampled. R3, R13, and R15 did not have declinations on file, nor was there documentation stating these residents or their representatives refused the vaccine and were educated on the benefits of receiving the influenza vaccine. Findings include: The facility policy titled, Influenza and Pneumococcal Vaccines Applies To: Residents reviewed 3/2024, states in part, Purpose: ensure resident's vaccinations are given as current CDC guidelines recommend. The CDC Influenza Vaccine Timing for Adults reads, in part, One dose of influenza vaccine is recommended for adults each flu season . R3 was admitted on [DATE] with medically complex conditions and a diagnosis that includes Parkinson's. R13 was admitted on [DATE] with medically complex conditions and a diagnosis that includes diabetes mellitus. R15 was admitted on [DATE] with medically complex conditions and a diagnosis that includes diabetes mellitus. On 11/12/24, Surveyor reviewed resident records. There was no evidence of R3, R13, or R15 receiving education or the influenza immunization in 2023 or 2024. Surveyor was unable to locate declination of the influenza immunization forms or education provided. On 11/13/24 at 11:37 AM, Surveyor interviewed Infection Preventionist (IP) F regarding R3, R13, and R15's influenza immunization status. IP F reported the influenza vaccine was refused by these residents. IP F indicated R15 has a signed declination of influenza on 9/22/22; however, there are no declination forms or progress notes indicating that the residents had been educated on or offered the influenza vaccine in 2023 or 2024. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/13/24 at approximately 11:50 a.m., Surveyor interviewed Director of Nursing (DON) B, who stated the facility's influenza refusal form indicates in part, I do not give the facility permission to administer an influenza vaccination annually. DON B indicated she thought the facility would not have to get a declination annually. Surveyor stated the facility must provide documentation indicating influenza vaccination education was provided and the vaccine was offered and refused each flu season. Surveyor was provided one influenza declination form for R15 signed in 2022. There was no evidence provided from the facility to support R3, R13, and R15 were provided education on, offered, or refused the influenza vaccine.