| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 525713 | A. Building<br>B. Wing | 09/26/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Neighbors - East Neighborhood (the) | 658 Howison Circle<br>Menomonie, WI 54751 |

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 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46694<br><br>Based on observation and record review, the facility did not ensure residents (R) were treated with dignity and respect and cared for in a manner to enhance their quality of life. Facility staff used clothing protectors and edge of spoon to wipe resident's face and stood over R32 and R6 while assisting them to eat.<br><br>Findings:<br><br>Example 1<br><br>R32 was admitted to the facility on [DATE], with diagnoses of Alzheimer's and dementia.<br><br>Quarterly minimum data set assessment (MDS) dated [DATE] indicated R32 required a mechanically altered diet and is dependent on others for meal assist.<br><br>On 09/24/24 at 11:44 AM, Surveyor observed Certified Nursing Assistant (CNA) F standing over R32 and using the spoon to clean food from around R32's mouth and then used R32's clothing protector to clean mouth instead of napkin. This observation occurred multiple times during the lunch observation of CNA F with R32.<br><br>Example 2<br><br>R6 was admitted to the facility on [DATE] with diagnoses of Lewy Body dementia and memory deficit following cerebral infarction (occurs as a result of disrupted blood flow to the brain due to problems with the blood vessels that supply it).<br><br>The annual MDS, dated [DATE], indicated R6 requires setup or clean up assistance while eating.<br><br>On 09/24/24 at 12:20 PM, Surveyor observed CNA G assist R6 while standing over R6.<br><br>R32 and R6 have dementia and are unable to speak for themselves. A reasonable person would feel inferior, vulnerable or fear having someone stand over them while being assisted with their meal. The resident would experience a lack of dignity with the use of a spoon or clothing protector to wipe their mouth as opposed to a reasonable person using a napkin. |



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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 525713 | A. Building<br>B. Wing | 09/26/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Neighbors - East Neighborhood (the) | 658 Howison Circle<br>Menomonie, WI 54751 |

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 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives an accurate assessment.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16692<br><br>Based on record review and interview, the facility did not accurately code the Minimum Data Set (MDS) assessment for 1 of 1 residents (R) reviewed for Preadmission Screening and Resident Review (PASARR) screen (R37).<br><br>R37's MDS assessment is coded in error stating that a PASARR level 2 screen had not been completed when it was.<br><br>This is evidenced by:<br><br>R37 was admitted to the facility on [DATE] with diagnoses including schizophrenia, dementia and anxiety.<br><br>Review of R37's medical record found a PASARR level 2 screen was completed, dated 05/06/24.<br><br>R37's admission MDS assessment, dated 05/14/24, and significant change MDS assessment, dated 07/26/24, indicated for question A1500 that no PASARR level 2 had been completed.<br><br>On 09/26/24 at 11:00 AM, Surveyor interviewed Social Worker (SW) C, who completed the MDS Section A1500 on R37's admission and significant change MDS. Surveyor asked about the error in MDS coding stating the PASARR level 2 was not completed, when Surveyor observed that it was completed. SW C stated, It must have been an error on my end. SW C acknowledged that a PASARR level 2 screen was completed and is in the records. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 525713 | A. Building<br>B. Wing | 09/26/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Neighbors - East Neighborhood (the) | 658 Howison Circle<br>Menomonie, WI 54751 |

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 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe and appropriate respiratory care for a resident when needed.<br><br>16692<br><br>Based on observation, interview and record review, the facility did not ensure that 1 of 1 resident (R) R3, reviewed for respiratory care was provided care consistent with professional standards of practice.<br><br>R3 requires continuous oxygen and has a physician's order to change oxygen tubing every 5 days. This was not changed as ordered.<br><br>This is evidenced by:<br><br>Facility Policy entitled OXYGEN ADMINISTRATION last revised 03/01/24 states in part 2. Oxygen tubing, masks, etc. c. Are to be changed every 5 days and as needed per the E-MAR/TAR.<br><br>R3 was admitted to the facility in 2023 and has diagnoses that include chronic obstructive pulmonary disease and atherosclerotic heart disease. R3 utilizes continuous oxygen.<br><br>On 09/24/24 at 9:14 AM, Surveyor observed R3's oxygen tubing connected to the concentrator in his bedroom. The oxygen tubing is dated 9/1. Surveyor also observed R3's portable oxygen tank on his wheelchair; the tubing connected to the portable oxygen was not dated.<br><br>R3's physician orders, dated 1/29/24, state in part Oxygen: Change oxygen tubing every 5 days.<br><br>On 09/25/24 at 10:53 AM, Surveyor interviewed Registered Nurse (RN) E. Surveyor asked RN E to confirm dates of R3's oxygen tubing being changed. RN E could not locate a date on the portable oxygen tubing but stated the tubing on the concentrator in R3's room was dated 09/01. RN E confirmed the date of 9/1 indicates the last date the tubing was changed. RN E confirmed R3 uses continuous oxygen at 2 liters per minute. When asked to look at R3's physician orders, RN E confirmed the physician orders state that oxygen tubing is to be changed every 5 days. RN E confirmed that oxygen tubing should be dated when it is changed on the portable tank. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 525713 | A. Building<br>B. Wing | 09/26/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Neighbors - East Neighborhood (the) | 658 Howison Circle<br>Menomonie, WI 54751 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Provide and implement an infection prevention and control program.<br><br>31086<br><br>Based on observation, interview and record review, the facility did not establish an Infection Control Program under which it investigates, controls, and prevents infections in the facility, or a system for recording incidents identified under the facility's Infection Control Program, including corrective action in a timely manner, for both residents and staff. This has the potential to affect all 43 residents in the facility.<br><br>The facility did not have an adequate surveillance and infection control program in place for tracking and monitoring infection and communicable disease for staff and residents.<br><br>Staff did not sanitize lift for R11 after resident use.<br><br>Staff did not sanitize hands during dressing change for R24.<br><br>Enhanced Barrier Precautions were not put in place for R24, R18 and R26.<br><br>This is evidenced by:<br><br>Example 1<br><br>Facility's policy titled Infection Surveillance version 2.2, documented, in part: 1. The purpose of the surveillance of infections is to identify both individual cases and trends of epidemiologically significant organisms and Healthcare-Associated infections, to guide appropriate interventions, and to prevent future infections .5. Nursing Staff will monitor residents for signs and symptoms that my suggest infection, according to current criteria and definitions of infections and will document and report suspected infections to the Charge Nurse as soon as possible .<br><br>Surveyor reviewed the facility's infection control program. The facility did not utilize a data collection tool for surveillance for early detection of symptomatic residents and staff that will identify, track, and monitor for possible communicable disease and outbreaks.<br><br>In September 2023 a COVID outbreak line list documents the first resident testing positive on 09/16/23. The outbreak line list had a total of 13 positive residents on the EB unit and 1 positive resident on the MS unit. The line lists did not include staff. The outbreak line lists did not document the start date and type of symptoms, or the date precautions were started. The facility did not have any surveillance monitoring documented for residents and staff having symptoms prior to the outbreak.<br><br>The 01/24 outbreak line list for the MS unit did not document the type of outbreak, the date of onset, type of symptoms, and resolved date for the two residents listed. The line list only marked as positive, but did not specify positive for any specific disease or infection. The outbreak line list did not include staff. Surveyor is unable to determine if the facility meets the criteria for an outbreak. The facility did not have surveillance monitoring of residents and staff having any symptoms prior to the outbreak.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 525713 | A. Building<br>B. Wing | 09/26/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Neighbors - East Neighborhood (the) | 658 Howison Circle<br>Menomonie, WI 54751 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | The 04/24 Covid outbreak line list for the MS unit did not include positive staff or the resolved date for the three residents listed. The facility did not have surveillance monitoring of residents and staff having any symptoms prior to the outbreak.<br><br>Surveyor reviewed the facility's monthly infection control logs from 09/23 - 08/24. The infection control logs were not completely filled out to include the room number, date resolved, symptoms, diagnostic results including organism, the date started and type of cautionary measures, and if health care or community acquired.<br><br>On 09/26/24 at 11:13 a.m., Surveyor interviewed Assistant Clinical Mentor (ACM) D, who is the infection preventionist, about the infection control surveillance and infection control logs. ACM D stated there is no documentation of daily surveillance; we do rounds daily with nurses and notify if any change of condition during morning meeting. ACM D and nursing staff are watching residents and if changes of conditions occur we notify providers for orders for testing. Based on the test results and orders for treatment, then we look for potentially more residents that may be sick. Surveyor asked if residents are having signs or symptoms that don't meet the definition of an infection are they put on a surveillance log to monitor for additional symptoms and prevent the spread to other residents. ACM D stated only if identified as an infection then the resident is put on the line list for that household.<br><br>Surveyor asked if staff are placed on a surveillance log to assist with the identification of a possible acute respiratory illness or gastrointestinal outbreak on a unit. ACM D indicated the scheduler notifies Nursing Home Administrator (NHA) A and campus Director of Nursing (DON) B when staff are sick and positive then NHA A and DON B say when the staff can return to work. If Covid, staff are tracked where they worked in the last 24 hours, then we would test the residents that they were in contact with.<br><br>Surveyor reviewed the incomplete infection control logs and lack of surveillance of residents and staff with ACM D. Surveyor shared concern that the surveillance in place will not identify, prevent, or control the spread of infections and communicable disease for all residents and staff in a timely manner. ACM D indicated understanding more detailed surveillance is needed.<br><br>46693<br><br>Example 2<br><br>Policy and procedure titled, Total Lift Mechanical Assist, states, .10. Wipe the lift down after use and in between residents with sanitary wipe or spray.<br><br>Policy and procedure titled, Hand Washing, Hand Hygiene, states, .Examples of hand hygiene moments: Before touching a resident, before clean/aseptic procedures, after body fluid exposure risk, after touching a resident, after touching a resident's surroundings, before and after utilizing gloves, before and after eating.<br><br>On 09/25/24 at 7:01 AM, Surveyor observed cares for R11 by Certified Nursing Assistant (CNA) I and Registered Nurse (RN) H. Following care, CNA I and RN H transferred R11 into a wheelchair using a Hoyer lift. After use, RN H brought the Hoyer lift to storage area without sanitizing. Sanitizing wipes are present on a bag connected to the Hoyer lift and readily available.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 525713 | A. Building<br>B. Wing | 09/26/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Neighbors - East Neighborhood (the) | 658 Howison Circle<br>Menomonie, WI 54751 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Example 3<br><br>On 09/25/24 at 9:30 AM, Surveyor observed wound care for R24 by RN H. During the dressing change, RN H did not sanitize hands after doffing gloves following removal of old dressing and before donning new gloves to finish the wound treatment.<br><br>RN H did not use a gown during R24's dressing change. Surveyor noted that R24 has an indwelling foley catheter and a chronic wound that would require R24 to be placed on enhanced barrier precautions (EBP). Surveyor reviewed R24's record and it indicates that R24 has a history of MRSA, which would also require the initiation of EBP. Surveyor notes that R24 has no signage on door for EBP and no bins in or outside of room.<br><br>On 09/25/24 at 9:45 AM, Surveyor asked RN H about sanitizing hands when changing gloves and RN H stated, Oh, I forgot that. Surveyor asked RN H how it is known which residents are on precautions which RN H stated the Infection Control Nurse tracks that and lets us know by telling us and placing signs on residents' doors and carts near their room.<br><br>On 09/25/24 at 11:45 AM, Surveyor interviewed ACM D and asked what the expectations would be for hand hygiene during dressing changes. ACM D stated, I would expect hand hygiene to be done before the procedure, with any glove changes, after the procedure and anytime as needed in between. Surveyor asked ACM D how often lifts should be sanitized. ACM D said they should be sanitized between residents. Surveyor asked ACM D about incorporating EBP, and ACM D stated they have not revised the policy since they thought it was up to the facility's discretion.<br><br>Surveyor then reviewed the facility policy and procedure titled, Enhanced Barrier Precautions effective date: 4/1/24. The policy did not include the updates from the CMS memo QSO-24-08-NH, dated March 20, to require Enhanced Barrier Precautions (EBP) in nursing homes. The memo became effective on April 1, 2024.<br><br>16692<br><br>Example 4<br><br>R18 was admitted to the facility with diagnoses that include chronic kidney disease, benign prostatic hyperplasia with lower urinary tract symptoms, obstructive and reflux uropathy, overactive bladder and history of malignant neoplasm of prostate.<br><br>R18 requires an indwelling urinary catheter related to urinary retention, and obstruction.<br><br>Observations of R18 on 09/24-25/24 at varied times revealed no enhanced barrier precautions were in use related to the chronic indwelling catheter use.<br><br>Example 5<br><br>R26 was admitted to the facility with diagnoses that include hypertensive chronic kidney disease, benign prostatic hyperplasia with lower urinary tract symptoms, retention of urine and renovascular hypertension.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 525713 | A. Building<br>B. Wing | 09/26/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Neighbors - East Neighborhood (the) | 658 Howison Circle<br>Menomonie, WI 54751 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | R26 requires an indwelling urinary catheter related to urinary retention.<br><br>Observations of R26 on 09/24-25/24 at varied times revealed no enhanced barrier precautions were in use related to the chronic indwelling catheter use. |