

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525714	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/08/2025
NAME OF PROVIDER OR SUPPLIER Neighbors - West Neighborhood (the)		STREET ADDRESS, CITY, STATE, ZIP CODE 651 Howison Circle 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)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31086</p> <p>Based on interview and record review, the facility did not complete comprehensive weekly wound assessments for 1 of 2 residents (R)30 to ensure that residents receive treatment and care in accordance with professional standards of practice.</p> <p>R30 did not receive weekly measuring and comprehensive assessment of a skin injury.</p> <p>This is evidenced by:</p> <p>Review of the facility's policy titled: Wound management with the revised date of 12/03/21, read in part:</p> <p>.PURPOSE: To track, prevent, heal pressure ulcers/wounds according to standards of practice .</p> <p>PROCEDURE: .II. Assistant Clinical Mentors or licensed designee are responsible for weekly wound documentation.</p> <p>Review of the facility's Treatment Order form, read in part: 9. Weekly measurement and documentation (in Matrix under wound management tab) on Wed. AM's until healed (pressure sores, venous stasis, arterial, diabetic ulcers, open surgical wound)</p> <p>R30 was admitted to the facility on [DATE] and has current diagnoses of open wound left lower leg, osteoporosis with current pathological fracture right femur, Alzheimer's disease, and dementia.</p> <p>The event report, dated 11/02/24 at 4:32 AM, documented R30 developed a skin tear to the left posterior lower calf measuring 5.5 cm by 3 cm. R30 stated had a itch on her leg and scratched to hard. Wound edges were irregular.</p> <p>R30's progress notes documented on 11/02/24 at 8:03 AM, Writer (Registered Nurse) went to change pt bandage that was placed on overnights on the back of pt's left calf due to blood dripping on to the Broda. Pt had c/o burning sensation from wound. Writer unwrapped and planned to place ABD and coban wrap on. Writer did see fatty tissue and protruding from the wound and with the bleeding, made the call to send pt to ER via non emergent ambulance.</p> <p>(continued on next page)</p>

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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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Progress notes documented on 11/02/24 at 10:15 AM, Pt returned from ER at 0845. Transported back by son [name] in personal vehicle. Transfer out of vehicle with staff was appropriate. Stitches that were placed, they are to be removed in two weeks (11/16).</p> <p>Review of the Treatment Administration Record (TAR) documented 11/02/24 - 11/17/24 dressing changes were completed every other day and as needed and monitored daily of drainage, wound edges, odor, pain, type of drainage, and wound progression.</p> <p>Progress notes documented on 11/13/24 at 2:42 PM, .Night CNA mentioned that bandage was being picked at. CNA staff changed bedding and writer and CCM changed bandage in the bathroom. Moderate to heavy drainage noted in the bandage. VSS .</p> <p>Progress notes documented on 11/14/24 at 1:02 PM, Md alerted to res digging at her left post calf wound repeatedly (sic) and will try coban 2 for further padding and protection .</p> <p>The TAR documented on 11/17/24, small amount of serosanguinous drainage, no odor, and wound is stable.</p> <p>Progress notes documented on 11/18/24 at 2:47 PM, Writer (RN) received call from POA [Name] that res is at ortho appt and hip is fine however res left LE post calf wound with green drainage at appt; res in a lot of pain r/t wound so they want to admit resident and send her back in am . [R30] was admitted to the hospital for debridement of the wound.</p> <p>Hospital wound care notes dated 11/25/24 documented wound length 5.8 cm, wound width 4.2 cm, wound depth 1 cm, wound bed is red, granulation, yellow, no odor, small amount exudate of serosanguineous fluid.</p> <p>On 11/27/24, R30 was readmitted to the facility with orders for a wound vac to the left calf wound. Dressing to be changed every Monday, Wednesday, and Friday.</p> <p>Progress notes documented on 11/27/24 at 1:02 PM, .res also sustained a new skin tear next to the wound vac wound as she frequently will pull it off; there is a foam drsg on the new skin tear; res is on 2 po abx for current wound ; res does have equagel cushion in [NAME] and w/c; not restless and cooperative at present; staff instructed to keep close eye on wound vac as may need to be plugged in.</p> <p>Surveyor noted the facility did not complete a comprehensive wound assessment on 11/27/24 when the wound vac was first changed in the facility.</p> <p>On 12/04/24 at 12:43 PM, a wound management detail report in part: The wound length is 4.3 cm and width 3.8 cm, incision with open area, skin surrounding incision is normal color and warm. Incision drainage: serous (clear, amber, thin and watery). Wound healing status: Improving Comments: wound vac at 75mmhg cont; depth is 1cm. This assessment did not assess and describe the wound bed. Note this is the first documented report of a comprehensive assessment of the wound, one week after admission. No further wound comprehensive assessments were completed for the month of December.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The next assessment of the wound size was documented in the progress notes on 01/02/25, four weeks later, .inpected (sic) res left IE with wound vac in place and no redness noted as well as size is significantly smaller compared to what it was; ~3x4cm and filling in per TL (team lead) . This assessment did not measure the depth of the wound, describe the wound bed, and if any drainage.</p> <p>On 01/08/24 at 8:46 AM, Surveyor interviewed Director of Nursing (DON) B about R30's comprehensive wound assessments. DON B indicated the facility does not complete measurements of surgical wounds. R30 wound was sutured, and it was closed. The wound did not open and when DON B assessed the area there was no odor or signs of infection. DON B was not surprised of an infection developing since R30 would scratch at the area and remove the dressing.</p> <p>Surveyor asked when R30 returned from the hospital with wound vac orders post debridement, would the facility expect a complete comprehensive wound assessment to be done. Surveyor asked about the missing weekly assessments that would include measurements, description of the wound depth, appearance of the wound bed to determine wound healing.</p> <p>DON B indicated this is a surgical wound and they don't do weekly measurement for surgical incisions. We do assessments on pressure sores, venous stasis, arterial, and diabetic ulcers. We can tell if the area is healing with granulation tissue and the wound edges pulling together when changing the wound vac.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49353</p> <p>Based on observation, interview and record review, the facility did not maintain an infection prevention and control program designed to help prevent the development and transmission of communicable diseases and infections.</p> <p>Staff did not initiate enhanced barrier precautions (EBP) for 1 of 3 residents observed (R21) with a wound.</p> <p>Facility staff did not wear personal protective equipment (PPE) for R30 who is on EBP or perform proper hand hygiene with cares.</p> <p>Facility staff used contaminated scissors to cut a wound dressing treatment and placed the cut dressing in R30's skin wound.</p> <p>Staff did not disinfect body sling after use for R11 and R21.</p> <p>Staff wore mask below nose when assisting one resident.</p> <p>This was evidenced by:</p> <p>Centers for Disease Control and Prevention (CDC) Enhanced Barrier Precautions recommendations, dated 06/28/24, state in part: Enhanced Barrier Precautions are recommended for residents with any of the following: 1) infection or colonization with a MDRO or 2) a wound or indwelling medical device, even if the resident is not known to be infected or colonized with a MDRO.</p> <p>Facility policy titled, Enhanced Barrier Precautions, with a revised date of 10/18/24, states in part:</p> <p>POLICY: Facility will implement Enhanced Barrier Precautions for the prevention of transmission of certain multidrug-resistant organisms.</p> <p>DEFINITIONS:</p> <p>Enhanced Barrier Precautions (EBP): refer to an infection control intervention to reduce transmission of multidrug-resistant organisms that employ targeted gown and gloves use during high contact resident activities.</p> <p>2. Initiation of Enhanced Barrier Precautions</p> <p>b. An order for EBP will be initiated for residents with any of the following:</p> <p>ii. Wounds (e.g. chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers)</p> <p>3. Implementation of Enhanced Barrier Precautions</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>b. PPE for EBP is only necessary when performing high-contact care activities and may not be donned prior to entering the resident's room.</p> <p>4. High-Contact Resident Care Activities Include</p> <p>a. Dressing</p> <p>b. Bathing</p> <p>c. Transferring</p> <p>d. Providing hygiene</p> <p>e. Changing linen</p> <p>f. Changing of incontinence products or assisting with toileting</p> <p>g. Device care or use: central lines, urinary catheters, feeding tubes, tracheostomy</p> <p>h. Wound care of chronic skin opening requiring a dressing</p> <p>Example 1</p> <p>R21 was admitted to the facility on [DATE] with pertinent diagnoses of diabetes mellitus type 2, congestive heart failure, and chronic kidney disease.</p> <p>R21's Minimum Data Set (MDS) assessment, dated 11/10/24, indicated that R21 had 1 current unhealed, unstageable diabetic foot ulcer with treatment of application of dressing to feet.</p> <p>R21's care plan, dated 05/15/24, with a target date of 02/05/25, states: Impaired skin integrity and potential for impaired skin integrity.</p> <p>No interventions listed for implementation and use of EBP.</p> <p>R21's orders included:</p> <p>Wound--DTI left heel--daily documentation until healed x7 days then DC. Daily documentation should include: amount drainage, type of drainage, dressing intact, odor after cleansing, pain, progress of wound, wound edges, healed.</p> <p>Special Instructions: Notify MD of symptoms of infection - change of appearance</p> <p>Once A Day</p> <p>START: 4/16/24</p> <p>No orders found to initiate EBP.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 01/08/25 at 2:30 PM, Surveyor interviewed Director of Nursing (DON) B regarding initiation of EBP. Surveyor asked DON B when EBP should be initiated. DON B stated EBP would be initiated for residents who have any indwelling device - such as a foley catheter or feeding tube, multidrug-resistant organism (MDRO), pressure injury, or chronic wound/ulcer. Surveyor asked DON B if this included chronic diabetic ulcers. DON B stated yes. Surveyor asked why EBP was not ordered or initiated for R21 who has a documented diabetic ulcer. DON B stated that even though R21 was receiving daily dressing changes for this wound, the presence of eschar provided a natural barrier and did not feel this required EBP. Surveyor asked DON B where this indication came from. DON B stated it was based on her experience and wound care training. Surveyor asked DON B if this was in agreement with facility policy and current practice recommendations. DON B shrugged and stated she did not know but felt R21 did not need EBP for her diabetic ulcer.</p> <p>31086</p> <p>Example 2</p> <p>R30 was admitted to the facility on [DATE] and has current diagnoses of open wound left lower leg, osteoporosis with current pathological fracture right femur, Alzheimer's disease, and dementia.</p> <p>R30 returned from the hospital on 11/27/24 with a diagnosis of a wound infection with bacteria of staphylococcus aureus, staphylococcus epidermidis, which are both resistive to oxacillin antibiotic, and escherichia coli. R30 was placed on EBP. Surveyor observed the door frame at the entrance of R30's room has a sign attached stating EBP.</p> <p>On 01/07/25 at 7:36 AM, Surveyor observed Certified Nursing Assistant (CNA) D transfer R30 in the Broda chair to R30's room. CNA D did not apply gown and gloves. Gown and gloves are required PPE for a resident on EBP.</p> <p>CNA D used a gait belt and transferred R30 from the Broda chair to the toilet. CNA D applied gloves and pulled R30's pants and brief down. CNA D removed the urine soaked brief, removed gloves, and without hand hygiene, applied clean gloves then applied a clean brief. CNA D assisted R30 to stand and cleaned frontal peri area with wipes and with clean wipes cleansed perineum and buttocks. With the same gloves, CNA D applied barrier cream to R30's buttocks. CNA D removed gloves and pivot transferred R30 to the Broda chair. CNA D washed hands for approximately 5 seconds, turned faucet off with clean hands, dried hands, and applied clean gloves to brush R30's hair. During the entire observation CNA D did not apply a gown.</p> <p>On 01/08/25 at 9:09 AM, Surveyor observed CNA E without wearing a gown assist R30 in bed and pull R30's pants down. Surveyor asked CNA E if CNA E had transferred R30 into bed. CNA E indicated yes she just transferred R30 to bed and pulled R30's pants down. Registered Nurse (RN) F stated to CNA E you should be wearing a gown when doing cares with R30. CNA E stated she just transferred R30 to bed. RN F washed hands, and without wearing a gown or gloves, RN F went to R30's bed side and removed R30's left leg from the pant leg. Then RN F applied gown and gloves.</p> <p>Example 3</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 01/08/25 at approximately 9:10 a.m., Surveyor observed RN F complete wound care for R30. RN F placed a barrier under R30's leg. RN F removed R30's sock, tubi grip, and ace bandage. RN F gathered supplies and placed on barrier on the overbed tray table. RN F used scissors to cut off kerlix bandage from R30's leg. RN F removed gloves, washed hands and applied clean gloves. RN F washed the wound with saline wound wash and dried area. RN F applied skin prep to the surrounding skin of the wound. RN F did not clean the scissors that were used to cut the old dressing. RN F used the contaminated scissors, cut the zeroform dressing and placed the cut dressing into R30's wound bed. RN F applied gauze sponge over the wound, applied kerlix dressing around the leg, and applied ace wrap around. RN F removed gloves, gathered garbage and washed hands.</p> <p>Surveyor interviewed RN F about using the scissors to cut old dressing then used the same scissors to cut the new zeroform dressing without prior cleaning of the scissors. RN F indicated she should have cleaned the scissors before cutting the new dressing. Surveyor asked if a gown should be worn before providing cares and when CNA transferred R30 to bed. RN F indicated yes a gown should be worn when providing cares and transferring because R30 is on precautions.</p> <p>On 01/09/25 at 3:48 p.m., Surveyor interviewed DON B about the use of PPE for R30's cares. Surveyor reviewed the observations with DON B, and DON B indicated PPE of a gown and gloves to be worn when providing cares and education will be provided.</p> <p>Example 4</p> <p>On 01/06/25 at 12:38 PM, Surveyor observed CNA G and CNA E complete a transfer with R11 using sit-to-stand lift. After transfer was complete, CNA G was observed disinfecting sit-to-stand and placing sling on top of the lift. Sling was not disinfected after use with R11.</p> <p>On 01/06/25 at 12:48 AM, Surveyor interviewed CNA G. Surveyor asked CNA G if the slings used for transfer with the sit-to-stand were used for multiple residents. CNA G stated they were. Surveyor asked CNA G if the slings were disinfected after use with a resident. CNA G stated no because there are only a few residents who use them.</p> <p>On 01/08/25 at 7:08 AM, Surveyor observed CNA H complete a transfer with R21 using sit-to-stand lift. After transfer was complete, CNA H disinfected sit-to-stand, placed sling on lift, and disinfected the sling straps. The body of the sling was not disinfected after use with R21.</p> <p>On 01/08/25 at 2:30 PM, Surveyor interviewed DON B regarding disinfecting slings. Surveyor asked if there was a policy on disinfecting slings after resident use. DON B was unable to provide a policy but stated the expectation is for staff to disinfect slings after every use with either a wipe or a spray disinfectant. Surveyor informed DON B of observation of staff not disinfecting slings after use. DON B stated disappointment with staff not practicing infection prevention practices and stated staff would be re-educated on this. DON B stated recognition of the potential of spreading infection from resident to resident if slings were not disinfected between uses.</p> <p>16692</p> <p>Example 5</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility policy titled Pandemic Plan dated reviewed 05/22/23, states in part. Pandemic viruses can be introduced through facility personnel and visitors; once a pandemic virus enters such facilities, controlling it's spread is problematic .diseases and outbreaks . Outbreak measures will be used to reduce the chances of transmitting pandemic viruses to others within the facility Wear masks when caring for residents.</p> <p>On 01/07/25 at 4:35 PM, Surveyor observed CNA C in the day room pushing a resident in her broda chair out to the dayroom for supper. As CNA C did this she wore her face mask below the level of her chin. The mask worn this way exposed both her nose and mouth. There were 5 residents in the day room at the time.</p> <p>On 01/08/25 at 11:30 AM, Surveyor interviewed DON B who is also the facility's infection preventionist. Surveyor relayed the above observation to DON B. DON B stated that CNA C is aware of how to wear a mask appropriately. DON B stated that all staff should have been masking at the time. Signs and masks are available at the entrances to the unit. Staff are currently masking as a preventative measure in place as the facility had an outbreak a while ago, and they implement masking for 14 days following this.</p>		