STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525719	A. Building B. Wing	03/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WI Veterans Hm Ainsworth Hall	N2665 Cty Rd Qq King, WI 54946

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49010 Based on observation, resident and staff interview, and record review, the facility did not provide a safe, clean, comfortable, and home-like environment for 1 resident (R) (R97) of 26 sampled residents. The third floor day room, dining room, and hallway contained several missing and broken floor tiles. Staff indicated the missing and broken floor tiles were a potential safety hazard. R97 indicated the tiles were unsightly and should be fixed. Findings include: The facility's Admission Agreement document, dated 2/2025, indicates: Rights of Nursing Home Members: The Home must protect and promote the rights of each Member, including each of the following rights: .I. Right to a dignified existence, self-determination .II. Right to be treated with respect and dignity and to be cared for in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing the Member's individuality. The facility did not provide a policy related to a home-like environment or safety of the environment. On 3/17/25, Surveyor reviewed R97's medical record. R97 was admitted to the facility on [DATE] and had diagnoses including dementia, femur fracture, anxiety, depression, and insomnia. R97 had a history of falls with major injury. R97's Minimum Data Set (MDS) assessment, dated 2/26/25, had a Brief Interview for Mental Status (BIMS) score of 14 out of 15 which indicated R97 had intact cognition. On 3/18/25 at 1:10 PM, Surveyor observed the third floor dining area/day room and the A and C hallways. Surveyor noted more than twenty floor tiles exhibited varying degrees of damage. Some tiles had missing corners, some tiles were half missing, and other tiles were completely missing. The missing and broken tiles were in highly visible areas frequently walked on by residents, staff, and visitors. On 3/18/25 at 1:38 PM, Certified Nursing Assistant (CNA)-R approached Surveyor while Surveyor walked down the C wing hallway and asked if Surveyor had noticed the floors. CNA-R indicated the floors were unsightly and a safety hazard and had been that way for years. CNA-R was not aware of any residents who had tripped on the damaged areas. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/19/25 at 12:29 PM, Surveyor interviewed CNA-Q who indicated the floors had been that way for years. CNA-Q indicated the floors don't look good and are not a nice aesthetic for the residents' home. CNA-Q indicated the missing tiles could be a trip or fall hazard. CNA-Q indicated CNA-Q slipped on a missing tile in the past. CNA-Q was not aware of any residents who had tripped on the missing tiles. On 3/19/25 at 12:41 PM, Surveyor interviewed Licensed Practical Nurse (LPN)-L who indicated the floor tiles have been that way for a long time. LPN-L indicated the floors do not look good and are broken and old. LPN-L indicated the floors could be a trip hazard, however, LPN-L was not aware of any residents who had tripped or fallen on them. LPN-L indicated the floors were reported as a concern in the past. On 3/19/25 at 1:01 PM, Surveyor interviewed R97 who indicated the missing floor tiles in R97's hallway are off to the side so R97 doesn't worry about tripping on the tiles. R97 indicated R97 watches R97's self closely while ambulating because R97 had recently fallen in R97's room and and broken a bone. R97 indicated the tiles in the hallways and dining area are unsightly, don't look nice, and should be fixed. On 3/19/25 at 1:54 PM, Surveyor interviewed Assistant Director of Nursing (ADON)-C who verified the broken and missing tiles on the third floor and confirmed the floor has been that way for a while. ADON-C indicated the facility plans to address the floor but needs to figure out where to move the third floor residents while the work is completed. ADON-C indicated ADON-C is aware the broken and missing tiles don't look home-like and could be a potential safety hazard. On 3/19/25 at 2:23 PM, Surveyor interviewed Director of Nursing (DON)-B who indicated the facility has a responsibility to identify and fix issues and potential safety concerns for residents' safety and happiness.

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 43381 Based on staff interview and record review, the facility did not ensure Minimum Data Set (MDS) assessments were coded correctly for 3 residents (R) (R30, R49, and R1) of 26 sampled residents. R30's MDS assessment, dated 2/26/25, contained diagnoses of long term (current) use of anticoagulant medication and long term (current) use of aspirin; however, R30 was not prescribed anticoagulant medication or aspirin. The MDS assessment also indicated R30 received hypnotic medication; however, R30 was not prescribed hypnotic medication. In addition, MDS assessments, dated 6/5/24, 6/21/23, 4/13/23, and 4/20/22, indicated R30 did not have a Preadmission Screening and Resident Review (PASRR) Level II Screen; however, a PASRR Level II Screen was completed and indicated R30 had a mental illness. R49's MDS assessment, dated 3/5/25, contained a diagnosis of long term (current) use of anticoagulant medication and indicated R49 received anticoagulant medication and insulin; however, R49 was not prescribed anticoagulant medication or insulin. R1's MDS assessment, dated 2/12/25, indicated R1 received anticoagulant medication; however, R1 was not prescribed anticoagulant medication. Findings include: The Resident Assessment Instrument (RAI) 3.0 user's manual version 1.19.1, dated October 2024, indicates: Code medications in item N0415 according to the medication's therapeutic category and/or pharmacological classification, not how it is used. Medline Plus, https://www.nlm.nih.gov/medlineplus/druginformation.html is a reference within the RAI to help determine classification of medications. Medline Plus indicates, Clopidogrel (or Plavix) is in a class of medications called antiplatelet medications.The RAI manual indicates to be coded as an active diagnosis on the MDS, it must be a physician-documented diagnosis in the last 60 days that has a direct relationship to the resident's current functional status, cognitive status, mood or behavior, medical treatments, nursing monitoring, or risk of death during the 7-day look-back period .RAI manual indicates to code yes if the PASRR Level II screening determined that the resident has a serious mental illness and/or intellectual disability (ID)/developmental disability (DD) or related condition, and continue to A1510, Level II PASRR conditions. 1. From 3/17/25 to 3/19/25, Surveyor reviewed R30's medical record. An MDS assessment, dated 2/26/25, indicated R30 had a diagnoses of long term (current) use of aspirin and long term (current) use of anticoagulant medication (Section I); however, Surveyor noted R30 was not prescribed aspirin or anticoagulant medication. The MDS assessment also indicated R30 received anticoagulant but not antiplatelet medication (Section N). In addition, the MDS assessment indicated R30 received hypnotic medication (Section N). Surveyor reviewed R30's medication list which included clopidogrel bisulfate (an antiplatelet medication). Surveyor noted there were no anticoagulant or hypnotic medications on R30's medication list. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R30's medical record contained a PASRR Level I Screen and an abbreviated Level II Screen, dated 10/8/15, that indicated R30 had a serious mental illness. MDS assessments, dated 6/5/24, 6/21/25, 4/13/23, and 4/20/22, indicated R30 was not evaluated by a Level II PASRR Screen and determined to have a serious mental illness (Section I). Surveyor noted R30's diagnosis list included post-traumatic stress disorder (PTSD). R30's care plan indicated R30 had a PASRR Level II Screen and did not require specialized services. On 3/18/25 at 1:00 PM, Surveyor interviewed MDS Nurse (MDSN)-F and asked which anticoagulant and hypnotic medications R30 was prescribed. MDSN-F indicated R30 was prescribed Plavix but was not prescribed a hypnotic medication. MDSN-F indicated MDSN-F would remove the hypnotic medication and change the anticoagulant medication to antiplatelet medication on R30's 2/26/25 MDS assessment. Surveyor mentioned to MDSN-F that R30 also had diagnoses of long term (current) use of anticoagulant medication and long term (current) use of aspirin. When Surveyor asked about the PASRR coding on R30's 2/26/25 MDS assessment, MDSN-F indicated the assessment was coded by a Social Worker (SW). On 3/18/25 at 1:23 PM, Surveyor interviewed SW-G who indicated R30's 3/5/25 MDS assessment did not indicate R30 had a PASRR Level II Screen. SW-G indicated R30 was referred for a new Level I Screen in 2023 and didn't require specialized services at that time. The facility did not provide a PASRR completed in 2023. R30's last PASRR, dated 10/8/15, indicated R30 had a serious mental illness. 2. From 3/17/25 to 3/19/25, Surveyor reviewed R49's medical record. An MDS assessment, dated 3/5/25, contained a diagnosis of long term (current) use of anticoagulant medication (Section I); however, R49 was not prescribed anticoagulant medication. In addition, the MDS assessment indicated R49 received anticoagulant but not antiplatelet medication (Section N). The MDS also indicated R49 received insulin seven days during the look back period (Section N). Surveyor reviewed R49's medication list which included clopidogrel bisulfate (an antiplatelet medication) but did not include anticoagulant medication or insulin. On 3/18/25 at 1:00 PM, Surveyor interviewed MDSN-F and asked if R49 received insulin. MDSN-F indicated R49 received Plavix (an antiplatelet medication) but did not receive insulin. Surveyor also noted R49 had a diagnosis of current anticoagulant use. MDSN-F indicated MDSN-F would investigate. MDSN-F indicated MDSN-F would remove the insulin and change Plavix from anticoagulant to antiplatelet on the MDS assessment. 3. From 3/17/25 to 3/19/25, Surveyor reviewed R1's medical record. R1's MDS assessment, dated 2/12/25, indicated R1 received anticoagulant medication (Section N) but not antiplatelet medication. Surveyor reviewed R1's medication list which included clopidogrel bisulfate. Surveyor noted there were no anticoagulant medications on R1's medication list.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities 48794 Based on staff interview and record review, the facility did not ensure Preadmission Screening and Resident Review (PASRR) requirements were met for 1 resident (R) (R16) of 7 sampled residents. R16 had a mental illness (MI) diagnosis. R16's PASRR Level I Screen stated No to MI. R16 did not have a PASRR Level II Screen. Findings include: The facility's Preadmission Screening and Resident Review (PASRR) policy, dated 11/8/24, indicates: A Level I Screen is required for all applicants being admitted to the facility to assess for mental illness or intellectual disability. It is used to determine if the individual requires specialized services. Level I Screens that indicate mental illness or intellectual disability require additional assessment to confirm the intellectual disability or mental illness, this is a Level II Screen .Members admitting to the facility from another nursing facility will require a new Level I Screen effective January 2025 to associate the level screening with a new level of care request. The discharging facility is expected to provide the admitted facility with all PASRR records. From 3/17/25 to 3/19/25, Surveyor reviewed R16's medical record. R16 was admitted to the facility from a sister facility on 9/15/22 and had diagnoses including dementia, anxiety disorder, and post-traumatic stress disorder (PTSD). R16's Minimum Data Set (MDS) assessment, dated 1/1/25, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R16 was not cognitively impaired. R16 was responsible for R16's healthcare decisions. R16's medical record contained a PASRR Level I Screen completed on 6/29/10 with a most recent review date of 7/17/24. Section A was marked No for current MI diagnosis. Surveyor reviewed R16's medical diagnoses which included anxiety disorder and PTSD. Surveyor reviewed R16's care plan (initiated 9/13/23) which indicated R16 was at risk for ineffective individual coping related to mental illness. R16's medical record did not contain a PASRR Level II Screen. On 3/19/25 at 8:47 AM, Surveyor interviewed Social Worker (SW)-E who confirmed PTSD and anxiety are mental illnesses. SW-E confirmed submission for a Level II Screen should be completed even if R16 was not on any medications. On 3/19/25 at 11:16 AM, Surveyor interviewed SW-G who confirmed SW-G was R16's social worker. SW-G confirmed PTSD and anxiety are mental illnesses. SW-G stated SW-G did not complete any PASRR screenings for R16 because R16 never had any symptoms. SW-G stated SW-G was not aware that a Level II Screen is required if the resident does not have symptoms and is not on any medications. On 3/19/25 at 2:52 PM, Surveyor interviewed Director of Nursing (DON)-B who confirmed R16 had mental illnesses of anxiety and PTSD. DON-B was unsure if R16 required a Level II Screen.

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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. 43381 Based on staff interview and record review, the facility did not ensure a comprehensive care plan to meet psychosocial needs was developed and implemented for 1 resident (R) (R30) of 26 sampled residents. R30 was identified as having a serious mental illness of post-traumatic stress disorder (PTSD). R30 did not have a a care plan or interventions in place to address the diagnoses. Findings include: From 3/17/25 to 3/19/25, Surveyor reviewed R30's medical record. R30 had a Preadmission Screening and Resident Review (PASRR) Level I Screen, dated 10/8/15, that indicated R30 had a serious mental illness. A Behavioral Consulting Services (BCS) determination, dated 10/8/15, indicated R30 had a serious mental illness but was appropriate for nursing home placement without specialized services. Surveyor reviewed a life events checklist (LEC-5 extended) assessment completed by Social Worker (SW)-G on 4/15/22 that indicated R30 witnessed a natural disaster, fire or explosion and sudden accidental death and suffered a transportation accident and life-threatening illness or injury. R30 described R30's worst event as an explosion in Vietnam. Minimum Data Set (MDS) assessments, dated 6/5/24, 6/1/25, 4/13/25, and 4/20/22 indicated R30 had PTSD (Section I). R30's diagnoses list included PTSD. R30's medical record did not contain a care plan or interventions related to PTSD. On 3/18/25 at 2:17 PM, Surveyor emailed BCS and asked if a diagnosis of PTSD indicates a mental illness on the Level I Screen and triggers a referral for a Level II Screen even if the resident doesn't currently take medications. BCS indicated yes. On 3/18/25 at 1:23 PM, Surveyor interviewed Social Worker (SW)-G who confirmed R30 had a diagnosis of PTSD. SW-G verified R30 did not have a care plan to address the diagnosis. SW-G indicated PTSD didn't trigger on R30's LEC-5 and SW-G doesn't do anything with the diagnosis on MDS assessments. Surveyor reviewed the LEC-5 assessment. Per the directions, there is no formal scoring protocol or interpretation. On 3/19/25 at 8:47 AM, Surveyor interviewed SW-E to identify the process of determining mental illness for a new admission. SW-E indicated the screening process for residents consists of different assessments, initial interviews, a discharge plan, a diagnoses list, Level Screens, medications, the discharge process, social history, and an LEC-5 trauma informed care screen. (LEC-5 is a Veterans Affairs (VA) form for trauma that may be experienced as an adult.) A referral can then be made to the facility's psych Advanced Practice Nurse Prescriber (APNP), licensed clinical social worker, the psychologist, or a contracted psych Nurse Practitioner (NP). Members are most likely to be referred to psych services. SW-E confirmed PTSD is a mental illness and it is important to review past records and develop a care plan for a resident with a history of trauma.

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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** 49010 Based on observation, staff and resident interview, and record review, the facility did not ensure the resident environment remained as free of accident hazards as possible for 2 residents (R) (R22 and R31) of 2 sampled residents. R22 and R31 were known smokers. Staff did not follow R22 and R31's assessments and care plans for safe smoking. Findings include: The Facility's Tobacco Use policy, dated 2/25/25, indicates: .Members who use tobacco must be able to do so independently. It shall be addressed in the member's plan of care. Supervised and assisted smoking is prohibited .6. After assessment and all observations, if no safety concerns were noted, the care team discusses the member's smoking. The team collaborates with the member to develop or revise a safety plan addressing their choice to use tobacco. 6.1 The plan must include an intervention identifying the member as a tobacco user and any items needed for safe, independent smoking (e.g., smoking apron) . The Facility's Member Smoking and Tobacco Use Rules, dated 1/2025, states: Smoking on grounds is permitted for grandfathered members. You must demonstrate the ability to: Smoke/vape safely, independently, including lighting and snuffing of the tobacco product or device; Call for assistance should an emergency occur; Store your tobacco products(s) and any materials safely and securely .If unsafe smoking is observed at any time, your privileges will be revoked until the interdisciplinary team (IDT) can review and discuss the incident. Depending on the severity of the offense, your privileges may not be reinstated. Examples of unsafe smoking are: .Not safely securing products and materials. Smoking or lighting of a tobacco product indoors . 1. On 3/17/25, Surveyor reviewed R22's medical record. R22 was admitted to the facility on [DATE] and had diagnoses including vascular dementia with mood disturbance, dizziness and giddiness, myopia, contracture, and tobacco use. R22's Minimum Data Set (MDS) assessment, dated 1/29/25, had a Brief Interview for Mental Status (BIMS) score of 6 out of 15 which indicated R22 was severely cognitively impaired. R22 had a Guardian who was responsible for R22's medical decisions. R22's plan of care indicated R22 was an independent smoker and staff should distribute smoking materials to R22. The care plan indicated R22 was at risk for injury related to cognitive losses which may contribute to unsafe smoking. The care plan indicated R22 should receive seven cigarettes per day from staff in the morning and should wear a smoking apron. R22's Kardex (an abbreviated care plan used by nursing staff) indicated R22 was an independent smoker who received seven cigarettes per day and had to sign them out. The Kardex also indicated R22 needed to wear a smoking apron. R22's most recent smoking assessment, dated 1/20/25, indicated: .2. Smoking materials: b. Smoking materials must be managed at the nurses' station .10. Member is able to return smoking supplies to approved storage. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/17/25 at 1:13 PM, Surveyor interviewed R22 who indicated R22 smoked and was wearing a smoking apron. R22 indicated R22 wore the smoking apron all the time. R22 indicated R22 receives eight to ten cigarettes in the morning. R22 stated when the cigarettes are gone, R22 is finished smoking for the day. R22 indicated R22 keeps cigarettes and a lighter on R22's person and does not need to return them to staff after smoking. Surveyor observed R22 in R22's room with cigarettes and a lighter. On 3/18/25 at 1:38 PM, Surveyor interviewed Certified Nursing Assistant (CNA)-R regarding R22. CNA-R showed Surveyor R22's bedside drawer where R22 keeps extra lighters. CNA-R indicated R22 receives seven cigarettes in the morning and keeps smoking materials on R22's person all day. CNA-R stated R22 is forgetful at times and asks for a lighter. CNA-R reminds R22 that R22 has a lighter in R22's pocket. CNA-R indicated R22 is an independent smoker and wears a smoking apron. CNA-R showed Surveyor where R22's smoking materials should be kept behind a locked door in a sealed plastic tote at the nurses' station. The plastic tote contained a sign that indicated R22 should receive seven cigarettes per day and wear a smoking apron. Surveyor observed a sign out sheet for R22's cigarettes. On 3/18/25 at 1:44 PM, Surveyor observed R22 smoke outside and then return to the building. Surveyor noted R22 did not return R22's smoking materials to the nurses' station. Surveyor did not observe staff ask R22 for the smoking materials. On 3/19/25 at 12:29 PM, Surveyor interviewed CNA-Q who stated R22 is an independent smoker who wears a smoking apron. CNA-Q indicated R22 keeps smoking materials on R22's person. CNA-Q was unsure how to monitor for residents who are supposed to return their smoking materials and stated the resident's assigned CNA should watch and ask for the smoking items when the resident returns from smoking. CNA-Q indicated the items are stored in a basked behind the door of the nurses' station. On 3/19/25 at 1:54 PM, Surveyor interviewed Assistant Director of Nursing (ADON)-C who indicated staff are educated on residents who smoke and the smoking policy. ADON-C indicated residents who smoke are assessed quarterly and with any smoking concerns or changes in condition. ADON-C indicated smoking assessments should be followed and be incorporated in the resident's care plan and Kardex. ADON-C indicated if a smoking assessment indicates a resident's smoking materials are maintained by nursing staff, the resident should turn in the smoking materials after smoking. ADON-C indicated there is an issue if a resident does not turn in smoking materials as designated and keeps them on their person or in their room with staffs' knowledge. On 3/19/25 at 2:23 PM, Surveyor interviewed Director of Nursing (DON)-B who indicated staff and residents should be aware of and follow the facility's smoking policy which includes completing and following smoking assessments. 51044 2. From 3/17/25 to 3/18/25, Surveyor reviewed R31's medical record. R31 was admitted to the facility on [DATE] and had diagnoses including Alzheimer's disease, dementia, post-traumatic stress disorder (PTSD), and tobacco use. R31's MDS assessment, dated 1/16/25, had a BIMS score of 9 out of 15 which indicated R31 had moderate cognitive impairment. R31's medical record indicated R31 signed the facility's smoking rules on 12/9/24. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R31's smoking care plan indicated R31 was at risk for injury related to R31's choice to smoke and by the recent findings by staff of burn holes in R31's jeans and scooter cushion. The care plan indicated R31 was an independent smoker and contained interventions to keep smoking materials at the Assistant Director of Nursing (ADON) nurses' station, distribute three cigarettes and a lighter, and ensure R31 is wearing a smoking apron prior to going out to smoke for R31's safety and the safety of others. A smoking assessment, dated 12/27/24, indicated the following: ~ R31 is an approved smoker with no safety concerns. ~ R31 uses a smoking apron related to a smoking incident where burn holes were discovered in R31's jeans and scooter cushion during the week of 12/23/24. A smoking apron was implemented. ~ R31's smoking materials must be maintained at the nurses' station due to safety per R31's Power of Attorney for Healthcare (POAHC). R31 can receive three cigarettes at a time. Staff should make sure R31 is wearing a smoking apron before R31 leaves the unit to the smoke. ~ A summary of a historical smoking incident indicated: Smoking assessment (12/27/24) Note: On 9/14/22, R31 stated R31 lit a cigarette in R31's room to see what would happen to the sprinkler head. As soon as the cigarette was lit, R31 put the cigarette out. R31 stated R31 would not smoke in R31's room and knew it was unsafe. On 3/17/25 at 10:47 AM, Surveyor observed R31 in a manual wheelchair with a smoking apron on. R31 was alert and oriented to person and place and stated R31 was going outside to smoke. Surveyor observed R31 go outside, take a cigarette out of a box, light the cigarette with a lighter, and smoke the cigarette unsupervised. R31 disposed of the cigarette appropriately, reentered the facility, and went to R31's room. On 3/18/25 at 10:02 AM, Surveyor interviewed Licensed Practical Nurse (LPN)-I who stated R31's cigarettes are kept at the nurses' station and R31 has to request cigarettes from staff. LPN-I stated R31 can have two cigarettes each time R31 goes out to smoke. LPN-I stated R31 is able to smoke independently per R31's smoking assessment. On 3/19/25 at 11:09 AM, Surveyor interviewed CNA-J who indicated R31 wears a smoking apron while smoking. CNA-J stated R31 must ask staff for cigarettes and a lighter. On 3/19/25 at 11:29 AM, Surveyor interviewed Registered Nurse (RN)-H who stated R31 is able to smoke unsupervised but must wear a smoking apron. RN-H stated R31 is given two cigarettes at a time by staff and is able to keep a lighter in R31's room. RN-H stated staff verify R31 does not have cigarettes in R31's possession by looking in R31's cigarette box when R31 re-enters the facility. On 3/19/25 at 11:33 AM, Surveyor observed a box of cigarettes and two lighters in R31's room on a side table. R31 was in the room and opened the cigarette box. Surveyor observed five cigarettes in the box. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WI Veterans Hm Ainsworth Hall	N2665 Cty Rd Qq King, WI 54946

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/19/25 at 1:12 PM, Surveyor interviewed ADON-C who indicated R31 has to go to the nurses' station with a smoking apron on and request cigarettes. ADON-C stated R31's POAHC prefers staff give R31 two cigarettes each time R31 goes out to smoke. ADON-C stated R31 is able to keep a lighter in R31's possession. ADON-C indicated staff are able to observe R31 smoking outside via the camera in the smoke shack. When Surveyor mentioned Surveyor observed five cigarettes in R31's room earlier that day, ADON-C stated R31's cigarettes should be at the nursing station and not in R31's room.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 48794 Based on observation, staff interview, and record review, the facility did not ensure food was stored and prepared in a safe and sanitary manner. This practice had the potential to affect more than 4 of the 105 residents residing in the facility. Food items for resident consumption were not appropriately labeled and/or were beyond the discard date. Equipment in the main kitchen and unit 2 kitchenette was not in clean condition and/or covered. Findings include: On 3/17/25 at 9:20 AM, Surveyor interviewed Dietary Manager (DM)-K who stated the facility follows the Federal Food Code. Food Labeling/Storage: The 2022 FDA Food Code documents at 3-501.17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking: .(B) Except as specified in (E)-(G) of this section, refrigerated, ready-to-eat time/temperature control for safety food prepared and packaged by a food processing plant shall be clearly marked, at the time the original container is opened in a food establishment and if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded, based on the temperature and time combinations specified in (A) of this section and: (1) The day the original container is opened in the food establishment shall be counted as day 1; and (2) The day or date marked by the food establishment may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on food safety. During an initial tour of the kitchen that began at 9:20 AM on 3/17/25, Surveyor noted an item in the cooler labeled tater tot casserole with a prepped date of 12/12/23, a pulled date of 12/13/23, and no use-by date. Surveyor noted an item in the freezer labeled gluten free (GF) hot dog bun (single) dated 2/12 with no year or use-by date. Surveyor also noted an open box of turkey breasts dated 9/25/22 with no use-by date. On 3/17/25 at 9:20 AM, Surveyor interviewed DM-K who confirmed the tater tot casserole, hot dog bun, and turkey breasts were past the expiration date and should have been discarded. Cleanliness: The 2022 FDA Food Code documents at 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils: (A) Equipment food-contact surfaces and utensils shall be clean to sight and touch. (B) The food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 2022 FDA Food Code documents at 4-602.13 Nonfood-Contact Surfaces: Nonfood-contact surfaces of equipment shall be cleaned at a frequency necessary to preclude accumulation of soil residue. The 2022 FDA Food Code documents at 4-903.11 Equipment, utensils, linens, and single-service and single-use articles: (a) Except as specified in (d) of this section, cleaned equipment and utensils, laundered linens, and single-service and single-use articles shall be stored: (1) in a clean, dry location; (2) where they are not exposed to splash, dust, or other contamination; and (3) at least 15 centimeters (cm) (6 inches) above the floor. (b) Clean equipment and utensils shall be stored as specified under (a) of this section and shall be stored: (1) in a self-draining position that allows air drying; and (2) covered or inverted. During an initial tour of the kitchen that began at 9:20 AM on 3/17/25, Surveyor observed a coffee dispensing machine and noted dried coffee ground-like debris on the interior compartment. Surveyor also noted a cleaning sign off log posted on the exterior of the machine. The cleaning log indicated the coffee dispenser should be cleaned weekly on Fridays. The log indicated the machine was last cleaned on 1/10/25. On 3/17/25 at 9:20 AM, Surveyor interviewed DM-K who confirmed the coffee dispenser should be cleaned weekly on Fridays. DM-K acknowledged the dried debris on the interior of dispenser and verified the log indicated the machine was last cleaned on 1/10/25. During a follow-up tour of the kitchen that began at 12:01 PM on 3/18/25, Surveyor noted the coffee dispenser appeared to have been cleaned and the log contained a date of 3/17/25. On 3/17/25 at 9:20 AM, Surveyor observed three standing mixers in the main kitchen. The mixers were not in use and were not covered. Surveyor also observed a vertical cutter mixer (VCM) and 5+ VCM disc blades that were hung on the wall. The VCM and disc blades were not covered. On 3/17/25 at 9:20 AM, Surveyor interviewed DM-K who stated the three stand mixers, the VCM, and the blades are not covered when not in use. On 3/17/25 at 12:31 PM, Surveyor toured the unit 2 kitchenette and observed food debris on the countertop and the top of the microwave. Surveyor also observed a toaster with food debris on the exterior and a layer of food debris on the bottom of the interior. On 3/19/25 at 9:15 AM, Surveyor completed a follow-up tour of the unit 2 kitchenette and again observed food debris on the top of the microwave and interior and exterior of the toaster. Surveyor also noted a banana labeled for resident (R65) on the countertop. Surveyor noted food debris covered the countertop. On 3/19/25 at 12:55 PM, Surveyor interviewed DM-K and discussed the unit 2 kitchen observations. DM-K acknowledged the concerns and stated nursing staff are responsible for unit kitchenettes.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49010 Based on observation, staff interview, and record review, the facility did not establish and maintain an infection prevention and control program designed to prevent the transmission of communicable disease and infection. This practice had the potential to affect more than 4 of the 105 residents residing in the facility. During two care observations, staff did not adhere to enhanced barrier precautions (EBP) for R8. Hand hygiene was not offered or completed for multiple residents prior to or after dining. Findings include: The facility's Transmission-Based Precautions (TBP) policy, dated 4/11/24, states: Enhanced Barrier Precautions (EBP): For members with novel or targeted multidrug-resistant organism (MDRO) infections, indwelling medical devices and wounds, including as part of a public health containment response. This type of precaution falls between standard and contact precautions and requires gown and glove use for certain members during specific high-contact member care activities that have been found to be at increased risk for MDRO transmission. When a member is colonized, or has completed treatment for infection with a novel or targeted MDRO, direct care staff don gown and gloves prior to high-contact activities including: 1.1 Dressing; 1.2 Bathing/showering; 1.3 Transferring; 1.4 Providing hygiene; 1.5 Changing linens; 1.6 Changing briefs or assisting with toileting . The facility's Member Meals and Snacks Policy. dated 1/10/25, states: .Hand Hygiene shall be offered to all members prior to and following a meal .Staff shall assist members who are unable to complete hand hygiene independently . 1. From 3/17/25 to 3/19/25, Surveyor reviewed R8's medical record. R8 was admitted to the facility on [DATE] and had diagnoses including history of methicillin-resistant staphylococcus aureus (MRSA), neuromuscular dysfunction of bladder, hydronephrosis, disorders of the urethra, disorders of the bladder, urinary tract infection, and presence of urogenital implants. R8 had an indwelling urinary catheter. R8's Minimum Data Set (MDS) assessment, dated 3/5/25, had a Brief Interview for Mental Status (BIMS) score of 15 of 15 which indicated R8 was not cognitively impaired. R8 had a physician order for EBP related to R8's Foley catheter and history of MRSA. R8's care plan indicated staff should use EBP (including donning gloves, a gown, and completing hand hygiene) when completing high-contact cares for R8 related to R8's Foley catheter and history of MRSA. R8's Kardex (an abbreviated care plan used by nursing staff) indicated R8 had a catheter and staff should use EBP during R8's cares. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/17/25 at 1:26 PM, Surveyor observed an EBP sign on the wall near the entrance to R8's room. The sign read: Enhanced Barrier Precautions Everyone Must: Clean hands, including before entering the room and when leaving the room. Provider and Staff Must Also: Wear gloves and a gown for the following high-contact resident care activities. Dressing, Bathing/Showering, Transferring, Changing Linens, Providing Hygiene, Changing briefs or assisting with toileting. Device care or use: Central line, urinary catheter, feeding tube, tracheostomy. Wound Care: any skin opening requiring a dressing. Surveyor also observed a personal protective equipment (PPE) cart outside R8's room that contained gloves, gowns, and hand sanitizer. On 3/17/25 at 1:32 PM, Surveyor observed Certified Nursing Assistant (CNA)-M knock on R8's door and enter R8's room. When CNA-M asked if R8 wanted to get up, R8 stated yes. CNA-M stated CNA-M would get R8 up and closed the door. CNA-M did not apply PPE prior to entering the room and shutting the door. On 3/17/25 at 1:39 PM, Surveyor observed CNA-M exit R8's room. CNA-M did not complete hand hygiene upon exit and was not wearing PPE. CNA-M then entered a room across the hall. At 1:40 PM, Surveyor observed CNA-M re-enter R8's room. CNA-M did not complete hand hygiene and did not don gloves or a gown. At 1:42 PM, Surveyor observed CNA-M exit R8's room. CNA-M did not complete hand hygiene. Surveyor observed R8 in a wheelchair. On 3/17/25 at 1:43 PM, Surveyor interviewed CNA-M who verified CNA-M got R8 out of bed. CNA-M confirmed CNA-M did not don PPE or follow EBP precautions while assisting R8. CNA-M confirmed R8 had a catheter and indicated CNA-M was aware R8 was on EBP. CNA-M indicated CNA-M didn't feel a gown was necessary for R8's cares and indicated CNA-M just needed to disinfect the catheter tubing after emptying it. CNA-M indicated EBP are for when body fluids could be splashed on staff. CNA-M indicated EBP isn't needed for R8 because CNA-M places the catheter drain tube far into the collection basin and isn't worried about splashing urine. CNA-M was aware R8's urine is colonized with an MDRO. On 3/17/25 at 1:51 PM, Surveyor observed CNA-M enter R8's room and leave the door open. CNA-M donned gloves without washing or sanitizing hands but did not don a gown. CNA-M then made R8's bed. On 3/19/25 at 1:54 PM, Surveyor interviewed Assistant Director of Nursing (ADON)-C who indicated a resident with a catheter and history of MRSA should be on EBP. ADON-C indicated staff are aware of EBP and should follow the facility's EBP policy which includes gowns, gloves, and hand hygiene for high-contact cares. On 3/19/25 at 2:23 PM, Surveyor interviewed Director of Nursing (DON)-B who indicated staff are trained in infection control practices including EBP and should follow residents' EBP orders and the facility's EBP policies. 2. On 3/17/25 at 12:02 PM, Surveyor observed the 100 wing east dining room which contained seventeen residents and five staff. Surveyor observed staff assist residents into the dining room and observed residents enter the dining room independently. Surveyor did not observe staff offer residents hand hygiene before the meal was served. On 3/17/25 at 12:31 PM, Surveyor noted multiple residents were finished eating and began to leave the area. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/17/25 at 12:32 PM, Surveyor interviewed CNA-N who was unsure if residents were offered hand hygiene before lunch. When asked the process for offering hand hygiene to residents, CNA-N looked in four cupboards and found a container of hand sanitizing wipes. CNA-N put the wipes on the counter across from the sink. On 3/17/25 at 12:35 PM, Surveyor interviewed CNA-O who indicated CNA-O uses a washcloth to wash residents' faces or lets residents wash their own faces after meals. CNA-O initially indicated CNA-O does not wash residents' hands before meals but later indicated staff toilet residents before meals and provide hand hygiene at that time. When Surveyor asked how residents who go to the dining room independently receive hand hygiene before meals, CNA-O indicated CNA-O wasn't sure. On 3/17/25 at 12:40 PM, Surveyor observed CNA-O remove the pump/lid from a container of hand sanitizer and pour an unmeasured amount of hand sanitizer into a basin of water. CNA-O then put several washcloths in the basin. CNA-O washed a resident's face and hands with a washcloth. CNA-O put the soiled washcloth on the counter and washed the hands and face of another resident with another washcloth. CNA-O continued the process with other residents and offered a washcloth to a resident to wash their own hands and face. On 3/17/25 at 12:41 PM, Surveyor observed CNA-P take the container of hand sanitizing hand wipes off the counter and put them back under the cupboard. On 3/17/25 at 12:49 PM, Surveyor interviewed CNA-O who verified CNA-O poured hand sanitizer into a basin of water to offer hygiene to residents which was CNA-O's regular practice. On 3/17/25 at 12:54 PM, Surveyor interviewed CNA-P who indicated residents' faces and hands are typically washed after meals by using a bowl of water with hand sanitizer On 3/17/25 at 12:56 PM, Surveyor observed the bottle of hand sanitizer used in the basin of water for resident hygiene. The bottle stated: Health Guard. Foaming 70% alcohol hand sanitizer with aloe and vitamin E. On 3/19/25 at 1:54 PM, Surveyor interviewed ADON-C who indicated it is not acceptable for staff to use hand sanitizer in water to wash residents' faces and hands after meals. ADON-C indicated resident hand hygiene is expected before meals. ADON-C indicated staff have been trained and should follow the facility's hand hygiene protocol. On 3/19/25 at 2:23 PM, Surveyor interviewed DON-B who indicated resident hand hygiene should be completed before meals. DON-B indicated staff have been trained should follow the facility's hand hygiene protocol.