Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 09/27/2024
Form Approved OMB
No. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525730 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 07/15/2024 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER: Medical Suites at Oak Creek (the) | | STREET ADDRESS, CITY, STATE, ZIP CODE: 2700 Honadel Boulevard Oak Creek, WI 53154 | |

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 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22692<br><br>Based on interview and record review, the facility did not protect 1 (R83) of 3 residents reviewed for abuse/neglect from being verbally abused and neglected.<br><br>R83 was transferred without a mechanical lift and fractured her right ankle. The Certified Nursing Assistants (CNAs) were aware that they should use a mechanical lift and decided to transfer R83 with an assist of 2 and a gait belt. When R83 fell during the transfer, the CNAs got her off the floor and into her wheelchair. These events were not reported to the nurse on duty until several hours later. During the transfer, a CNA was heard telling R83 I'm not your bitch causing R83 to experience anxiety and resulting in actual harm to R84.<br><br>Findings include:<br><br>R83 was admitted to the facility on [DATE] with a diagnoses that included weakness and falls that resulted in a right femur fracture.<br><br>R83's Quarterly Minimum Data Set (MDS) dated [DATE] documented a Brief interview for Mental Status (BIMS) score of 10, indicating that R83 is moderately impaired. The MDS also documented that R83 is dependent for transfers to and from her bed to the wheelchair.<br><br>On 7/8/24, the facility submitted by an incident investigation the state agency. The investigation was reviewed and it documented: On 6/9/24 R83 had a staff assisted fall. R83 complained of pain and her right ankle appeared discolored. Nurse Practitioner was contacted and R83 was sent to the emergency room for further evaluation. On 6/10/24, the facility was informed R83 had a closed displaced bimalleolar fracture of the right ankle. On 6/9/24 at approximately 2:30 PM, CNA-JJ and CNA-KK went to R83's room to assist her in her wheelchair so she could attend bingo. CNA-JJ and CNA-KK were unable to locate a Hoyer (full mechanical lift) sling per R83's plan of care and attempted to transfer R83 with a gait belt into her wheelchair. During the transfer, R83 was lowered to the floor by CNA-KK. CNA-JJ and CNA-KK stated they were not aware that they needed to get a nurse after a staff assisted fall so both CNA-JJ and CNA-KK assisted R83 into her wheelchair and R83 went to bingo. After R83 returned from bingo CNA-JJ told LPN-LL about the assisted fall that happened with R83 earlier. CNA-JJ indicated that during the interaction with CNA-KK that CNA-KK was being aggressive with R83. CNA-JJ indicated CNA-KK told R83 I am not your slave. When CNA-KK was asked about the situation she indicated she said to R83 I'm not your bitch when she saw R83 about to call her a bitch.<br><br>(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 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The investigation conclusion in the report documents: The allegation of neglect of R83 was substantiated for the following reasons: Both CNA-JJ and CNA-KK were aware of R83 being a two-person mechanical sling lift, but transferred her using a gait belt. Neither CNA-JJ or CNA-KK updated Licensed Practical Nurse (LPN)-LL of the assisted fall until after R83 returned from bingo which was approximately 2 hours later. R83 has been tearful and experiencing mood changes when speaking about the incident that occurred.<br><br>A statement from LPN-LL (who no longer works at the facility) was included in the investigation and documented: at approximately 5:30 PM (3 hours after the fall) I was informed by CNA-JJ that R83 was in pain. CNA-JJ told me that R83 was lowered to the ground during a transfer. I evaluated R83 and the Nurse Supervisor was updated. During the evaluation R83 was teary eyed, which is her base line. R83 did verbalize being upset regarding the transfer that occurred.<br><br>On 7/10/24, a nursing note written by LPN-LL on 6/9/24 at 6:19 PM was reviewed and documented: Staff informed writer that R83 was lowered to ground. Staff were able to get R83 back up her wheelchair. This was not immediately reported to this writer. Upon being notified, went to R83's room finding her in high back wheelchair. R83 was upset and informed me that her right ankle is always pronated inwards and this is baseline. She has trace pedal edema but no localized swelling. Acetaminophen and cold compress applied. Updated Manager on duty and Nurse Practitioner who will see her tomorrow. No redness or bruising noted at this moment. No acute distress or abnormal findings noted. Continuing to monitor per protocol.<br><br>On 07/10/24 at 10:49 AM, LPN-LL was interviewed and indicated he had not been notified of R83's fall until several hours after. LPN-LL indicated he told the LPN-II, who was the house supervisor, of the fall and assumed she would take over the investigation. LPN-LL indicated he did not call the Administrator or suspend CNA-JJ and CNA-KK pending investigation and both completed their shifts. LPN-LL indicated he was unaware of any verbal abuse/aggression to R83 by CNA-KK as this was not reported to him.<br><br>On 07/10/24 at 10:28 AM, Nursing Home Administrator (NHA)-A was interviewed and indicated she was not notified of the fall incident with R83 until 6/10/24 at approximately 9:30 AM. NHA-A informed Surveyor that after she was notified, she proceeded to get statements and start an investigation. NHA-A indicated the nursing supervisor who was LPN-II should have informed her right away. NHA-A indicated CNA-JJ and CNA-KK were not suspended until 6/10/24 and should have been suspended immediately after the allegation. NHA-A indicated she asked CNA-JJ about the comments CNA-KK made to R83. NHA-A indicated CNA-JJ stated CNA-KK was abrasive in her way of talking to R83 but could not remember exactly what CNA-KK said.<br><br>Surveyor asked if NHA-A would consider CNA-KK saying I'm not your bitch to R83 to be verbal abuse and NHA-A said yes I would. NHA-A indicated she also asked CNA-JJ if she reported the abrasive comments CNA-KK made and that CNA-JJ did not report any comments to LPN-LL and only reported the fall.<br><br>On 7/10/24, the nursing schedule for 6/9/24 was reviewed and it documented that CNA-JJ was scheduled to work until 3:00 PM. Surveyor noted that LPN-LL documented she reported R83's fall to him at 3:30 PM and CNA-KK worked till 7:00 PM.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 07/10/24 at 1:39 PM, LPN-II was interviewed and stated she doesn't remember much about R83's fall because that was too long ago. LPN-II stated she was not sure if she documented anything on the incident or if she completed any investigation. Surveyor noted that no documentation was found regarding LPN-II's involvement in the investigation and that LPN-II is not mentioned in the facility investigation even though NHA-A indicated LPN-II should have called her to report the incident as LPN-II was the house supervisor.<br><br>On 7/8/24, R83 was interviewed and stated that about a month ago 2 CNA's transferred her and dropped her because they didn't use the lift like she told them to. R83 also stated that one of the CNA's swore at her and it greatly upset her. R83 did not know the CNA's name and did not see either CNA after the day of the fall.<br><br>On 7/9/24, a nursing note written by LPN-NN was reviewed and documented: R83 is complaining of increased pain to right ankle. Ankle is swollen and bruising purple in color. Third eye (virtual doctor) updated about R83 wanting to go to the hospital for evaluation. Third eye physician gave orders to send to emergency room for evaluation, ambulance called.<br><br>On 7/9/24, R83's emergency room report dated 6/10/24 was reviewed and documented: Diagnosis of a closed displaced bimalleolar fracture of the right ankle. A short leg splint was applied to R83's right leg and a consultation with orthopedic surgery was ordered in one week. R83 was ordered oxycodone 10 milligrams (MG) every 6 hours as needed.<br><br>On 7/10/24, R83's medication administration record (MAR) was reviewed for her oxycodone use from 6/10/24 to 7/9/24 and it documented that R83 received it per request approximately 1-3 times a day.<br><br>On 7/10/24, R83's orthopedic consult notes dated 6/26/24 which indicated R83 underwent an outpatient closed reduction and casting of the right leg for the right ankle fracture.<br><br>On 7/10/24, R83's current care plan for activities of daily living dated 6/22/22 was reviewed and documented: Intervention: Transfers, resident requires Hoyer lift with 2 assist started 7/8/22.<br><br>On 7/11/24, the facility's policy titled Abuse, Neglect and Exploitation dated 9/18/23 was reviewed and documents: Neglect means failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress. Willful mean the individual must have acted deliberately, not that the individual must have intended to inflict injury or emotional harm. Verbal abuse means the use of oral written or gestured communication or sounds that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance regardless of their age, ability to comprehend or disability. An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur. Identify staff responsible for the investigation. Provide complete and through documentation of the investigation.<br><br>The above findings were shared with the NHA-A and Director of Nurses-B on 7/11/24. Additional information was requested if available, but none was provided as to why CNA-JJ and CNA-KK did not follow R83's care plan for transfers and why when CNA-KK verbally abused R83, CNA-JJ did not protect R83 and report it to LPN-LL. |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22692<br><br>Based on record review and interview, the facility did not ensure that 2 (R83 & R23) of 2 reviewed allegations of abuse were immediately reported to the Administrator and that the completed investigation was sent to the state agency within 5 business days.<br><br>* R83 was transferred without a mechanical lift and fractured her right ankle. During the transfer the Certified Nursing Assistant (CNA) was heard to say to R83 I'm not your bitch causing anxiety to R83. This was not immediately reported to the NHA (Nursing Home Administrator) or the LPN (Licensed Practical Nurse) on duty at the time.<br><br>* R34's results of an abuse investigation were not reported to the State Survey Agency within 5 working days.<br><br>Findings include:<br><br>The facility's policy titled Abuse, Neglect and Exploitation and dated 9/18/23 documents: Verbal abuse means the use of oral written or gestured communication or sounds that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance regardless of their age, ability to comprehend or disability. Reporting/Response: Reporting of all alleged violations to the Administrator, state agency, adult protective services and all other required agencies within specified timeframe's. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegations involve abuse or result in serious bodily injury. The Administrator will follow up with government agencies, to confirm the initial report was received, and to report the results of the investigation when final within 5 working days of the incident.<br><br>1.) R83 was admitted to the facility on [DATE] with diagnoses that included weakness and falls which resulted in a right femur fracture.<br><br>R83's Quarterly Minimum Data Set (MDS) dated [DATE] documents a Brief interview for Mental Status score of 10 , indicating R83 is moderately cognitively impaired.The MDS also documented that R83 is dependent for transfers to and from bed and to the wheelchair.<br><br>(continued on next page) |

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F 0609

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

The facility's reported incident investigation submitted by the facility on 6/10/24 documented: On 6/9/24 R83 had a staff assisted fall. R83 complained of pain and her right ankle appeared discolored. Nurse Practitioner was contacted and R83 was sent to the emergency room for further evaluation. On 6/10/24, the facility was informed R83 had a closed displaced bimalleolar fracture of the right ankle. On 6/9/24 at approximately 2:30 PM CNA-JJ and CNA-KK went to R83's room to assist her in her wheelchair so she could attend bingo. CNA-JJ and CNA-KK were unable to locate a Hoyer (full mechanical lift) sling per R83's plan of care and attempted to transfer R83 with a gait belt into her wheelchair. During the transfer, R83 was lowered to the floor by CNA-KK. CNA-JJ and CNA-KK stated they were not aware that they needed to get a nurse after a staff assisted fall so both CNA-JJ and CNA-KK assisted R83 into her wheelchair and R83 went to bingo. After R83 returned from bingo CNA-JJ told LPN-LL about the assisted fall that happened with R83 earlier. CNA-JJ indicated that during the interaction with CNA-KK that CNA-KK was being aggressive with R83. CNA-JJ indicated CNA-KK told R83 I am not your slave. When CNA-KK was asked about the situation she indicated she said to R83 I'm not your bitch when she saw R83 about to call her a bitch.

A statement from LPN-LL (who no longer works at the facility) was included in the investigation and documented: at approximately 5:30 PM (3 hours after the fall) I was informed by CNA-JJ that R83 was in pain. CNA-JJ told me that R83 was lowered to the ground evaluated R83 and the Nurse Supervisor was updated. During the evaluation R83 was teary eyed, which is her base line. R83 did verbalize being upset regarding the transfer that occurred.

R83's nursing note written by LPN-LL on 6/9/24 at 6:19 PM documented: Staff informed writer that R83 was lowered to ground. Staff were able to get R83 back up her wheelchair. This was not immediately reported to this writer. Upon being notified, went to R83's room finding her in high back wheelchair. R83 was upset and informed me that her right ankle is always pronated inwards and this is baseline. She has trace pedal edema but no localized swelling. Acetaminophen and cold compress applied. Updated Manager on duty and Nurse Practitioner who will see her tomorrow. No redness or bruising noted at this moment. No acute distress or abnormal findings noted. Continuing to monitor per protocol.

On 07/10/24 at 10:49 AM, LPN-LL was interviewed and indicated he wad not been notified of R83's fall until several hours after. LPN-LL indicated he told the LPN-II, who was the house supervisor) of the fall and assumed she would take over the investigation. LPN-LL indicated he did not call the Administrator or suspend CNA-JJ and CNA-KK pending investigation and both completed their shifts. LPN-LL indicated he was unaware of any verbal abuse/aggression to R83 by CNA-KK and that was not reported to him, only the fall.

On 07/10/24 at 10:28 AM, NHA-A was interviewed and indicated she was not notified of the incident with R83 until 6/10/24 about 9:30 AM and after that she proceeded to get statements and start an investigation. NHA-A indicated the nursing supervisor who was LPN-II should have informed her right away.

On 07/10/24 at 1:39 PM, LPN-II was interviewed and indicated she doesn't remember much about R83's fall because that was too long ago. LPN-II indicated she was not sure if she documented anything on the incident or if she completed any investigation. (No documentation was found regarding LPN-II's involvement in the investigation and LPN-II is not mentioned in the facility investigation even though Administrator-A indicated LPN-II should have called her as she was the house supervisor).

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 7/8/24, R83 was interviewed and indicated that about a month ago 2 CNA's transferred her and dropped her because they didn't use the lift like she told them too. R83 also indicated that one of the CNA's swore at her and it greatly upset her. R83 did not know the CNA's name and did not see either CNA after the day of the fall.<br><br>On 7/11/24 at 3:00 PM, Surveyor informed NHA-A and Director of Nursing (DON)-B of the above findings. Additional information was requested if available, none was provided as to why NHA-A was not notified immediately after the allegation of verbal abuse to R83 when CNA-JJ witnessed CNA-KK talk to R83 in a derogatory manner or why the facility did not report to the allegation to the State Agency within two hours.<br><br>49435<br><br>2.) R34 was admitted to the facility on [DATE] and has diagnoses that include Cancer of the Large intestine, Type 2 Diabetes, Chronic Kidney Disease and Hypothyroidism.<br><br>R34's Quarterly Minimum Data Set (MDS) assessment dated [DATE] documents R34 is always understood and understands. R34 is cognitively intact.<br><br>On 7/8/2024 at 9:24 AM, Surveyor interviewed R34. R34 stated over a month ago, Licensed Practical Nurse (LPN)-MM was rude to R34. R34 stated LPN-MM shook LPN-MM' fist at R34 and told R34 that LPN-MM was in the military.<br><br>Surveyor conducted a review of the facility's self-report incident involving R34 and LPN-MM. The facility investigation documents this allegation of abuse was discovered on 5/24/2024. The facility reported the alleged abuse to the State Survey Agency on 5/24/2024.<br><br>Surveyor conducted a further review of the facility's investigation and noted the Department of Health Services form F-62447 was not submitted to the State Survey Agency until 6/7/2024, which was outside of the required 5 business day window.<br><br>Surveyor reviewed an email included in the facility's self-report. The email was from the facility's previous Nursing Home Administrator sent on 6/1/2024 to the State Survey Agency. The email documented, in part: We are going through a change of ownership, and I am unable to access my documents to send the 5-day self-report . This allegation was unsubstantiated and there have been no further concerns from this resident. She feels safe here. Once I can get access to my files and a secure internet and email, I will submit this information .<br><br>Surveyor reviewed an email reply from the State Survey Agency to the previous Nursing Home Administrator sent on 6/3/2024. The email documented, in part: Thank you for sending this update . If you are finding it will be a while before you are able to access your files, I would suggest submitting the 62447 . with the information you have, just without the attachments. Then you can submit the attachments via email when you have access .<br><br>Surveyor notes that on 6/3/2024, the State Survey Agency instructed the previous Nursing Home Administrator to submit the 62447 form and email the attachments via email later. Surveyor notes the 62447 form was not submitted until 6/7/2024 which was 9 business days after the initial report was submitted to the State Survey Agency.<br><br>(continued on next page) |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 7/15/2024 at 8:52 AM, Surveyor interviewed Nursing Home Administrator (NHA)-A. Surveyor asked why the facility submitted the report late. NHA-A stated that the previous owner was having issues logging into the facility system during the transition of ownership. NHA-A began as the Administrator at the facility on 6/7/2024. As soon as NHA-A had access, NHA-A submitted the report. Surveyor informed NHA-A of the continued concern that the report was submitted 9 working days after the initial report was submitted.<br><br>No further information was provided as to why the facility failed to report allegations of abuse to the state agency within 5 business days. |

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F 0610

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Many

Respond appropriately to all alleged violations.

**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22692

Based on interview and record review, the facility did not ensure an allegation of neglect and verbal abuse for 1 (R83) of 1 residents reviewed, included steps that were taken by the facility to ensure safety of the facility residents.

* R83 was transferred without a mechanical lift and fell , fracturing her right ankle. The Certified Nursing Assistants (CNAs) knew they should use a mechanical lift and decided to transfer R83 with an assist of 2 and a gait belt. When R83 fell during the transfer, the CNAs got her off the floor and into her wheelchair. The fall was not reported to the nurse on duty until several hours later. During the transfer, the CNA was heard telling R83, I'm not your bitch, causing R83 to experience anxiety.

Neither CNA-JJ nor CNA-KK were suspended pending an investigation and both were allowed to finish their shifts on 6/9/24, the day of R83's fall. There was no evidence that an investigation into the allegations was started until the next day when the Nursing Home Administrator was notified of the incident.

This deficient practice had the potential to affect 115 of 115 residents in the facility.

Findings include:

R83 was admitted to the facility on [DATE] with a diagnosis that included weakness and falls which resulted in a right femur fracture.

R83's Quarterly Minimum Data Set (MDS) dated [DATE] documented a Brief interview for Mental Status (BIMS) score of 10, indicating that R83 is moderately cognitively impaired. The MDS also documented that R83 is dependent for transfers to and from her bed to the wheelchair.

On 7/8/24, the facility submitted by an incident investigation to the State agency. The investigation was reviewed and it documented: On 6/9/24 R83 had a staff assisted fall. R83 complained of pain and her right ankle appeared discolored. Nurse Practitioner was contacted and R83 was sent to the emergency room for further evaluation. On 6/10/24, the facility was informed R83 had a closed displaced bimalleolar fracture of the right ankle. On 6/9/24 at approximately 2:30 PM, CNA-JJ and CNA-KK went to R83's room to assist her in her wheelchair so she could attend bingo. CNA-JJ and CNA-KK were unable to locate a Hoyer (full mechanical lift) sling per R83's plan of care and attempted to transfer R83 with a gait belt into her wheelchair. During the transfer, R83 was lowered to the floor by CNA-KK. CNA-JJ and CNA-KK stated they were not aware that they needed to get a nurse after a staff assisted fall so both CNA-JJ and CNA-KK assisted R83 into her wheelchair and R83 went to bingo. After R83 returned from bingo CNA-JJ told LPN-LL about the assisted fall that happened with R83 earlier. CNA-JJ indicated that during the interaction with CNA-KK that CNA-KK was being aggressive with R83. CNA-JJ indicated CNA-KK told R83 I am not your slave. When CNA-KK was asked about the situation she indicated she said to R83 I'm not your bitch when she saw R83 about to call her a bitch.

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | The investigation conclusion in the report documents: The allegation of neglect of R83 was substantiated for the following reasons: Both CNA-JJ and CNA-KK were aware of R83 being a two-person mechanical sling lift, but transferred her using a gait belt. Neither CNA-JJ or CNA-KK updated Licensed Practical Nurse (LPN)-LL of the assisted fall until after R83 returned from bingo which was approximately 2 hours later. R83 has been tearful and experiencing mood changes when speaking about the incident that occurred.<br><br>A statement from LPN-LL (who no longer works at the facility) was included in the investigation and documented: at approximately 5:30 PM (3 hours after the fall) I was informed by CNA-JJ that R83 was in pain. CNA-JJ told me that R83 was lowered to the ground during a transfer. I evaluated R83 and the Nurse Supervisor was updated. During the evaluation R83 was teary eyed, which is her base line. R83 did verbalize being upset regarding the transfer that occurred.<br><br>On 7/10/24, a nursing note written by LPN-LL on 6/9/24 at 6:19 PM was reviewed and documented: Staff informed writer that R83 was lowered to ground. Staff were able to get R83 back up her wheelchair. This was not immediately reported to this writer. Upon being notified, went to R83's room finding her in high back wheelchair. R83 was upset and informed me that her right ankle is always pronated inwards and this is baseline. She has trace pedal edema but no localized swelling. Acetaminophen and cold compress applied. Updated Manager on duty and Nurse Practitioner who will see her tomorrow. No redness or bruising noted at this moment. No acute distress or abnormal findings noted. Continuing to monitor per protocol.<br><br>On 07/10/24 at 10:49 AM, LPN-LL was interviewed and indicated he had not been notified of R83's fall until several hours after. LPN-LL indicated he told the LPN-II, who was the house supervisor, of the fall and assumed she would take over the investigation. LPN-LL indicated he did not call the Administrator or suspend CNA-JJ and CNA-KK pending investigation and both completed their shifts. LPN-LL indicated he was unaware of any verbal abuse/aggression to R83 by CNA-KK as this was not reported to him.<br><br>On 07/10/24 at 10:28 AM, Nursing Home Administrator (NHA)-A was interviewed and indicated she was not notified of the fall incident with R83 until 6/10/24 at approximately 9:30 AM. NHA-A informed Surveyor that after she was notified, she proceeded to get statements and start an investigation. NHA-A indicated the nursing supervisor who was LPN-II should have informed her right away. NHA-A indicated CNA-JJ and CNA-KK were not suspended until 6/10/24 and should have been suspended immediately after the allegation. NHA-A indicated she asked CNA-JJ about the comments CNA-KK made to R83. NHA-A indicated CNA-JJ stated CNA-KK was abrasive in her way of talking to R83 but could not remember exactly what CNA-KK said.<br><br>Surveyor asked if NHA-A would consider CNA-KK saying I'm not your bitch to R83 to be verbal abuse and NHA-A said yes I would. NHA-A indicated she also asked CNA-JJ if she reported the abrasive comments CNA-KK made and that CNA-JJ did not report any comments to LPN-LL and only reported the fall.<br><br>On 7/10/24, the nursing schedule for 6/9/24 was reviewed and it documented that CNA-JJ was scheduled to work until 3:00 PM. Surveyor noted that LPN-LL documented she reported R83's fall to him at 3:30 PM and CNA-KK worked till 7:00 PM.<br><br>(continued on next page) |

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| NAME OF PROVIDER OR SUPPLIER Medical Suites at Oak Creek (the) | | STREET ADDRESS, CITY, STATE, ZIP CODE 2700 Honadel Boulevard Oak Creek, WI 53154 | |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | On 07/10/24 at 1:39 PM, LPN-II was interviewed and stated she doesn't remember much about R83's fall because that was too long ago. LPN-II stated she was not sure if she documented anything on the incident or if she completed any investigation. Surveyor noted that no documentation was found regarding LPN-II's involvement in the investigation and that LPN-II is not mentioned in the facility investigation even though NHA-A indicated LPN-II should have called her to report the incident as LPN-II was the house supervisor.<br><br>On 7/8/24, R83 was interviewed and stated that about a month ago 2 CNAs transferred her and dropped her because they didn't use the lift like she told them to. R83 also stated that one of the CNAs swore at her and it greatly upset her. R83 did not know the CNA's name and did not see either CNA after the day of the fall.<br><br>On 7/9/24, a nursing note written by LPN-NN was reviewed and documented: R83 is complaining of increased pain to right ankle. Ankle is swollen and bruising purple in color. Third eye (virtual doctor) updated about R83 wanting to go to the hospital for evaluation. Third eye physician gave orders to send to emergency room for evaluation, ambulance called.<br><br>On 7/9/24, R83's emergency room report dated 6/10/24 was reviewed and documented: Diagnosis of a closed displaced bimalleolar fracture of the right ankle. A short leg splint was applied to R83's right leg and a consultation with orthopedic surgery was ordered in one week. R83 was ordered oxycodone 10 milligrams (MG) every 6 hours as needed.<br><br>On 7/10/24, R83's orthopedic consult notes dated 6/26/24 were reviewed which indicated R83 underwent an outpatient closed reduction and casting of the right leg for the right ankle fracture.<br><br>On 7/10/24, R83's current care plan for activities of daily living dated 6/22/22 was reviewed and documented: Intervention: Transfers, resident requires Hoyer lift with 2 assist started 7/8/22.<br><br>On 7/10/24, R83's CNA care sheet dated 6/9/24 was reviewed and documented: Transfers R83 requires Hoyer lift with 2 assist.<br><br>On 7/11/24, the facility's policy titled Abuse, Neglect and Exploitation dated 9/18/23 was reviewed and documented: Neglect means failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress. Willful mean the individual must have acted deliberately, not that the individual must have intended to inflict injury or emotional harm. Verbal abuse means the use of oral written or gestured communication or sounds that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance regardless of their age, ability to comprehend or disability. An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur. Identify staff responsible for the investigation. Provide complete and through documentation of the investigation. The facility will make efforts to ensure all residents are protected from physical and psychosocial harm, as well as additional abuse, during and after the investigation.<br><br>The above findings were shared with the Administrator-A and Director of Nurses-B on 7/11/24. Additional information was requested if available, but none was provided as to why CNA-JJ and CNA-KK were not suspended pending investigation or why an investigation was not immediately started on 6/9/24 after R83 was improperly transferred and injured. |

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| F 0623<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49011<br><br>Based on record review and interview, the facility did not provide written notification requirements with resident transfers from the facility. This was observed with 7 (R70, R37, R31, R40, R35, R59 and R84) of 7 residents reviewed that were transferred from the facility.<br><br>* R70, R37, R31, R40, R35, R59 and R84 were transferred to the hospital while residing in the facility and evidence was not provided that they or their representative were given the required transfer notice information including appeal rights.<br><br>Findings include:<br><br>The Facility Policy titled Transfer and Discharge (including AMA) implemented 10/26/2022, documents (in part) .<br><br>Policy Explanation and Compliance Guidelines:<br><br>.4. The facility's transfer/discharge notice will be provided to the resident and the resident's representative in a language and manner in which they can understand. The notice will include all of the following at the time it is provided:<br><br>a. The specific reason and basis for the transfer or discharge.<br><br>b. The effective date of transfer or discharge.<br><br>c. The specific location . to which the resident is to be transferred or discharged .<br><br>d. An explanation of the right to appeal the transfer or discharge to the State.<br><br>e. The name, address (mailing and email), and telephone number of the State entity which received such appeal hearing requests.<br><br>f. Information on how to obtain an appeal form.<br><br>g. Information on obtaining assistance in completing and submitting the appeal hearing request.<br><br>h. The name, address (mailing and email), and phone number of the representative of the Office of the State Long Term Care Ombudsman .<br><br>12. Emergency Transfers/Discharges - initiated by the facility for medical reasons to an acute care setting such as a hospital, for the immediate safety and welfare of a resident .<br><br>g. Provide a notice of transfer and the facility's bed hold policy to the resident and representative as indicated .<br><br>(continued on next page) |

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| F 0623<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 1.) R70 was admitted to the facility on [DATE]. R70's Quarterly Minimum Data Set (MDS) with an assessment reference date of 5/27/2024 indicated R70 had a Brief Interview for Mental Status score of 15 (cognitively intact). R70 is responsible for self.<br><br>On 07/08/24, at 10:02 AM, Surveyor interviewed R70 who indicated being sent to the hospital recently. Surveyor reviewed R70's electronic medical record which indicated R70 was transferred to the hospital on 4/21/2024 and admitted for pneumonia symptoms, R70 returned to the same room in the facility on 5/21/2024.<br><br>Surveyor requested evidence from the facility that notice of bed hold and transfer was provided to R70 and to R70's responsible party when R70 was hospitalized on [DATE]. The facility provided a copy of the IMR-*Bed hold Policy/Ombudsman Notification paperwork dated 4/21/2024. Surveyor noted the information on the forms did not have proper transfer information to include contact information, including address, phone number and email address for the State Agency, Ombudsman, or Disability Rights agency.<br><br>Surveyor requested notice of transfer paperwork again and was given the SBAR Communication Form and SNF/NF to Hospital Transfer Form. Surveyor noted the information on the forms did not have contact information, including address, phone number and email address for the State Agency, Ombudsman, or Disability Rights agency.<br><br>On 07/11/24, at 01:50 PM, Surveyor spoke with the Facility about the notice of transfer and ombudsman notice that should be given at time of transfer out of facility. Surveyor relayed that the paperwork must be more specific with contact information, including address, phone number and email address for the State Agency, Ombudsman, or Disability Rights agency. Facility Consultant acknowledged this need and will pull the regulation and update the form.<br><br>On 07/11/24, at 03:18 PM, Surveyor provided a list of residents who were reviewed and were missing the transfer notice and/or the bed hold notice to the facility during the end of day meeting. No information was provided as to why R70 did not receive a notice of bed hold and transfer on 4/21/24.<br><br>2.) R37 was admitted to the facility on [DATE]. R37's Quarterly Minimum Data Set (MDS) with an assessment reference date of 7/4/2024 indicated R37 had a Brief Interview for Mental Status score of 04 (severe cognitive impairment). R37 has an activated Power of Attorney for Healthcare.<br><br>On 07/10/24, at 12:17 PM, Surveyor reviewed R37's electronic medical record which indicated R37 was transferred to the hospital on 6/24/2024 and admitted for an unresponsive episode, R37 returned to the same room in the facility on 7/3/2024.<br><br>Surveyor requested evidence from the facility that notice of bed hold and transfer was provided to R37's responsible party when R37 was hospitalized on [DATE]. The facility provided a copy of the IMR-*Bed hold Policy/Ombudsman Notification paperwork dated 6/24/2024. Surveyor noted the information on the forms did not have proper transfer information to include contact information, including address, phone number and email address for the State Agency, Ombudsman, or Disability Rights agency.<br><br>(continued on next page) |

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| F 0623<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Surveyor requested notice of transfer paperwork again and was given the SBAR Communication Form and SNF/NF to Hospital Transfer Form. Surveyor noted the information on the forms did not have contact information, including address, phone number and email address for the State Agency, Ombudsman, or Disability Rights agency.<br><br>On 07/11/24, at 01:50 PM, Surveyor spoke with the Facility about the notice of transfer and ombudsman notice that should be given at time of transfer out of facility. Surveyor relayed that the paperwork must be more specific with contact information, including address, phone number and email address for the State Agency, Ombudsman, or Disability Rights agency. Facility Consultant acknowledged this need and will pull the regulation and update the form.<br><br>On 07/11/24, at 03:18 PM, Surveyor provided a list of residents who were reviewed and were missing the transfer notice and/or the bed hold notice during the end of day meeting. No information was provided as to why R37 did not receive a notice of bed hold and transfer on 6/24/24.<br><br>38146<br><br>3.) R31 admitted to the facility on [DATE] and has diagnoses that include Acute Respiratory Failure with Hypoxia, Chronic Obstructive Pulmonary Diseases, End Stage Renal Disease, Malignant Neoplasm of Colon, Major Depressive Disorder, Dementia, Anxiety, Colostomy status, Obstructive and Reflux Uropathy, Nephrostomy Catheter, Peripheral Vascular Disease, Hypertension, Acute Pyelonephritis and Sepsis.<br><br>R31's E-interact dated 3/16/24 documented: Situation: The Change In Condition/s (CIC) reported on this CIC Evaluation are/were: Bleeding (other than GI) Tired, Weak, Confused, or Drowsy. Nursing observations, evaluation, and recommendations are: resident c/o (complained of) increased lethargic, weakness and poor appetite. C/O abdominal pain. Primary Care Provider Feedback: Primary Care Provider responded with the following feedback: Recommendations: Send to ER (emergency room ) for eval (evaluation). R31 was subsequently admitted to the hospital.<br><br>Surveyor was unable to locate evidence a transfer notice with the required regulatory information was provided to R31 or his representative.<br><br>On 7/9/24 at 11:50 AM Nursing Home Administrator (NHA)-A provided surveyor SNF (Skilled Nursing Facility)/NF (Nursing Facility) to hospital transfer form. NHA-A stated That's what we use, we send to the hospital with the patient. Surveyor reviewed the form and asked if the facility provided R31 or his representative a transfer notice with the required regulatory information. NHA-A reported she thinks the SNF/NF form is what the facility provides, but will look to see if there is anything else.<br><br>On 7/9/24 at 3:15 PM Surveyor asked NHA-A if she had any more information regarding transfer/discharge notice provided to the resident. NHA-A reported she thinks the SNF/NF to hospital transfer form is the only thing that was provided, but is still looking into it.<br><br>On 7/11/24 at 2:15 PM NHA-A was advised of concern the facility did not provide R31 or his representative a transfer or discharge notice with the required regulatory information. No additional information was provided.<br><br>48391<br><br>(continued on next page) |

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| F 0623<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 4.) R40 was admitted to the facility on [DATE] with diagnoses of acute embolism and thrombosis of right femoral vein and left iliac vein, type 2 diabetes, muscle weakness, cognitive communication deficit, anemia, urinary tract infection, chronic kidney disease, encephalopathy, and congestive heart failure.<br><br>R40's medical record indicates R40 was transferred to the emergency room (ER) on 6/6/24 for evaluation due to a change in condition. R40 was then admitted to the hospital on 6/6/24 for further evaluation and treatment.<br><br>On 7/10/24 at 10:24 AM, Surveyor asked Nursing Home Administrator (NHA)- A for a copy of R40's written documentation of transfer to the hospital and documentation of the State Ombudsmen being notified of R40's transfer on 6/6/24.<br><br>On 7/10/24 at 11:14 AM, in an interview with Assistant NHA- BB, Surveyor asked if R40 was given written notice of transfer to the hospital on 6/6/24 and if the Ombudsmen was notified. Assistant NHA- BB stated the facility is unable to locate documentation of a notice of transfer and documentation of the Ombudsmen being notified with R40 being transferred to the hospital on 6/6/24. Surveyor explained the concern to Assistant NHA- BB, that R40 did not receive written notification of transfer to the hospital and the State Ombudsmen was not notified of the hospital transfer. Surveyor requested additional information if available. None was provided.<br><br>49435<br><br>5.) R35 was admitted to the facility on [DATE] and has diagnoses that include Multiple Sclerosis, Hemiplegia/Hemiparesis following a stroke, Hydronephrosis, Neurogenic bladder, Urinary retention, and Hypotension.<br><br>R35's Quarterly Minimum Data Set (MDS) assessment dated [DATE] documents that R35 is cognitively intact.<br><br>R35's medical record revealed R35 was hospitalized for a change of condition 4 times: 8/31/23 through 9/7/23, 10/3/23 through 10/11/23, 11/3/23 through 11/29/23 and 12/2/23 through 12/9/23.<br><br>Surveyor reviewed R35's medical record and was unable to locate evidence of transfer notices provided to R35.<br><br>On 7/10/2024, during the end of the day meeting with Nursing Home Administrator (NHA)-A and Director Nursing (DON)-B, Surveyor asked for the transfer notices for R35.<br><br>On 7/11/2024, DON-B reported the facility did not have evidence the transfer notice was provided to R35.<br><br>On 7/11/2024 during the end of day meeting, Surveyor informed Nursing Home Administrator (NHA)-A and DON-B of the concern that R35 was not provided with transfer notices.<br><br>No further information was provided as to why R35 was not given written transfer/discharge notices that included the date of transfer, reason for transfer, location of transfer, appeal rights and contact information of the State Long-Term Care Ombudsman.<br><br>(continued on next page) |

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| F 0623<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 6.) R59 was admitted to the facility on [DATE] and has diagnoses that include Chronic Respiratory failure, Type 2 Diabetes, End stage renal disease with dependence on renal dialysis.<br><br>R59's Quarterly Minimum Data Set (MDS) assessment dated [DATE] documents R59 has a moderate cognitive impairment.<br><br>R59's medical record revealed R59 was hospitalized from 3/12/2024 through 3/24/2024 for a change in condition.<br><br>Surveyor reviewed R59's medical record and was unable to locate evidence of a transfer notice provided to R59.<br><br>On 7/11/2024 at 1:52 PM, Surveyor asked Director of Nursing (DON)-B for R59's transfer notice. No transfer notice was provided.<br><br>On 7/11/2024 during the end of day meeting, Surveyor informed Nursing Home Administrator (NHA)-A and DON-B of the concern that R59 was not provided with a transfer notice.<br><br>No further information was provided as to why R59 was not given a written transfer/discharge notice that included the date of transfer, reason for transfer, location of transfer, appeal rights and contact information of the State Long-Term Care Ombudsman.<br><br>7.) R84 was admitted to the facility on [DATE] and has diagnoses that include Quadriplegia/Paraplegia, and Chronic Heart Failure.<br><br>R84's Quarterly Minimum Data Set (MDS) assessment dated [DATE] documents that R84 is cognitively intact.<br><br>On 7/8/2024 at 12:34 PM, Surveyor interviewed R84. R84 stated that R84 had a recent hospitalization .<br><br>R84's medical record revealed that R84 was hospitalized from 6/22/2024 through 6/27/2024 for a change in condition.<br><br>Surveyor reviewed R84's medical record and was unable to locate evidence of a transfer notice provided to R84.<br><br>On 7/10/2024 at 11:05 AM, Surveyor asked Director of Nursing (DON)-B for R84's transfer notice. No transfer notice was provided.<br><br>On 7/11/2024 during the end of day meeting, Surveyor informed Nursing Home Administrator (NHA)-A and DON-B of the concern that R84 was not provided with a transfer notice.<br><br>No further information was provided as to why R84 was not given a written transfer/discharge notice that included the date of transfer, reason for transfer, location of transfer, appeal rights and contact information of the State Long-Term Care Ombudsman. |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38146<br><br>Based on observations, interviews and record review the facility did not ensure residents who are unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for 3 of 23 (R15, R64 and R229) residents reviewed for Activity of Daily Living (ADL's).<br><br>* R229 was not set up for meals and was not toileted, checked or changed for a period of 4 hours.<br><br>* R15 did not receive scheduled showers.<br><br>* R64 was observed to have long nails during survey.<br><br>Findings include:<br><br>The facility policy titled Activities of Daily Living (ADLs) dated 10/24/22 documents (in part) .<br><br>.Policy<br><br>The facility will, based on the resident's comprehensive assessment and consistent with the resident's needs and choices, ensure a resident's abilities in ADLs do not deteriorate unless deterioration is unavoidable.<br><br>Caress and services will be provided for the following activities of daily living:<br><br>1. Bathing, dressing, grooming and oral care;<br><br>2. Transfer and ambulation;<br><br>3. Toileting;<br><br>4. Eating to include meals and snacks<br><br>Policy Explanation and Compliance Guidelines:<br><br>3. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.<br><br>1.) R229 admitted to the facility on [DATE] and has diagnoses that include Neuroleptic Induced Parkinsonism, Type 2 Diabetes Mellitus, Chronic Obstructive Pulmonary Disease, Atherosclerotic Heart Disease, Paroxysmal Atrial Fibrillation, Hypertension, Anxiety Disorder, Major Depressive Disorder, Heart Failure and Osteoarthritis.<br><br>R229's Admission Minimum Data Set (MDS) with an Annual Reference Date (ARD) of 6/20/24 documents:<br><br>Urinary continence - Select the one category that best describes the resident: Always incontinent.<br><br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Functional Limitation in Range of Motion: UE/LE (Upper Extremity/Lower Extremity) impairment on both sides.<br><br>Eating - The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident: Set up or clean up assistance.<br><br>Toileting hygiene - The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not managing equipment: Dependent.<br><br>R229's Care plan Focus revised 6/23/24 documents: The resident has an ADL self-care performance deficit r/t (related to) neuroleptic induced Parkinson's, falls, T2DM (Type 2 Diabetes Mellitus), COPD (Chronic Obstructive Pulmonary Disease), weakness, hx (history) of fracture, CHF (Congestive Heart Failure), OSA (Obsructive Sleep Apnea) HTN (Hypertension), V tach (Ventricular Taccycardia), CAD (Coronary Artery Disease), anxiety, depression, osteoarthritis. Interventions dated 6/17/24 include:<br><br>EATING: The resident requires setup assistance of 1. Open packages, cut food. Diet: Regular diet, Regular texture, Regular consistency.<br><br>BED MOBILITY: The resident requires substantial assist of 1.<br><br>PERSONAL HYGIENE/ORAL CARE: The resident requires substantial/total assist of 1.<br><br>TOILET USE: The resident requires substantial assist of 1 with bedpan and toileting hygiene.<br><br>R229's Care Plan Focus dated 6/23/24 documents: The resident has bladder incontinence r/t impaired mobility, weakness, Parkinson's disease. Interventions dated 6/23/24 include:<br><br>INCONTINENT: Check every 2-3 hours and as required for incontinence. Wash, rinse and dry perineum. Change clothing PRN (as needed) after incontinence episodes.<br><br>On 7/8/24 at 10:39 AM, Surveyor observed R229 lying in bed with the head of bed elevated approximately 30 degrees and was leaning to her right side. Surveyor noted her left arm in a sling/immobilizer device and a soft splint on her hand. R229's breakfast tray was on the table in front of her, untouched and R229 was not positioned upright to eat. As Surveyor entered the room and introduced self, R229 asked what was on the plate. Surveyor advised R229 of the meal contents consisting of a square piece of egg bake, toast and juice. R229 reported she was unable to see or reach her breakfast tray. R229 reported she fell and broke her wrist both knees. Surveyor observed the lid to the plate was in bed with the resident.<br><br>On 7/9/24 at 8:32 AM, Surveyor noted the metal meal cart delivered to the unit.<br><br>On 7/9/24 at 8:44 AM, Surveyor observed R229's breakfast tray sitting on the counter at the nurses station.<br><br>On 7/9/24 at 8:50 AM, Surveyor observed R229's meal tray on her bedside table, which was positioned to the right side of her bed, not in front of her and the plate was covered. R229 was lying flat in bed with her eyes closed and was not positioned upright to eat.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525730 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 07/15/2024 |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Medical Suites at Oak Creek (the) | 2700 Honadel Boulevard Oak Creek, WI 53154 |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 7/9/24 9:10 AM, Surveyor observed R229's meal tray remained on the bedside table next to the right side of her bed, not in front of her. The tray remained covered and R229 was lying flat in bed, not positioned upright to eat.<br><br>On 7/9/24 at 9:20 AM, Surveyor observed 2 staff members apply personal protective equipment, enter room and closed the door.<br><br>On 7/9/24 at 12:20 PM, Surveyor observed the noon/lunch metal meal cart tray delivered to unit.<br><br>On 7/9/24 at 12:50 PM, Surveyor observed a facility staff member place R229's lunch tray on the counter at the nurses station, covered.<br><br>On 7/9/24 at 1:10 PM, Surveyor observed R229's lunch tray remained on the counter at the nurses station, covered.<br><br>On 7/9/24 at 1:20 PM, Surveyor asked Licensed Practical Nurse (LPN)-U why R229's meal tray was on the counter. LPN-U reported she was not sure. Surveyor advised LPN-U the meal cart was delivered to the unit at 12:20 PM and R229's tray was placed on the counter at 12:50 PM where it has remained for the last 30 minutes. LPN-U stated That's terrible, I don't know why it's left there. Maybe her husband brought her something or she refused, I'll take it in there. Surveyor advised LPN-U that R229's tray was placed on the counter and no staff have been in her room. LPN-U picked up the meal tray and delivered it to R229. LPN-U asked the resident Did you refuse your lunch? R229 replied No. LPN-U set up R229 to eat and asked if the food was hot enough and offered to reheat the food. R29 reported the foot was hot enough and did not want it reheated.<br><br>On 7/10/24 at 8:27 AM, Surveyor observed facility staff deliver R229 her breakfast tray and set her up to eat. R229 began eating independently.<br><br>Surveyor reviewed R229's POC (Point of Care) meal consumption record for the past 30 days. Documentation indicated average meal consumption 75-100%. Upon further review of documentation, Surveyor noted several meal intakes not recorded and inaccurate documentation. For example, 7/7/24 documentation indicated 3 entries entered at 11:56 AM - all marked 100%.<br><br>7/8/24 documentation indicated 3 entries entered at 6:18 PM: Refused, N/A and N/A.<br><br>On 7/10/24 at 9:11 AM, Surveyor spoke with Registered Nurse Unit Manager-K. Surveyor advised of observations and concerns R229 was not set up for meals and was unable to reach her tray to eat. In addition, the meal cart was delivered to the unit at 12:20 PM. R229's tray was placed on the counter at 12:50 PM and not delivered to the resident until 1:20 PM after Surveyor advised the nurse (1 hour after the cart arrived). Surveyor reviewed R229's meal intake documentation. RN UM-K confirmed 3 entries for a day would indicate 3 meals. RN UM-K stated Sometimes they keep the tickets in their pocket and enter it all at the end of their shift. Surveyor reviewed the 3 meal intake entries for 7/7/24 entered at 11:56 AM. Surveyor advised concern times entered were before meals were provided. Surveyor advised of concern meal intake documentation is lacking and/or not accurate.<br><br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 7/11/24 at 8:45 AM, Surveyor observed R229 lying on her back in bed with the head of bed elevated approximately 30 degrees. R229 was not positioned upright to eat. Her eyes were closed and her breakfast tray was on the bedside table on the right side of the bed, covered and untouched. The meal consisted of a fried egg, toast, an unopened milk carton and juice. Silverware on the napkin was not used. Surveyor observed urine discoloration on R229's sheet from mid calf to below her shoulders. Surveyor felt the area to be wet. Surveyor noted 2 blue incontinence bed pads on top of the sheet/urine discoloration positioned under her back and buttocks. Surveyor observed crumbs of food (popcorn) on the front of her gown.<br><br>On 7/11/24 at 9:10 AM, Surveyor observed R229 lying in the same position, on her back. R229 was not positioned upright to eat and her breakfast tray remained on the table next to the bed, covered/not touched or eaten. Surveyor observed the same urine discoloration on the sheet from mid calf to below her shoulders. R229 appeared to be sleeping with her eyes were closed and mouth open. Surveyor observed the same popcorn crumbs on the front of her gown.<br><br>On 7/11/24 at 12:25 PM, Surveyor observed R229 lying in the same position, on her back. Surveyor observed the same popcorn crumbs on the front of her gown and the same urine discoloration on the sheet from mid calf to below her shoulders.<br><br>On 7/11/24 at 12:33 PM, Surveyor observed the noon meal cart on the unit and staff were passing trays. Surveyor observed Certified Nursing Assistant (CNA)-H enter R229's room with her meal tray and leave the room [ROOM NUMBER] seconds later. Surveyor entered R229's room and observed her lunch tray was placed on the bedside table next to the right side of her bed. Surveyor noted R229 was in the same position, on her back with her eyes closed and mouth open. R229 was not positioned upright to eat and her meal tray was on the bedside table positioned on the right side of her bed, covered. Surveyor observed the same popcorn crumbs on the front of her gown and the same urine discoloration on the sheet.<br><br>On 7/11/24 at 12:46 PM, Surveyor spoke with CNA-H about R229. CNA-H reported she was not her aide today and has not provided any cares. Surveyor asked if R229 is able to feed herself. CNA-H replied Yes. Surveyor asked if there was a reason R229's tray was placed on the table next to her bed and she was not set up to eat. CNA-H stated: I did. I came in, raised the head of bed and moved the table in front of her, she pushed it away. That's what she does, she's more of a snacker. Surveyor advised CNA-H she wasn't in the room very long and confirmed she is saying she raised R229's bed, set up her tray and she pushed it away. CNA-H stated Yes I did.<br><br>Surveyor noted R229 was in the same position as previously observed with the same popcorn crumbs on the front of her gown.<br><br>On 7/11/24 at 12:55 PM, Surveyor asked RN UM-K to accompany Surveyor to R229's room. Surveyor advised of the above observations in detail including the times observed. Surveyor pulled up the sheet covering R229 to show RN UM-K the urine discoloration extending from mid calf to below R229's shoulders. RN UM-K asked Surveyor if she just noticed the wet sheets now. Surveyor advised RN UM-K the wet urine discoloration was first observed at 8:45 AM and has been present since that time (more than 4 hours).<br><br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 7/11/24 at 2:15 PM, Nursing Home Administrator (NHA)-A was advised of the above concerns. NHA-A reported she understood, adding We have identified a lot of areas we need to work on to improve going forward. (RN UM-K) has already came to me about this and we are addressing it with the CNA.<br><br>On 7/15/24 at 8:57 AM, Surveyor observed R229 lying in bed on her back with her head of bed elevated and her breakfast tray in front of her. R229 had consumed 100% of breakfast and reports feeling pretty good today.<br><br>On 7/15/24 at 9:14 AM, Surveyor advised Director of Nursing (DON)-B of the above concerns regarding R229 not provided meal set up and observations of the urine discoloration/wet sheet and not having been toileted, checked or changed for more than 4 hours. Surveyor reviewed concerns with R229's meal documentation. DON-B reported she understood, adding We're trying to improve things one at a time. I will be printing that off as a reference when we do education. No additional information was provided.<br><br>2.) R15 admitted to the facility on [DATE] and has diagnoses that include anal abscess, ulcerative rectosigmoiditis with fistula, morbid obesity, dependence on renal dialysis, Type 2 Diabetes Mellitus, asthma, cirrhosis of liver, Enterocolitis, Arteriovenous malformation of digestive system vessel, Pericardial Effusion, Heart Disease, anemia and Polyneuropathy.<br><br>R15's Quarterly MDS with an ARD of 2/10/24 documents: Self-Care. Shower/bathe self - The ability to bathe self, including washing, rinsing, and drying self: Partial/moderate assistance.<br><br>R15's Annual MDS with an ARD of 5/10/24 documents: Interview for Daily Preferences: How important is it to you to choose between a tub bath, shower, bed bath, or sponge bath - Somewhat important.<br><br>R15's Care Plan Focus dated 6/24/24 documents: The resident has an ADL self-care performance deficit and limited physical mobility r/t BKA (below knee amputation) and poor mobility. Interventions: Bathing: Physical Assist of 1 Reclining shower chair or Shower bed to be utilized on shower days.<br><br>On 7/8/24 at 2:21 PM R15 reported to Surveyor he has not had a shower or bath in 4 weeks.<br><br>R15's June 2024 Treatment Administration Record documents:<br><br>Skin Checks Weekly every day shift every Tuesday - Must open and document Skin Evaluation for each assessment (including no new areas found). -Start Date 4/30/24 D/C (discontinued) 7/1/24.<br><br>Weekly skin check by licensed nurse; Y = Skin Intact, N = Skin Not Intact. Complete weekly skin evaluation every day shift every Tuesday for skin observation -Start Date 6/11/24 - D/C 6/30/24.<br><br>R15's July 2024 TAR documents: Weekly Skin Check - completed by licensed nurse - Must open and document a new Evaluation (including no new areas found) every day shift every Tuesday 7/2/24.<br><br>Surveyor noted weekly skin checks for the month of June to present completed 6/20/24 (Thursday), 6/26/24 (Wednesday) and 6/30/24 (Sunday). There was no evidence skin checks were completed on R15's shower day.<br><br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Surveyor reviewed the CNA book on the [NAME] unit which R15 resides. R15's room is listed to receive a shower on Tuesday. The shower book includes sheet of paper titled Daily Shower Assignments and Skin Findings which documents:<br><br>All showers are to be documented in POC.<br><br>If refused, notify the assigned nurse, and document the bed bath if given in POC.<br><br>**A skin eval needs to be filled out for each shower given and any findings reported to the assigned nurse or management immediately.<br><br>Surveyor review of R15's POC charting for the past 30 days documents:<br><br>What type of bathing did resident receive? Surveyor noted a check mark under bed bath on 6/11 and 7/2/24. There was no check mark under refused for shower.<br><br>There was no other documentation in R15 progress notes or medical record that R15 refused his shower in the past 30 days.<br><br>On 7/10/24 at 3:00 PM, Surveyor asked for evidence R15 has received showers.<br><br>On 7/11/24 at 9:56 AM, Surveyor was provided R15's POC ADL bathing log for the past 30 days. Surveyor noted the same information as noted above (bed bath 6/11 and 7/2/24), and no documentation of refusal.<br><br>On 7/11/24 at 2:15 PM, NHA-A was advised of concern regarding R15's showers. No additional information was provided.<br><br>22692<br><br>On 7/15/24 the facilities policy titled Activities of Daily Living dated 10/24/22 was reviewed and documented: Care and services will be provided for bathing, dressing, grooming and oral care and eating to include meals and snacks. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming and personal and oral hygiene.<br><br>3.) R64 was admitted to the facility on [DATE] with diagnosis that included Neurocognitive disorder and Traumatic Brain Injury. R64's Quarterly Minimum Data Set (MDS) dated [DATE] was reviewed and documented that R64 is not understood and his cognition is severely impaired.<br><br>On 7/9/24 at 10:00 AM, R64 was observed in bed with both wrists contracted. R64's fingernails were very long and dirty.<br><br>On 7/10/24 at 11:00 AM, R64 was observed in bed with both wrists contracted. R64's fingernails were very long and dirty.<br><br>On 7/11/24 at 3:00 PM, R64 was observed in bed with both wrists contracted. R64's fingernails were very long and dirty.<br><br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 7/11/24, R64's documentation for bathing indicated he had a full bed bath on 7/10/24 and did not receive nail care at that time as his nails looked unchanged on 7/11/24.<br><br>On 7/10/24, R64's care plan for ADL's last dated 4/21/23 was reviewed and documented: self care deficit related to bilateral hand and upper extremity contractures. Personal hygiene physical assist of one. R64 has contractures. Keep clean to prevent breakdown.<br><br>On 7/15/24 at 10:30 AM, Director of Nursing (DON)-B was interviewed and indicated R64's nails should be trimmed once a week on bath day. Additional information was requested if available. None was provided as to why R64's fingernails were not cleaned and trimmed. |

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| F 0679<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide activities to meet all resident's needs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49011<br><br>Based on interview and record review, the facility did not provide an ongoing, individualized, and meaningful activities program designed to meet the residents interest and support their physical, mental and psychosocial well-being for 1 (R11) of 23 residents reviewed for activities.<br><br>* The facility failed to complete an assessment of activity goals for R11 and no plan of care related to activities was developed. R11 reported that they are bored, nothing to do but watch TV in room, R11 is bed bound and legally blind.<br><br>Findings include:<br><br>The Facility Policy titled Activities implemented 12/23/2022, documents (in part) .<br><br>Policy:<br><br>It is the policy of this facility to provide on ongoing program to support residents in their choice of activities based on their comprehensive assessment, care plan, and preferences. Facility-sponsored group, individual, and independent activities will be designed to meet the interests of each resident, as well as support their physical, mental, and psychosocial well-being. Activities will encourage both independence and interaction within the community .<br><br>Policy Explanation and Compliance Guidelines:<br><br>1. Each resident's interest and needs will be assessed on a routine basis. The assessment shall include, but is not limited to:<br><br>.b. Activity assessment to include resident's interest, preferences and needed adaptations .<br><br>2. Activities will be designed with the intent to:<br><br>a. Enhance the resident's sense of well-being, belonging, and usefulness.<br><br>b. Promote of enhance physical activity.<br><br>c. Promote or enhance cognition.<br><br>d. Promote or enhance emotional health.<br><br>e. Promote self-esteem, dignity, pleasure, comfort, education, creativity, success and independence.<br><br>f. Reflect resident's interests and age.<br><br>g. Reflect cultural and religious interests of the residents.<br><br>(continued on next page) |

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| F 0679<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | h. Reflect choices of the residents .<br><br>4. Activities may be conducted in different ways:<br><br>a. One-to-one programs.<br><br>b. Person appropriate-activities relevant to the specific needs, interests, culture, background, etc. for the resident they are developed for .<br><br>1.) R11 was admitted to the facility on [DATE]. R11 has diagnoses which include multiple sclerosis, fracture of unspecified part of neck of right femur, muscle weakness, unspecified dementia, neuromuscular dysfunction of bladder, and legal blindness.<br><br>R11's 5 Day Minimum Data Set (MDS) with an assessment reference date of 6/4/2024 indicated R11 had a Brief Interview for Mental Status score of 06 (severe cognitive impairment). R11 is responsible for self, however, has a Power of Attorney for Healthcare set up. The MDS reads that for vision R11 is highly impaired. For rejection of care, the behavior was not exhibited. R11's MDS showed that upper extremities have no impairment and lower extremities have impairment on one side. R11's MDS is coded as frequently in pain and pain interferes with therapy and day to day activities occasionally. Section F of the MDS documented that it is somewhat important to R11 to do your favorite activities.<br><br>On 07/08/24, at 11:11 AM, Surveyor interviewed R11 and asked about activities. R11 responded there is nothing to do but watch TV, nothing is done in R11's room. Surveyor notes R11 has physician orders to remain in bed and is legally blind.<br><br>On 07/11/24, at 09:23 AM , Surveyor spoke with Care Coordinator (CC)-N and asked what activities there are for bed bound residents. CC-N responded that activity staff go around with mobile carts, a couple times a month, that have puzzles, books, games, and crafts. Tomorrow the library cart will go around. Surveyor asked what is available for a legally blind resident to which CC-N replied activity staff can sit with them for one on ones. CC-N stated that R11 is not interested in group activities and activity staff will offer one on one services and mobile library tomorrow.<br><br>On 07/11/24, at 01:06 PM, Surveyor followed up with CC-N and asked if any books in the library are audio? CC-N stated that none are audio, however if a resident wants a book read to them, activities staff can schedule a time for readings. Surveyor then asked when was the last time R11 partook of services? CC-N does not know, staff would chart if R11 partook in activities, however they do not annotate if offered and refused.<br><br>Surveyor notes only one activity progress note was found from 6/6/2024, at 14:15, Activities Note: Guest attended and participated in today's BINGO activity. Will continue to encourage guest to participate in future activities. Surveyor notes this was before physician order for bed rest was entered.<br><br>Surveyor reviewed R11's plan of care and there is no activity information included. Surveyor notes that this is not individualized to provide meaningful activities for R11.<br><br>(continued on next page) |

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|---|---|---|---|
| | 525730 | A. Building<br>B. Wing | 07/15/2024 |

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| F 0679<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 07/11/24, at 01:57 PM, Surveyor shared concerns about the lack of activity assessment and inclusion for R11 in a meeting with Facility consultants. They stated they would take a look and get back to Surveyor.<br><br>The Facility provided Activity Evaluation forms to Surveyor. Instructions are to complete within 4 days of admission, quarterly, annual and significant change assessments. Please attempt to obtain as much information as possible from the resident's medical records prior to meeting with the resident to avoid asking for duplicate information. The effective dates for the forms are 6/21/2024 (21 days after admission), 6/25/2024, and 7/1/2024, all of which have nothing completed on them. Surveyor notes no assessment completed to understand R11's activity preferences or goals.<br><br>On 07/11/24, at 03:18 PM, during the end of day meeting with facility, Surveyor shared that activity assessment was not done or activity plan of care created for R11.<br><br>No additional information was provided as to why the facility did not provide an ongoing, individualized, and meaningful activities program designed to meet R11's interest and support R11's physical, mental and psychosocial well-being. |

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| F 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49435<br><br>Based on interview and record review, the facility did not ensure 1 (R35) of 23 residents experiencing a change of condition received treatment and care in accordance with professional standards of practice.<br><br>*R35 went to the emergency roiagnom on [DATE]. R35 was prescribed Prednisone for neck inflammation with no end date. R35 received a high dose of Prednisone from 9/12/23 through 9/29/2023 when the Provider ordered a Prednisone taper. R35 was hospitalized on [DATE]. Hospital documentation indicated R35 might have an element of adrenal insufficiency considering [R35] was on high dose of Prednisone for 2 to 3 weeks.<br><br>R35 had a history of recurrent Urinary Tract Infections (UTI) and sepsis. On 10/1/2023 and 10/2/2023, R35 experienced low blood pressure readings. No provider was notified of R35's low blood pressures. R35 had an active order for Midodrine (a medication given to help low blood pressures). Midodrine was not given as ordered on 10/1/2023 and 10/2/2023. A provider was not notified of the missing Midodrine administrations. On 10/3/2023, Nurse Practitioner (NP)-HH documented R35 as being unstable and noted that R35 had low blood pressures that NP-HH was not contacted about. NP-HH ordered R35 be sent to the emergency room (ER). On 10/3/2023, R35 was admitted to the Intensive Care Unit (ICU) and was hospitalized with Sepsis and UTI.<br><br>The facility failure to identify a change in condition and notify a provider timely, created a finding of immediate jeopardy that began on 10/1/2023. Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B were notified of the immediate jeopardy on 7/11/2024 at 12:31 PM. The immediate jeopardy was removed on 7/11/2024, however the deficient practice continues at a scope/severity of D (potential for harm/isolated).<br><br>Findings include:<br><br>The facility policy, entitled Notification of Changes, dated 10/24/2023, documents, in part: The purpose of this policy is to ensure the facility promptly informs the resident, consults the resident's physician and notifies, consistent with his or her authority, the resident's representative when there is a change requiring notification . The facility must inform the resident, consult with the resident's physician . when there is a change requiring such notification . Circumstances requiring notification include: . 2. Significant change in the resident's physical .status. This may include: Life threatening conditions or clinical complications.<br><br>The facility policy, entitled Non-Controlled Medication Orders, dated 1/2023, documents, in part: Medications are administered only upon the receipt of a clear, complete and signed order by a person lawfully authorized to prescribe .<br><br>Medication orders include the following specifics: Resident's Name. Date. Name of medication. Strength of medication . Dose and dosage form. Time or frequency of administration. Route of administration. Quantity or duration (length) of therapy, when applicable-If not specified by prescriber on a new order, the duration may be limited by automatic stop order policy .<br><br>(continued on next page) |

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| Medical Suites at Oak Creek (the) | 2700 Honadel Boulevard<br>Oak Creek, WI 53154 |

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| F 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Any dose or order that appears inappropriate, considering the resident's age, condition, allergies or diagnosis, is verified by nursing with the prescriber .<br><br>Written transfer orders (sent from a hospital or other health care facility) .If the order is unsigned or signed by another prescriber . the receiving nurse verifies the order with the current attending prescriber before medications are administered. The nurse documents verification on the admission order record by entering the time, date and signature .The nurse who transcribes the orders to the physician order sheet and/or MAR (Medication Administration Record) documents on the admission form the date, the time and by whom the orders were noted . Orders are transmitted to the pharmacy with any additional information required for new admission .<br><br>Complete documentation by clarifying orders as necessary.<br><br>R35 was admitted to the facility on [DATE] and has diagnoses that include Multiple Sclerosis, Hemiplegia/Hemiparesis following a stroke, Hydronephrosis, Neurogenic bladder, Urinary retention, and Hypotension.<br><br>R35's Quarterly Minimum Data Set (MDS) assessment dated [DATE] documents that R35 is usually understood and understands. R35 is cognitively intact.<br><br>R35's was hospitalized on [DATE] prior to R35's admission to the facility. Hospital Discharge paperwork dated 8/9/2023, documents the following discharge diagnoses: Sepsis, UTI, left nephrolithiasis (kidney stone) with hydronephrosis (excess fluid in a kidney due to back up of urine).<br><br>R35 was admitted to the hospital on 8/10/2023 due to a new onset of weakness that occurred at the facility. R35 was hospitalized from 8/10/2023 through 8/12/2023. R35's Hospital Discharge paperwork, dated 8/12/2023, documents the following discharge diagnoses: complicated UTI, Suspected sepsis, and transient hypotension. R35 returned to the facility on [DATE].<br><br>R35's progress note, dated 8/31/2023 at 10:43 AM, NP-HH documents: review [R35's] bilateral renal ultrasound results. [R35] noted to have mild hydronephrosis . Labs also reviewed showing 25% worsening GFR (a blood test that checks how well your kidneys are working) over the past 7-10 days . [NP-HH] decided to have [R35] sent to [Emergency Department] for [evaluation] and [treatment].<br><br>R35 was admitted to the hospital from 8/31/2023 through 9/7/2023. R35's Hospital Discharge paperwork dated 9/7/2023 documents the following discharge diagnoses: Renal Insufficiency, Complicated UTI, and C-diff (a germ that causes diarrhea and inflammation of the colon). R35 returned to the facility on [DATE].<br><br>Surveyor notes from 8/2/2023 through 9/7/2023, R35 had 3 admissions with the diagnosis of UTI, 2 admissions with the diagnosis of Sepsis and a documented history of hypotension. Surveyor notes R35 did not have a care plan addressing R35's risk for infection due to recurrent UTI's with Sepsis. Surveyor notes R35 did not have a care plan addressing R35's diagnosis of hypotension.<br><br>On 7/10/2024 at 10:09 AM, Surveyor interviewed Director of Nursing (DON)-B. Surveyor asked if DON-B would expect staff to create a care plan with a diagnosis of recurrent UTIs with sepsis. DON-B indicated that a resident should have a care plan addressing the recurrent infections. Surveyor asked if DON-B would expect staff to create a care plan with a diagnosis of Hypotension. DON-B stated Yes.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | R35's MD order with a start date of 9/7/2023, documents: Midodrine oral tablet 5mg (milligrams). Give one tablet by mouth before meals for hypotension. Midodrine is used to treat low blood pressure. It works by stimulating nerve endings in blood vessels, causing the blood vessels to tighten and, thus, increasing blood pressure.<br><br>Surveyor notes the Midodrine order did not have any blood pressure parameters documented within the MD order.<br><br>On 9/12/2023 at 2:45 PM, NP-HH documents in a progress note: [R35] is seen and examined today . [R35] is reporting severe neck pain . [R35] stated [R35] does not feel good and requesting to be transferred to the hospital.<br><br>R35 was sent to theER on [DATE] and returned to the facility the same day. R35 was treated for neck pain. R35's Hospital After Visit Summary (AVS) dated 9/12/2023, documents R35 should start taking Prednisone 20mg take 2 tablets by mouth daily.<br><br>R35's MD (Medical Doctor) order with a start date of 9/13/2023, documents Prednisone 20mg. Give 2 tablets by mouth one time a day.<br><br>Surveyor notes neither the hospital AVS nor the facility's MD orders had a stop date or tapered dosing for Prednisone administration.<br><br>R35's progress note dated 9/19/2023 at 6:56 PM, NP-HH documents: [R35] has new hematuria (blood in urine). [Urinary analysis] ordered and suggestive of UTI . Plan to wait for culture and sensitivity and treat as appropriate. WBC (white blood cell count) 14. (According to the laboratory report from the facility's laboratory report, a normal WBC count is between 4.8 and 10.8)<br><br>R35's MD order with a start date of 9/20/2023, documents Cipro (an antibiotic medication used to treat UTI) 500mg. Give 1 tablet by mouth two times a day for a UTI for 5 days.<br><br>Surveyor notes R35 received Cipro from 9/20/2023 through 9/25/2023.<br><br>R35's WBC count on 9/25/2023 was 10.5.<br><br>R35's progress note dated 9/29/2023 at 2:17 PM, documents: New orders received from [MD]-C for Prednisone taper.<br><br>R35's MD order with a start date of 9/30/2023, documents Prednisone 10mg. Give 3 tablets by mouth one time a day for 5 days. Give 2 tablets by mouth one time a day for 5 days. Give 1 tablet by mouth one time a day for 5 days.<br><br>Surveyor noted that R35 had received 40mgs of Prednisone daily from 9/12/2023 through 9/29/2023.<br><br>On 7/10/2024 at 9:20 AM, Surveyor interviewed Medical Doctor (MD)-C. Surveyor asked when R35's Prednisone should have been stopped. MD-C stated that Prednisone dosage is very individualized. MD-C stated it could be 5, 7, 10 days or longer. Surveyor asked if R35 was supposed to receive Prednisone for 17 days. MD-C stated that MD-C did not have an answer.<br><br>(continued on next page) |

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| NAME OF PROVIDER OR SUPPLIER Medical Suites at Oak Creek (the) | | STREET ADDRESS, CITY, STATE, ZIP CODE 2700 Honadel Boulevard Oak Creek, WI 53154 | |

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| F 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | On 7/10/2024 at 10:09 AM, Surveyor interviewed DON-B regarding R35's Prednisone order with no stop date or tapered dosing. Surveyor asked what the process for entering readmission orders. DON-B stated that floor staff would take and enter the orders, a unit manager would audit the admission orders and then the Pharmacist would review the orders. DON-B stated this process was not followed when R35 was readmitted after the 9/12/2023 ER visit. DON-B indicated that the stop date or tapered dosing was missed.<br><br>R35's Medication Administration Record (MAR) documents a Blood pressure (BP) before each administration of Midodrine.<br><br>R35's BPs on 9/28/2023 were documented as 106/65, 108/72, and 110/65.<br><br>R35's BPs on 9/29/2023 were documented as 114/68, 110/64, and 124/62.<br><br>R35's MD order with a start date of 9/30/2023, documents: STAT [immediately] CBC (complete blood count) on 9/30/2023 (must call [Lab] in the morning to place STAT order) one time only for hematuria.<br><br>R35's BPs on 9/30/2023 were documented as 111/60, 111/60 and 108/58.<br><br>On 10/1/2023 at 7:30 AM, R35's BP was documented as 152/90. Midodrine was documented as given on the MAR.<br><br>On 10/1/2023 at 11:30 AM, R35's BP was not documented. Midodrine was documented as code 9 on the MAR. The code 9 on the MAR indicates, other see notes. An eMAR (Medication administration note) documented at 2:59 PM documents: Too late to give.<br><br>Surveyor notes R35 did not have a BP reading documented and a provider was not notified when R35 did not receive the afternoon dose of Midodrine.<br><br>On 10/1/2023 at 4:30 PM, R35's BP was documented as 78/50, Pulse 71. Temperature 97.2. Midodrine was documented as code 11 on the MAR. The code 11 on the MAR indicates, Vitals outside parameters.<br><br>Surveyor notes the facility did not consult with a physician about R35's low blood pressure and the fact that R35 did not receive the evening dose of Midodrine.<br><br>On 10/2/2023 at 7:30 AM, R35's BP was not documented. Midodrine was documented as code 2 on the MAR. The code 2 on the MAR indicates, Drug refused.<br><br>Surveyor notes R35 did not have a BP reading documented and a provider was not notified when R35 refused the morning dose of Midodrine.<br><br>On 10/2/2023 at 11:22, R35's BP was documented as 88/56, Pulse 98, Temperature 98. Midodrine was documented as code 2 on the MAR.<br><br>Surveyor notes a provider was not consulted about R35's low blood pressure and the fact tht R35 had refused the afternoon dose of Midodrine.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | On 10/2/2023 at 4:30 PM, R35's BP was not documented. Midodrine was documented as code 2 on the MAR.<br><br>Surveyor notes R35 did not have a BP reading documented and a provider was not consulted with when R35 refused the evening dose of Midodrine.<br><br>R35's progress note dated, 10/2/2023 at 3:55 PM, NP-HH documents: Labs from 9/30/2023 reviewed. Orders placed .<br><br>Surveyor notes R35's WBC results from 9/30/2023 were 13.2. Surveyor notes R35's WBC count increased from 10.5 on 9/25/2023.<br><br>R35's MD order with a start date of 10/2/2023 documents, in part: STAT CBC . for recurrent elevated WBC .<br><br>On 10/3/2023 at 0730, R35's BP was documented as 96/54. Pulse 73. No Temperature was documented<br><br>R35's progress note, dated 10/3/2023 at 10:36 AM, NP-HH documents: Labs from 10/2/23 reviewed .<br><br>Surveyor notes R35's WBC results from 10/2/2023 were 16.3. Surveyor notes R35's WBC count increased from 13.2 on 9/30/2023.<br><br>R35's progress note, dated 10/3/2023 at 11:50 AM, documents, in part: The change in condition reported on this evaluation are: Abnormal vital signs . Resident request to be sent to the ER.<br><br>R35's progress note, dated 10/3/2023 at 12:32 PM, documents: [R35] is being sent to the [local ER] per resident request for hypotension, elevated WBC's, tachycardia. Orders to send resident to ER [placed by] [NP-HH] .<br><br>R35's late-entry progress note, dated 10/3/2023 at 9:10 PM, NP-HH documents, in part: [R35] is seen and examined today in [R35's] room. [R35] is diaphoretic, stating, 'I do not feel good,' unable to give any specific symptoms. With assessment tachycardia noted, soft BP's. After review vitals from weekend noted [R35] has been hypotensive with low [systolic] BPs to 70-80s, no provider was notified. Also noted that [R35] was continued on prednisone which was ordered only for short term at theER on ,d+[DATE]; noted on 9/30 and addressed with MD who [ordered] titration dose Labs reviewed, noted elevated WBCs again but [R35] is on prednisone Due to [R35's] presentation and being unstable, concerns of possibility of sepsis and some degree of adrenal insufficiency patient is sent to ER for evaluation.<br><br>R35's Hospital History and Physical dated 10/3/2023 documents, in part: [R35] presented to the ED on 10/3/2023 with complaints of hypotension and tachycardia which has been ongoing for the past 3 days associated with intermittent fevers . On arrival to the emergency department, [R35] had a temperature of 100. 1 . [R35] was hypotensive with [systolic] BP in the 70's to 80's . [R35] was started on sepsis protocol . WBC result from 10/3/2023 at 12:55 PM was 20.1 .[R35] was admitted to the ICU for further management . Assessment/Plan: Septic shock secondary to [UTI] . There might be element of adrenal insufficiency also considering she was on high dose of prednisone for 2 to 3 weeks . Chronic hypotension: continue Midodrine .<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | R35 was admitted to the ICU on 10/3/2023 and was hospitalized until 10/11/2023 when R35 returned to the facility.<br><br>On 7/9/2024 at 11:15 AM, DON-B informed surveyor that NP-HH is no longer with the same medical group and does not come to the facility. DON-B provided Surveyor with MD-C's phone number and stated MD-C could answer questions regarding R35.<br><br>On 7/10/24 at 9:20 AM. Surveyor interviewed MD-C regarding R35's change in condition and hospitalization on [DATE]. Surveyor asked when MD-C would expect to be notified of a low blood pressure reading. MD-C stated if a systolic blood pressure was less than 90, MD-C would expect a notification. Surveyor informed MD-C of the low blood pressure readings (78/50 and 88/56) R35 experienced days prior to being admitted to the hospital with sepsis. MD-C stated he would absolutely expect a call with R35's documented low blood pressures. Surveyor asked if MD-C would expect a notification alerting MD-C that R35 did not take multiple doses of Midodrine. MD-C stated, knowing the BPs (78/50 and 88/56), staff should have called with the missing doses of Midodrine.<br><br>On 7/10/2024 at 10:09 AM, Surveyor interviewed DON-B. Surveyor asked what the expectation is for staff to notify a Provider if a resident is experiencing low blood pressures. DON-B stated that staff should notify the provider immediately based on the severity of symptoms. Surveyor reviewed R35's low blood pressures (78/50 and 88/56) with DON-B. DON-B stated staff should have notified the provider. Surveyor asked if staff should have notified the provider after R35 was not given multiple doses of Midodrine on 10/1/2023 and 10/2/2023. DON-B stated that DON-B would expect staff to call for the missed doses of Midodrine.<br><br>The failure to identify a change of condition and to consult with a provider timely created a finding of Immediate Jeopardy. The facility removed the jeopardy on 7/11/2024 when it had completed the following:<br><br>RESIDENT DIRECTLY INVOLVED:<br><br>1) [R35] was evaluated for any noted change in condition to include evaluation of vital signs on 7/11/2024.<br><br>2) [R35] had [R35's] medications reviewed to ensure provider call parameters are in place on 7/11/2024.<br><br>ACTIONS FOR POTENTIALLY AFFECTED RESIDENTS:<br><br>1) Residents residing in the facility were evaluated for any noted change in condition to include evaluation of vital signs on 7/11/2024.<br><br>EDUCATION:<br><br>1) Nursing staff will be educated on the facility notification of change policy to include provider notification and RN assessment and will complete a test to validate competency.<br><br>2) All staff will be educated on proper reporting of any noted changes in condition.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | 3) Licensed nursing staff will be educated on appropriate documentation for changes in condition.<br><br>4) Licensed nursing staff will be educated on the facility policy regarding medication reconciliation and administration.<br><br>Licensed nursing staff and CNAs; including agency will receive the above re-education by 7/15/2024 or prior to next scheduled shift.<br><br>MONITORING:<br><br>1) A daily audit during clinical standup will be conducted to monitor for any changes in condition to include vital signs. This audit will be conducted for one month.<br><br>Results of audits/monitoring will be provided to QAPI, which may further modify audit expectations based on results of initial audits.<br><br>1) AD HOC QAPI meeting - The QAPI Committee (composed of but not limited to; Administrator, Director or Nursing, Assisted Director of Nursing, and Medical Director) to be held by 5/15/2024 to review the alleged deficiency, discuss above action items and planned audits related to findings. |

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| F 0686<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49011<br><br>Based on observation, interview, and record review the facility did not ensure that residents with pressure injuries received necessary treatment and services consistent with professional standards of practice to promote healing and prevent new pressure injuries from developing for 3 (R11) of 8 residents reviewed for pressure injuries.<br><br>* R11 developed a stage 4 pressure injury to the sacrum and a stage 3 to the left buttock. The left buttock was deemed heeled [DATE]. The Facility knew the risk for pressure ulcers was present due to R11 having a femur fracture and other related comorbidities. The Facility failed to take immediate action by creating a plan of care to include comprehensive interventions for prevention of pressure ulcers. The resident did not receive an air mattress until 12 days after admission and 7 days after development of pressure ulcer. A Braden Scale Evaluation was not completed until ,d+[DATE] when the pressure ulcer was discovered, and the score was 11 indicating high risk.<br><br>These actions created the findings of the IJ starting [DATE]. The facility was notified of the IJ on [DATE], at 12:27 PM. The IJ was removed on [DATE] when the facility completed the following:<br><br>Related to R11:<br><br>-A comprehensive wound evaluation completed on 6/ ,d+[DATE]<br><br>-Braden completed on [DATE]<br><br>-New treatment orders obtained [DATE]<br><br>-Foley initiated to aid in healing on [DATE]<br><br>-Care plan initiated on [DATE] including LAL mattress<br><br>-COC completed [DATE] with MD notification<br><br>-Clinical leadership and RD met, reviewed and revised CP on [DATE]<br><br>Facility wide:<br><br>-A full house skin sweep was completed on [DATE].<br><br>-Braden's re-evaluated.<br><br>-A full-time wound nurse has been hired and started on [DATE].<br><br>-Licensed nursing staff education on skin and wound policy to include what to do when a new wound is found, weekly skin check, what to do if there is a change in a wound and validated with a test initiated on [DATE].<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | -Certified nursing assistants' education on skin and wound policy to include what to do when a new wound is found, how to communicate changes in conditions and validated with a test initiated on [DATE].<br><br>-Risk meetings were initiated on [DATE]. Quality monitor introduction on [DATE].<br><br>-CMS Meta Star training is scheduled for [DATE].<br><br>-An audit of weekly skin will be completed during clinical stand up.<br><br>* R64's bed was observed to not at the correct setting. R64 had a stage III pressure injury.<br><br>* R217 obtained a pressure injury that were not documented or measured until [DATE] and [DATE].<br><br>Findings include:<br><br>The Facility Policy titled Pressure Injury Prevention and Management implemented [DATE], documents (in part) .<br><br>Policy Explanation and Compliance Guidelines:<br><br>.3. Evaluation of Pressure Injury Risk<br><br>a. Licensed nurses will conduct a pressure injury risk evaluation, using the Braden, on all residents upon admission/re-admission, weekly x four weeks, then quarterly or whenever the resident's condition changes significantly.<br><br>b. The tool will be used in conjunction with other risk factors not captured by the risk evaluation tool. Examples of risk factors include, but are not limited to:<br><br>i. Impaired/deceased mobility and deceased functional ability; .<br><br>vii. Exposure of skin to urinary and fecal incontinence; .<br><br>4. Interventions for Prevention and to Promote Healing<br><br>a. After completing a thorough assessment/evaluation, the interdisciplinary team shall develop a relevant care plan that includes measurable goals for prevention and management of pressure injuries with appropriate interventions.<br><br>b. Interventions will be based on specific factors identified in the risk assessment, skin assessment, and any pressure injury assessment .<br><br>c. Evidence-based interventions for prevention will be implemented for all residents who are assessed at risk or who have a pressure injury present. Basic or routine interventions could include, but are not limited to:<br><br>i. Redistribute pressure (such as repositioning, protecting and/or offloading heels, etc.);<br><br>(continued on next page) |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0686<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | ii. Minimize exposure to moisture and keep skin clean, especially of fecal contamination;<br><br>iii. Provide appropriate, pressure-redistributing, support surfaces; .<br><br>e. The goals and preferences of the resident and/or authorized representative will be included in the plan of care.<br><br>f. Interventions will be documented in the care plan and communicated to all relevant staff.<br><br>g. Compliance with interventions will be documented in the weekly summary charting .<br><br>1.) R11 was admitted to the facility on [DATE]. R11 has diagnoses which include multiple sclerosis, fracture of unspecified part of neck of right femur, muscle weakness, unspecified dementia, neuromuscular dysfunction of bladder, and legal blindness.<br><br>R11's 5 Day Minimum Data Set (MDS) with an assessment reference date of [DATE] indicated R11 had a Brief Interview for Mental Status score of 06 (severe cognitive impairment). R11 is responsible for self, however, has a Power of Attorney for Healthcare set up. The MDS reads that for vision R11 is highly impaired. For rejection of care, the behavior was not exhibited. R11's MDS showed that upper extremities have no impairment and lower extremities have impairment on one side. The MDS has no unhealed pressure ulcers/injuries noted, however, is coded as a risk for pressure ulcer/injury. R11 is dependent for toileting, needs substantial/maximal assistance for shower/bathe, is partial/moderate assist for upper body dressing and is dependent for lower body dressing. R11's MDS is coded as frequently in pain and pain interferes with therapy and day to day activities occasionally.<br><br>Braden Scale Evaluations were completed first on [DATE] with a score of 11 indicating high risk for pressure ulcer development and again on [DATE] with a score of 13 indicating moderate risk of pressure ulcer development. Surveyor notes the first was done 5 days after admission and the same day the pressure ulcers were identified.<br><br>R11 has a Focus on plan of care at admission which reads, The resident is at risk for alteration in skin integrity.<br><br>The Goal is The resident will remain free of new skin impairment through the review date with a target date of [DATE].<br><br>Interventions at admission include:<br><br>o Apply barrier cream per facility protocol to help protect skin from excess moisture.<br><br>Created on: [DATE]<br><br>o Encourage/assist with turning and repositioning every ,d+[DATE] hours<br><br>Created on: [DATE]<br><br>o Provide skin/wound treatments as ordered<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Created on: [DATE]<br><br>R11 had a Focus on plan of care added when the pressure injury was discovered which reads:<br><br>o The resident has potential/actual impairment to skin integrity of the:<br><br>Sacrum - Unstageable pressure ulcer<br><br>L buttock - Unstageable pressure ulcer<br><br>Bridge of nose - Biopsy surgical site<br><br>Created on: [DATE]<br><br>Revision on: [DATE]<br><br>Interventions include (in part):<br><br>o Air Mattress, Setting:290<br><br>Created on: [DATE]<br><br>Revision on: [DATE]<br><br>o Braden upon admission, weekly x 4 weeks, quarterly, and as needed.<br><br>Created on: [DATE]<br><br>o Cushion to wheelchair<br><br>Created on: [DATE]<br><br>o Encourage good nutrition and hydration in order to promote healthier skin.<br><br>Created on: [DATE]<br><br>o Low air loss mattress<br><br>Created on: [DATE]<br><br>o Turn/Reposition approx. every ,d+[DATE] hours<br><br>Created on: [DATE]<br><br>o Use a draw sheet or lifting device to move resident.<br><br>Created on: [DATE]<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | The admission Skin Integrity Assessment done on [DATE] shows the only skin impairment is a post biopsy on bridge of R11's nose.<br><br>New Initial Wound Assessments were completed by Registered Nurse (RN)-K on [DATE] and two pressure ulcers were identified. One on the sacrum, unstageable, and one on the left buttock, stage 3, the left buttock was deemed healed on [DATE]. Surveyor notes these were identified five days after R11 admitted to the Facility.<br><br>The first charting of the pressure ulcers on [DATE] measured:<br><br>left buttock: 4.0cm, 5.0cm, 0.1cm depth deemed stage 3 with 100% granulation<br><br>sacrum: 6.0cm, 2.5cm, n/a depth deemed unstageable with 25% granulation and 75% slough<br><br>Surveyor notes a SBAR Communication Form and Progress Note form was completed on [DATE] for R11's physician. It was identified that things that make this condition worse are impaired mobility, urinary incontinence and refusal of repositioning/getting out of bed. RN-K added an observation of the resident revealing unstageable pressure ulcer to sacrum and stage 3 pressure ulcer to L buttocks with surrounding purple DTI to peri wound. Patient has impaired mobility r/t hip fx. Patient is reluctant to reposition d/t pain. Pre-medication with oxycodone required for wound evaluation. Patient incontinent of bowel and bladder, hx including neurogenic bladder. Increased amount of fluid intake resulting in heavy urination and multiple linen changes today. Patient refusing to get out of bed and repositioning d/t pain with hip fx.<br><br>Surveyor notes no plan of care interventions were put in place for refusals before or after wounds discovered.<br><br>Assessment by Tissue Analytics wound doctor on [DATE]:<br><br>left buttock: 2.03cm, 1.58cm, 0.10cm depth deemed unstageable with slough ,d+[DATE]%<br><br>sacrum: 3.31cm, 2.69cm, 0.10cm depth deemed unstageable with slough ,d+[DATE]% and eschar , d+[DATE]%<br><br>The sacrum was debrided at this time and post debridement measured: 3.21cm, 3.69cm, 2.6cm depth deemed unstageable with slough ,d+[DATE]%<br><br>Physician Orders post assessment:<br><br>-Encourage repositioning Q 2hrs: Document refusal every 2 hours for Wound to Sacrum Start Date: [DATE]<br><br>-Complete bed rest d/t sacral wound induration. Encourage/assist with aggressive side-to-side offloading q , d+[DATE] hours. Float heels on ,d+[DATE] pillows (unable to use Prevalon boots d/t abduction wedge). Document resistance/refusals of repositioning in progress note(s) every shift for wound care Start Date: [DATE], discontinue date: [DATE]<br><br>Surveyor notes no orders for abduction wedge usage found.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | The wound doctor recommended a pressure redistribution mattress and wheelchair cushion for R11 and to offload heels. On [DATE] an intervention was added to the plan of care for the mattress. It had been added [DATE] for the wheelchair pressure redistribution devices. A Physician Order was entered [DATE] that addressed floating of heels. Surveyor notes all of these were put in place after the discovery of the wound and 2 of them not until after the wound doctor saw R11.<br><br>Assessment by Tissue Analytics wound doctor on [DATE]:<br><br>left buttock: 0.16cm, 0.42cm, 0.10cm depth deemed stage 3 with granulation ,d+[DATE]% and slough , d+[DATE]%<br><br>sacrum: 3.88cm. 2.54cm, 2.2cm depth deemed unstageable with slough ,d+[DATE]% and eschar , d+[DATE]%<br><br>The sacrum was debrided at this time and post debridement measured: 3.21cm, 3.69cm, 2.6cm depth deemed unstageable with slough ,d+[DATE]%<br><br>Surveyor notes that on [DATE] a Risk/Benefit Record Tool form was completed by the Facility related to R11 refusing repositioning. This documents that R11 was verbally educated that it is important for you to allow staff to reposition you. It will help with wound healing. Updates are notated to have been made to the physician and care plan. Surveyor notes no plan of care was developed for refusals of care. Surveyor notes this was done 20 days after admission and 15 days after R11 was discovered to have a pressure injury<br><br>Assessment by Tissue Analytics wound doctor on [DATE]:<br><br>no left buttock assessment<br><br>sacrum: 4.51cm, 2.55cm, 2.5cm depth deemed stage 4 with granulation of ,d+[DATE]% and slough , d+[DATE]%<br><br>negative pressure wound therapy started<br><br>The [DATE] Facility Wound Assessment details report for L Buttock shows healed and 100% intact skin.<br><br>Assessment by Tissue Analytics wound doctor on [DATE]:<br><br>sacrum: 4.33cm, 2.23cm, 1.0cm depth deemed stage 4 with granulation of ,d+[DATE]% and slough , d+[DATE]%<br><br>On [DATE], at 10:34am, Surveyor observed wound care with Registered Wound Care Nurse (RWCN)-G. The sacrum wound measured 3.8cm, 1.7cm, 1.1cm deep with undermining from 7 to 12o'clock and 1.4cm at 9o'clock. The wound was 10% slough and 90% granulation per RWCN-G.<br><br>0n [DATE], during wound care, Surveyor asked RWCN-G why this wound developed, and the response was that noncompliance started the wound before RWCN-G started with the facility.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | On [DATE], at 08:22 AM, Surveyor spoke with RWCN-G and asked again about the wounds starting and was told that the buttock was small and superficial. For the sacrum the nurse was not here but would attribute wound to pressure, incontinence, and pain with movement. RWCN-G's expectation for someone who is bed bound would be to reposition and off load and have incontinence measures to prevent skin breakdown. Have pain management in place and have an alternating pressure mattress.<br><br>On [DATE], at 01:52 PM, Surveyor spoke with the Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B who stated they cannot speak of the incident prior to taking over. R11's admission on [DATE] was a transition time. The Facility has since completed education and skin sweeps. R11 wounds were identified on ,d+[DATE], the last skin sweep on [DATE] was a full house where they identified issues and moved forward to correct. The morning meeting process was revamped for more skin issue regulation. They allege compliance for skin issues was reached [DATE].<br><br>Surveyor notes that the Facility knew the risk for pressure ulcers was present due to R11 having a femur fracture. The Facility failed to take immediate action by creating a plan of care to include comprehensive interventions for prevention of pressure ulcers. The resident did not receive an air mattress until 12 days after admission and 7 days after development of pressure ulcers. A Braden Scale evaluation was not completed until ,d+[DATE] when the pressure ulcer was discovered, and the score was 11 indicating high risk. These actions created the findings of the IJ starting [DATE].<br><br>22692<br><br>2.) R64 was admitted to the facility on [DATE] with diagnosis that included Peripheral Vascular Disease and Traumatic Brain Injury. R64's Quarterly Minimum Data Set (MDS) dated [DATE] was reviewed and documented that R64 is not understood and his cognition is severely impaired. R64's MDs also indicated he had 3 stage 3 pressure injuries at the time of the MDS<br><br>On [DATE] at 11:17 AM, R64 was observed in bed with his air mattress set at 660 pounds.<br><br>On [DATE] at 2:15 PM, R64 was observed in bed with his air mattress set at 660 pounds.<br><br>On [DATE] at 8:49 AM, R64 was observed in bed with his air mattress set at 660 pounds.<br><br>On [DATE] at 12:45 PM, R64 was observed in bed with his air mattress set at 660 pounds. Wound Registered Nurse (WRN)-G completed treatment to both of R64's Stage 3 pressure injuries on his right wrist and left arm. After WRN-G completed the treatment she was interviewed as to why R64's bed was set to 660 pounds when his last weight was 123.8 pounds. WRN-G indicated the Certified Nursing Assistant's (CNA's) probably forgot to turn it to the correct setting after doing cares. The Surveyor indicated it had been consistently at that setting for 2 days of observations. WRN-G then changed the air mattress setting to 150 pounds.<br><br>On [DATE] at 12:45, R64 was observed to have 2 stage 3 pressure injuries to his left inner forearm measuring 2 centimeters (CM) long by 1.4 CM wide by 0.1 CM deep and to his right wrist measuring 0.8 CM long by 1.1 CM wide by 0.1 CM deep. This remained essentially unchanged from previous weeks measurements.<br><br>On [DATE], R64's weights were reviewed and documented his last weight on [DATE] was 123.8 pounds.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | On [DATE], R64's current care plan for potential for impairment of skin integrity dated [DATE] was reviewed and documented: Air mattress check function daily. Settings 180 pounds.<br><br>On [DATE] at 3:00 PM, Administrator-A and Director of Nurses-B were made aware of the above findings. Additional information was requested if available. None was provided as to why R64's bed was not at the correct setting.<br><br>38146<br><br>3.) R217 admitted to the facility on [DATE] following a fall at home. Diagnoses include lymphedema, Acute Kidney Failure, Urinary Tract Infection, Contusion of left lower leg, Type 2 Diabetes Mellitus, Viral Hepatitis, Heart Failure, Hypotension and Osteoarthritis.<br><br>R217's Admission Minimum Data Set (MDS) with an Annual Reference Date (ARD) of [DATE] documents: Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage:<br><br>Number of Stage 2 pressure ulcers - 0<br><br>Number of Stage 3 pressure ulcers - 1<br><br>Number of these Stage 3 pressure ulcers that were present upon admission/entry or reentry - 1<br><br>Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar - 0<br><br>Number of unstageable pressure ulcers with suspected deep tissue injury (DTI) in evolution - 2<br><br>Number of these unstageable pressure ulcers that were present upon admission/entry or reentry - 2<br><br>Enter the total number of venous and arterial ulcers present - 5<br><br>On [DATE] at 11:02 AM, Surveyor observed R217 lying in bed on back with his head resting on his left hand. Prevalon boots were on both feet and and air mattress was on his bed. R217 reported he has wounds on his legs and feet from a fall in the shower at home. R217 reported he was not sure how long he was down, but didn't think it was too long because his son was home at the time.<br><br>On [DATE] at 11:53 AM, Surveyor asked Director of Nursing (DON)-B what was the expectation when a nurse finds a wound. DON-B reported the nurse should document measurements and what the would looks like. Then, if we have a wound nurse, she'll come in an do an assessment and tweak it. We recently got a wound nurse hired, we didn't have one before, but I pushed for that after I was hired. Surveyor asked for all of R217's wound documentation.<br><br>R217's Admission/Readmission/Routine Head-to toe Evaluation dated [DATE] documents:<br><br>Braden score 15. Does the resident have any skin alterations? Yes. Description: L (left) back of knee hematoma. L lat (lateral) foot calluses. R (right) heel pressure injury. Skin tear L elbow.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Surveyor noted there was not a comprehensive assessment, measurements or staging of the right heel pressure injury documented. In addition, R217's admission MDS documents 1 stage 3 pressure injury, 2 unstageable/deep tissue injuries and 5 venous and arterial ulcers as present on admission none of which were on the admission assessment.<br><br>R217's Weekly Skin Check dated [DATE] documents:<br><br>BLE- dry skin<br><br>L calf back- unstageable 3.0 cm (centimeters) x 2.0 cm x 0.1cm (not on admission assessment)<br><br>L heel- DTI 3.0 cm x 3.0 cm x 0.0 cm- wound bed dark purple in color (not on admission assessment)<br><br>L lateral foot- unstageable 2.0 cm x 0.2 cm (admission assessment documents callous)<br><br>L lateral great toe- callous 0.5 cm x 0.5 cm (not on admission assessment)<br><br>L lateral heel- unstageable 5.0 cm x 2.0 cm x 0.0 cm (not on admission assessment)<br><br>R buttocks- stage 2- 3.0 cm x 1.0 cm x 0.1cm (not on admission assessment)<br><br>R heel- DTI 2.0 cm x 3.0 cm (admission assessment documents only pressure injury - no stage)<br><br>R lateral calf- scabbed area 3.0 cm x 0.5 cm (not on admission assessment)<br><br>R medial heel-unstageable 6.0 cm x 4.0 cm x 0.1cm (not on admission assessment)<br><br>The facility Wound Assessment Details Report dated [DATE] documents wounds measured in cm:<br><br>(No documentation of L calf back unstageable)<br><br>Left heel DTI 5 x 3 x unknown. Deep Maroon 100%.<br><br>Left lateral foot pressure unstageable 1.5 x 1.5 x 0.4 - bright pink/red 25% necrotic 75%<br><br>Left lateral heel pressure unstageable 3.5 x 2.0 Purple ecchymosis 25%, necrotic 75%<br><br>Right buttock DTI 1.0 x 1.0 deep maroon 100% (documentation day prior on ,d+[DATE] documents stage 2)<br><br>Right heel DTI 4.0 x 3.0 Deep Maroon 100%<br><br>Left medial foot vascular Diabetic/Callous 4.5 x 3.0 x unknown. Intact skin 50% deep maroon 50% (not on previous assessments).<br><br>Right medial heel pressure unstageable 2 x 2.4 x unknown. 25% slough, 75% necrotic.<br><br>Right lateral leg vascular 3.5 x 2.9 x 0.1. Bright beefy red 25%, necrotic 75%.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Surveyor noted all wounds document Date Identified as [DATE], however the admission assessment completed on [DATE] listed only the left lateral foot calluses and right heel pressure injury (neither of which had an assessment, measurements or staging documented).<br><br>R217's wounds are followed by Tissue Analytics Nurse Practitioner. [DATE] Tissue Analytic notes document:<br><br>Wound #1: Left lateral foot evaluation: Diabetic Ulcer 1.28 cm Width: 1.69 cm Depth: 0.10 cm Wound bed Assessment Slough ,d+[DATE]% Eschar ,d+[DATE]%<br><br>Wound #2: Left heel Evaluation: Pressure Ulcer - Suspected DTI. Length: 4.42 cm Width: 3.72 cm Depth: 0. 10 cm Wound bed Assessment Purple.<br><br>Wound #3: Right heel Evaluation: Pressure Ulcer - Suspected DTI Length: 3.49 cm Width: 5.10 cm Depth: 0. 00 cm . Wound bed Assessment Purple.<br><br>Wound #4: Right buttock Evaluation: Pressure Ulcer - Stage 3. Length: 1.57 cm Width: 0.55 cm Depth: 0.10 cm Wound bed Assessment Fully granulated.<br><br>On [DATE] at 11:26 AM, Surveyor spoke with MDS LPN (Licensed Practical Nurse)-Z. Surveyor asked where she obtained the information regarding pressure injuries for R217's admission MDS. MDS LPN-Z reported she went to the wound rounds tab in PCC (Point Click Care) and listed all the wounds that were dated [DATE] as present on admission. Surveyor reviewed documentation of R217's admission skin assessment on [DATE] which listed only 1 pressure injury (which was not staged). Surveyor advised the facility wound notes on [DATE] then documented 3 DTI's, 3 Unstageable pressure injuries and 1 diabetic/vascular wound. MDS LPN-Z reported she was not sure, I just went by the date in the PCC wound notes, by the date entered as date identified. I know he came in with a lot of wounds, and a lot of them healed pretty quickly.<br><br>On [DATE] at 12:25 PM, Surveyor observed wound care with Registered Nurse (RN) Wounds-G. Surveyor was advised R217 currently has only 2 wounds: Left heel necrotic area and left lateral foot vascular wound, all other wounds have healed. Surveyor observations of R217's wounds:<br><br>Left heel: Necrotic area, no separation of edges, no drainage or odor.<br><br>Left lateral foot: Vascular wound clean with red tissue wound base. No drainage, odor or redness to surrounding skin.<br><br>[DATE] facility wound notes document: Left heel DTI 4.1 x 3.8 x Unknown. Deep Maroon=75%, Necrotic Hard, Firm, Adherent =25%.<br><br>L lateral foot Vascular Diabetic/Ulcer 1.0 x 1.1 x 0.2 Bright Pink or Red=25%, Slough [NAME] Fibrinous=75%.<br><br>Surveyor identified no concern with treatment application or infection control. No signs or symptoms of infection was noted.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Surveyor advised RN Wounds-G of concern there was no assessment or measurements of R217's wounds upon admission to the facility. The facility doumentation indicates all wounds were present on admission, however the admission assessment documents only 1 pressure injury, which was not staged. It wasn't until [DATE] and [DATE] when multiple additional pressure injuries were documented and measured. RN Wounds-D stated I know we've had issues. When I started I could see right away there were issues with pressure injuries, like assessments and measurements. We had Metastar do training 2 weeks ago on assessments and measurements. They're going to come back an do another training [DATE] & 18th.<br><br>On [DATE] at 2:15 PM, Nursing Home Administrator (NHA)-A was advised of the above concerns. NHA-A reported she understood, adding We have identified a lot of areas we need to work on to improve going forward. No additional information was provided. |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48391<br><br>Based on observation, interview and record review, the facility did not ensure 5 (R167, R83, R35, R11, and R99) of 5 residents reviewed were provided adequate supervision and interventions to prevent accidents.<br><br>R167 was admitted to the facility on [DATE] and discharged from the facility on [DATE] after an unwitnessed fall occurred on [DATE], at 10:50 PM. R167 had a Fall Risk Assessment completed on [DATE], which put R167 at high risk for falls. There were no further fall risk assessments completed after [DATE]. Despite being at high risk for falls and despite staff indicating R167 would scoot at times to the edge of the bed, there were no individualized care plan interventions addressing the high risk for falling (e.g., bed in lowest position, floor mat next to bed).<br><br>On [DATE], at 10:50 PM, R167 had an unwitnessed fall from bed. The bed was not in the lowest position and there was not a floor mat next to the bed. This fall resulted in surgical intervention on [DATE] at 2:18 PM to repair a left femoral neck fracture. On [DATE], R167 developed post-surgical complications with elevated white blood cells (WBC), decreased oxygen saturations, and decreased urine output. R167 was transferred to inpatient hospice care on [DATE] at 2:41 PM and expired on [DATE].<br><br>The facility's failure to identify R167's risk factors for falls, its failure to comprehensively assess R167 by completing quarterly Fall Risk Assessments and developing an individualized fall risk care plan with revisions, and to provide care, treatment, and supervision necessary to prevent accidents, created a finding of Immediate Jeopardy (IJ), which began on [DATE]. Nursing Home Administrator (NHA)- A and Director of Nursing (DON)- B were notified of the immediate jeopardy on [DATE], at 12:29 PM. The immediate jeopardy was removed on [DATE]. However, the deficient practice continues at a severity/scope of G (actual harm that is not immediate) as the facility continues to implement its removal plan and as evidenced by the following examples:<br><br>* R83 was transferred without a mechanical lift and fractured her right ankle, and the Certified Nursing Assistant's (CNA's) knew they should use the mechanical lift and decided to transfer her with 2 assist and a gait belt. When R83 fell during the transfer the CNA's got her off the floor and into her wheelchair this was not reported to the nurse on duty till several hours later. During the transfer the CNA was heard to say to R83. This resulted in actual harm to R83.<br><br>* R35 was assessed to be at high risk for falls. R35 had a fall on [DATE]. The facility did not conduct a fall investigation to provide a thorough root cause analysis and to ensure that fall interventions were in place and remained appropriate.<br><br>* R11 has grab bars attached to their bed frame with not documentation of an assessment being completed or risks being explained to R11 and/or their representative.<br><br>* R99 has grab bars attached to their bed frame with not documentation of an assessment being completed or risks being explained to R11 and/or their representative.<br><br>Findings include:<br><br>(continued on next page) |

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| NAME OF PROVIDER OR SUPPLIER Medical Suites at Oak Creek (the) | | STREET ADDRESS, CITY, STATE, ZIP CODE 2700 Honadel Boulevard Oak Creek, WI 53154 | |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | The facility's policy Accidents and Supervision dated [DATE] documents:<br><br>Policy:<br><br>The resident environment will remain as free of accident hazards as is possible. Each resident will receive adequate supervision and assistive devices to prevent accidents. This includes:<br><br>1. Identifying hazard(s) and risk(s).<br><br>2. Evaluating and analyzing hazard(s) and risk(s).<br><br>3. Implementing interventions to reduce hazard(s) and risk(s).<br><br>4. Monitoring for effectiveness and modifying interventions when necessary.<br><br>Definitions:<br><br>Accident refers to any unexpected or unintentional incident, which results in injury or illness to a resident.<br><br>Environment refers to any environment or area in the facility that is frequented by or accessible to residents, including (but not limited to) the residents' rooms, bathrooms, hallways, dining areas, lobby, outdoor patios, therapy areas, and activity areas.<br><br>Fall refers to unintentionally coming to rest on the ground, floor, or other lower level, but not as a result of an overwhelming external force (e.g., resident pushes another resident). An episode where a resident lost his/her balance and would have fallen, if not for another person or if he/she had caught him/herself, is considered a fall. A fall without injury is still a fall. Unless there is evidenced suggesting otherwise, when a resident is found on the floor, a fall is considered to have occurred.<br><br>Hazards refers to elements of the resident environment that have the potential to cause injury or illness.<br><br>Risk refers to any external factor, facility characteristic (e.g., staffing or physical environment) or characteristic of an individual resident that influences the likelihood of an accident.<br><br>Supervision/Adequate Supervision refers to intervention and means of mitigating risk of an accident.<br><br>Policy Explanation and Compliance Guidelines:<br><br>The facility shall establish and utilize a systematic approach to address resident risk and environmental hazards to minimize the likelihood of accidents.<br><br>1. Identification of Hazards and Risks - the process through which the facility becomes aware of potential hazards in the resident environment and the risk of all resident having an avoidable accident.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | a. All staff (e.g., professional, administrative, maintenance, etc.) are to be involved in observing and identifying potential hazards in the environment, while taking into consideration the unique characteristics and abilities of each resident.<br><br>b. The facility should make a reasonable effort to identify the hazards and risk factors for each resident.<br><br>c. Various sources provide information about hazards and risks in the resident environment.<br><br>d. These sources may include, but are not limited to:<br><br>i. Quality assessment and assurance (QAA) activities<br><br>ii. Environmental rounds<br><br>iii. MDS/CAA data<br><br>iv. Medical history<br><br>v. Physical exam<br><br>vi. Facility assessment<br><br>vii. Individual observation<br><br>e. This information is to be documented and communicated across all disciplines.<br><br>2. Evaluation and Analysis- the process of examining data to identify specific hazards and risks and to develop targeted interventions to reduce the potential for accidents. Interdisciplinary involvement is a critical component of this process.<br><br>a. Analysis may include, for example, considering the severity of hazards, the immediacy of risk, and trends such as time of day, location, etc.<br><br>b. Both the facility-centered and resident-directed approaches include evaluating hazard and accident risk data, which includes prior accidents/incidents, analyzing potential causes for each hazard and accident risk, and identifying or developing interventions based on the severity of the hazards and immediacy of risk.<br><br>c. Evaluations also look at trends, such as time of day, location, etc.<br><br>3. Implementation of Interventions- using specific interventions to try to reduce a resident's risks from hazards in the environment. The process includes:<br><br>a. Communicating the interventions to all relevant staff<br><br>b. Assigning responsibility<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | c. Providing training as needed<br><br>d. Documenting interventions (e.g, plans of action developed through the QAA Committee or care plans for the individual resident)<br><br>e. Ensuring that the interventions are put into action<br><br>f. Interventions are based on the results of the evaluation and analysis of information about hazards and risks and are consistent with relevant standards, including evidence-based practice<br><br>g. Development of interim safety measures may be necessary if interventions cannot immediately be<br><br>implemented fully<br><br>h. Facility-based interventions may include, but are not limited to:<br><br>i. Educating staff<br><br>ii. Repairing the device/equipment<br><br>iii. Developing or revising policies and procedures<br><br>i. Resident-directed approaches may include:<br><br>i. Implementing specific interventions as part of the plan of care<br><br>ii. Supervising staff and residents, etc.<br><br>iii. Facility records document the implementation of these interventions<br><br>4. Monitoring and Modification- Monitoring is the process of evaluating the effectiveness of care plan interventions. Modification is the process of adjusting interventions as needed to make them more effective in addressing hazards and risks. Monitoring and modification processes include:<br><br>a. Ensuring that interventions are implemented correctly and consistently<br><br>b. Evaluating the effectiveness of interventions<br><br>c. Modifying or replacing interventions as needed<br><br>d. Evaluating the effectiveness of new interventions<br><br>5. Supervision- Supervision is an intervention and a means of mitigating accident risk. The facility will provide adequate supervision to prevent accidents. Adequacy of supervision:<br><br>a. defined by type and frequency<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | b. Based on the individual resident's assessed needs and identified hazards in the resident environment<br><br>Through Quality Assurance and Performance Improvement (QAPI) and daily rounds continue to establish and utilize the systematic approach to address resident risk and environmental hazards to minimize the likelihood of accidents.<br><br>1.) R167 was admitted to the facility on [DATE]. R167's diagnoses include dementia, palliative care, malnutrition, pleural effusion, gastritis, anxiety, orthostatic hypotension, disorientation, history of right femur fracture, fall, anemia, aortic valve insufficiency, lymphedema, and osteoarthritis. R167's Annual MDS (Minimum Data Set) completed on [DATE] documents that R167 is dependent with transferring, bathing and toileting requiring a two-person assistance with a hoyer. R167 was documented as having a BIMS (Brief Interview for Mental Status) score of 6, indicating that R167 has severe cognitive impairment.<br><br>R167's care plan, dated [DATE], documents:<br><br>R167 is at risk for falls related to impaired mobility, weakness, and dementia. Created on [DATE]. Interventions include:<br><br>~ Anticipate and meet R167's needs. Date initiated [DATE].<br><br>~ Educate R167, family, and visitors on need to call for assistance when transferring in and out of the chair. Date initiated [DATE].<br><br>~ Ensure bed brakes are locked. Date initiated [DATE].<br><br>~ Ensure footwear fits properly. Date initiated [DATE].<br><br>~ Ensure R167's call light is within reach and encourage the resident to use it for assistance as needed. R167 requires prompt response to all requests for assistance. Date initiated [DATE].<br><br>.~ Follow facility fall protocol. Date initiated [DATE].<br><br>~ R167 requires non-skid socks and footwear gripper socks on at all times. Date initiated [DATE].<br><br>After the fall on [DATE], the facility added:<br><br>~ Bed in lowest position and call light within reach. Date initiated [DATE].<br><br>~ R167 requires a fall mat. Created on [DATE]<br><br>Surveyor notes R167's care plan does not include individualized care plan interventions.<br><br>Surveyor reviewed R167's medical records which includes a Fall Risk Assessment performed on [DATE] and [DATE]. R167 scored high risk for falls on [DATE] and [DATE]. Surveyor notes there are no changes to R167's care plan after scoring high risk for falls on [DATE].<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | On [DATE], at 9:36 AM, Surveyor interviewed NHA- A and Assistant NHA- BB who indicated a Fall Risk Assessment is to be performed quarterly and as needed (PRN) for each resident within the facility. NHA- A and Assistant NHA- BB indicated if a resident is determined to be high risk for falls, the facility would investigate resident specific interventions and take a deeper dive into environmental factors. NHA- A indicates DON- B completes the Fall Risk Assessments and includes interventions on resident's care plans based on Fall Risk Assessment results. Surveyor notified NHA- A and Assistant NHA- BB of R167 having Fall Risk Assessments completed on [DATE] and [DATE]. Surveyor requested additional Fall Risk Assessments and additional information if available. NHA- A indicated what is in the system is what is available and provided no additional Fall Risk Assessments for R167.<br><br>On [DATE], at 9:51 AM, Surveyor interviewed DON- B who indicates Fall Risk Assessments are to be completed quarterly and PRN. DON- B indicates the standards of care for a resident at high risk for falls would include a fall mat, bed in the lowest position and individualized care plan interventions. DON- B indicates a fall mat and low bed would be expected if a resident was high risk based on their Fall Risk Assessment. Surveyor notified DON- B of no fall mat intervention noted on R167's care plan along with no individualized care plan interventions after R167 was determined to be high risk for falls on [DATE]. Surveyor notified DON- B of R167 having a Fall Risk Assessment completed on [DATE] and [DATE]. Surveyor asked for additional information and if there were additional Fall Risk Assessments completed for R167. DON- B indicated the facility did not have additional Fall Risk Assessments completed for R167 and indicated if she were working at the facility at the time of the missing quarterly Fall Risk Assessments for R167, they would have been completed.<br><br>The facility incident report dated [DATE], for incident description, documents the nurse and CNA heard R167 yelling for help. The nurse and CNA went into R167's room and found R167 on the floor lying face down. R167 had complaints of pain in her arm, neck and back and indicated her arm may be broken. R167 declined a blood pressure attempt due to pain. The nursing supervisor was contacted and assessed R167. The nurse called 911 and R167 was transported to the hospital for evaluation.<br><br>The facility incident report included a Fall Scene Investigation Report indicating R167 stated she rolled out of bed.<br><br>The facility incident report included a nursing progress note from the nursing supervisor dated [DATE] at 11:11 PM, indicating the nurse supervisor was notified of R167 having an unwitnessed fall in her room. The nursing supervisor observed R167 lying face down on the floor next her bed. R167 had c/o pain in her head, neck, back and right arm. The nursing supervisor instructed staff to call 911 and to not move R167. The nursing supervisor observed R167 to be continent at the time of her fall, not having footwear on and the bed was not in the lowest position.<br><br>The facility incident report included a statement from CNA- W dated [DATE]. CNA- W performed cares on R167 on [DATE], at 9:00 PM. CNA- W overheard R167 yell out for help 3 times. CNA- W went into R167's room and found R167 lying face down on the floor complaining of pain. CNA- W notified the nurse.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | On [DATE], at 1:48 PM, Surveyor interviewed CNA- W who indicates R167 is very confused, anxious and yells out when she is confused. CNA- W indicates she was doing rounds on the unit when she heard R167 screaming for help. CNA- W went into R167's room and found R167 on the floor, face down next to her bed. CNA- W reports R167 rolled off the right side of her bed. CNA- W got the nurse after finding R167 face down on the floor. CNA- W reports R167 having a habit of trying to get up out of bed and being confused. CNA- W indicates R167 would frequently say she wants to get up which means she's probably going to do it sooner or later. CNA- W indicates R167 did not have a fall mat in place. CNA- W reports the facility called 911 and stated, I hope she's ok because we haven't seen her since.<br><br>On [DATE], at 2:20 PM, Surveyor interviewed Licensed Practical Nurse (LPN)- R who reports R167 being confused at times and will scream out at times. LPN- R stated R167 did not transfer on her own and would mostly stay in bed. LPN- R stated the CNAs told LPN- R that R167 would scoot to the edge of the bed at times and the CNAs would help her get back to the middle of the bed. LPN- R indicates he never witnessed R167 scooting to the edge of her bed. LPN- R states R167 had her call light next to her, floor mats in place, and signs in her room indicating call don't fall. LPN- R indicated on [DATE], at 10:50 PM, he was at the nursing desk charting after completing his rounds when he overheard R167 scream out for help. LPN- R stated he went to R167's room and on the way overheard CNA- W say R167 was laying on the floor face down complaining of pain. LPN- R contacted the RN supervisor who completed an assessment and advised staff to not move R167 and call 911. LPN- R reports R167 on the floor, on the right side of her bed, if lying in bed. LPN- R states he was new to the facility and was not aware of R167 having previous falls.<br><br>The facility incident report included interviews with facility staff. Question number 3 on the facility staff interviews asked, Have you ever witnessed R167 reaching for any items around her in the past?. There were 45 facility staff members interviewed, and 9 of those staff members indicated yes, they had witnessed R167 reaching for items around her in the past.<br><br>The facility incident report included an Assigned CNA Fall Investigations dated [DATE]. On the CNA Fall Investigation, CNA- W indicates last cares performed and last interaction with R167 prior to her fall was on [DATE], at 9:00 PM. Question 15 on the Assigned CNA Fall Investigation asks, What could have been done differently to prevent this fall?. CNA- W answered question 15 indicating hourly checking because she's so confused and maybe think she can get up and walk. Question 13 on the Assigned CNA Fall Investigation asks, Have there been any changes in the resident's condition or routine in the last week? CNA- W and CNA- GG both answered question 13, indicating R167 is more confused.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | R167's hospital records dated [DATE], documents R167 was evaluated in the emergency room (ER) on [DATE] and sustained a left femoral neck fracture. Surgical intervention was advised by hospital staff and R167's family was hesitant for surgical intervention to repair the left femoral neck fracture. R167's family and hospital staff met several times and agreed to proceed with a left hip hemiarthroplasty which was completed on [DATE], at 2:18 PM. On [DATE], R167 developed complications with elevated white blood cells (WBC), decreased oxygen saturations, and decreased urine output post-surgical intervention. On [DATE], at 11:30 PM, R167 was noted to have very low urine output in her foley catheter and hospital staff started IV fluids. On [DATE], at 5:31 AM, hospital staff notes R167 having very low urine output of only 50 CC of urine from [DATE] at 1:45 PM to [DATE] at 5:31 AM, while receiving continuous Intravenous (IV) fluids for 5 hours. On [DATE], at 5:36 AM, R167 was receiving oxygen (O2) post left hip hemiarthroplasty and hospital staff attempted to remove O2 therapy two different times without success. R167's O2 levels would decrease to 86% after these two attempts to remove O2 therapy. Hospital records report R167 having normal WBCs of 10.5 on [DATE] prior to her left hip hemiarthroplasty. R167's WBCs increased to 22.7 on [DATE], at 4:52 AM, which is likely stress-induced post-surgical intervention per hospital records. Family and hospital staff decided to transfer R167's care to hospice due to surgical complications. R167 was transferred to inpatient hospice care on [DATE] at 2:41 PM. On [DATE], at 10:32 AM, Surveyor spoke with R167's Power of Attorney (POA) who indicated R167 passed on [DATE].<br><br>These actions created the findings of the IJ. The facility was notified of the immediate jeopardy on [DATE], at 12:29 PM.<br><br>The IJ was removed on [DATE] when the facility completed the following:<br><br>~ Reviewed residents fall risk care plan starting [DATE] to ensure individualized interventions in place as needed by [DATE].<br><br>~ Reviewed with therapy resident transfer status with care plan revisions as needed. Initiated on [DATE].<br><br>~ Care plans reviewed for mechanical sling lifts to include sling size. Initiated on [DATE].<br><br>~ Review of post fall meeting and new process put into place to include review of chart and full IDT review on [DATE].<br><br>~ A weekly risk meeting will be initiated and completed weekly ongoing starting on [DATE].<br><br>~ Quality monitor introduction on [DATE].<br><br>~ Fall education for licensed nurses and CNAs. Initiated on [DATE].<br><br>~ Review of trending fall report on [DATE]. Staffing allocation reviewed for the facility.<br><br>~ Transfer competencies. Initiated on [DATE].<br><br>~ Additional lifts rented for the facility on [DATE].<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | ~ An audit will be completed daily during clinical stand up to complete Interdisciplinary Team (IDT) review.<br><br>~ A member of the governing body will review the plan on a weekly and as needed basis until substantial compliance has been achieved.<br><br>49435<br><br>2.) R35 was assessed to be at high risk for falls. R35 had a fall without injury on [DATE]. The facility did not conduct a fall investigation to provide a thorough root cause analysis and to ensure that fall interventions were in place and remained appropriate.<br><br>Findings include:<br><br>R35 was admitted to the facility on [DATE] and has diagnoses that include: Multiple sclerosis, Hemiplegia/hemiparesis following a stroke and affecting the left side, Hypotension, and Weakness.<br><br>R35's Quarterly Minimum Data Set (MDS) assessment, dated [DATE], documents R35 is cognitively intact.<br><br>R35's Admission MDS, dated [DATE], documents the following: Did the resident have a fall any time in the last month prior to admission? Unable to determine. Did the resident have a fall any time in the last , d+[DATE] months prior to admission? Unable to determine. Admission performance for picking up object. 09-Not applicable. R35 requires partial moderate assistance to roll left and right and to move from sitting on the side of the bed to lying flat on the bed.<br><br>R35's ADL (Activities of Daily Living) Care plan dated [DATE], documents R35 requires a physical assist of 2 with Hoyer mechanical lift.<br><br>R35's At risk for falls Care plan dated [DATE], documents interventions that include: Anticipate and meet the resident's needs. Ensure bed brakes are locked. Ensure footwear fits properly. Ensure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance.<br><br>R35's Fall risk evaluation dated [DATE], documents that R35 is at high risk for falls.<br><br>On [DATE] at 2:52 PM, R35's change in condition progress note documents, in part: Fall. [Blood pressure] , d+[DATE], [Pulse] 111, [Respiratory Rate] 18 . Mental status evaluation: No changes observed. Functional Status Evaluation: Fall. Neurological Status Evaluation: No changes observed .<br><br>On [DATE] at 3:32 PM, R35's progress notes document, [R35] sent to [emergency room (ER)] for further evaluation due to fall. [R35] reports that [R35] was attempting to grab a paper off the floor and leaned forward and fell . [R35] states [R35] did hit the back of [R35's] head. Nurse of Duty updated [Nurse Practitioner], order obtained to send to ER for further evaluation. [R35] agreeable.<br><br>On [DATE] at 9:10 AM, R35's progress notes document, [Follow up] ER visit . [due to] fall [DATE]. [R35] is under an observation stay at this time. CT scan and x-rays all negative .<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | R35 did not experience an injury from the fall.<br><br>Surveyor noted a fall investigation was not located in R35's medical record.<br><br>On [DATE] at 8:25 AM, Surveyor interviewed Medication Technician (Med Tech)-P. Med Tech-P stated that if a resident falls, Med Tech-P would notify the nurse. A Registered Nurse (RN) needs to do an assessment. The facility has a fall packet that should be completed. The nurse fills out the fall packet, but Certified Nursing Assistance (CNA)s will give statements as part of the investigation.<br><br>On [DATE] at 8:16 AM, Surveyor interviewed Licensed Practical Nurse, Unit Manager (LPN UM)-J. LPN UM-J stated that if a resident has a fall, the staff are to notify a nurse so that a RN assessment can be completed. The Medical Doctor (MD) and family are notified of the fall and a fall packet is completed. Surveyor asked what was in a fall packet. LPN UM-J stated a fall packet has a list of everything that needs to be done and is located at the nurse's station. The nurse is to complete the fall packet as soon as possible after a fall.<br><br>Surveyor noted R35's fall packet with a RN assessment, statements from CNAs, a thorough route cause analysis and an assessment if fall interventions were in place at the time of the fall was not located within R35's medical record.<br><br>On [DATE] at 11:50 AM, Surveyor interviewed Director of Nursing (DON)-B. Surveyor asked for R35's fall investigation from R35's fall on [DATE]. DON-B stated that DON-B was not working at the facility at the time of R35's fall. DON-B stated that DON-B would expect a fall investigation to be completed with every fall, but DON-B could not locate a fall investigation for R35's fall on [DATE].<br><br>On [DATE] at the daily exit meeting, Nursing Home Administrator (NHA)-A and DON-B were notified of the concern that no fall investigation was completed on R35's [DATE] fall.<br><br>No further information was provided.<br><br>22692<br><br>3.) R83 was admitted to the facility on [DATE] with diagnoses that included weakness and falls which resulted in a right femur fracture.<br><br>R83's Quarterly Minimum Data Set (MDS) dated [DATE] documents a Brief interview for Mental Status score of 10, indicating that R83 is moderately impaired. The MDS also documents R83 is dependent for transfers from her bed to the wheelchair.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525730 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 07/15/2024 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER Medical Suites at Oak Creek (the) | | STREET ADDRESS, CITY, STATE, ZIP CODE 2700 Honadel Boulevard Oak Creek, WI 53154 | |

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

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | The facility reported incident investigation submitted by the facility on [DATE] documented: On [DATE] R83 had a staff assisted fall. R83 complained of pain and her right ankle appeared discolored. Nurse Practitioner was contacted and R83 was sent to the emergency room for further evaluation. On [DATE], the facility was informed R83 had a closed displaced bimalleolar fracture of the right ankle. On [DATE] at approximately 2:30 PM CNA-JJ and CNA-KK went to R83's room to assist her in her wheelchair so she could attend bingo. CNA-JJ and CNA-KK were unable to locate a Hoyer (full mechanical lift) sling per R83's plan of care and attempted to transfer R83 with a gait belt into her wheelchair. During the transfer, R83 was lowered to the floor by CNA-KK. CNA-JJ and CNA-KK stated they were not aware that they needed to get a nurse after a staff assisted fall so both CNA-JJ and CNA-KK assisted R83 into her wheelchair and R83 went to bingo. After R83 returned from bingo CNA-JJ told LPN-LL about the assisted fall that happened with R83 earlier.<br><br>The Investigation conclusion section documented: The allegation of neglect of R83 was substantiated for the following reasons: Both CNA-JJ and CNA-KK were aware of R83 being a two-person mechanical sling lift, but transferred her using a gait belt. Neither CNA-JJ or CNA-KK updated Licensed Practical Nurse (LPN)-LL of the assisted fall until after R83 returned from bingo approximately 2 hours later. R83 has been tearful, but her mood changes when not speaking about the incident that occurred.<br><br>A statement from LPN-LL (who no longer works at the facility) was included in the investigation and documented: at approximately 5:30 PM (3 hours after the fall) I was informed by CNA-JJ that R83 was in pain. CNA-JJ told me that R83 was lowered to the ground evaluated R83 and the Nurse Supervisor was updated. During the evaluation R83 was teary eyed, which is her base line. R83 did verbalize being upset regarding the transfer that occurred.<br><br>R83's nursing note written by LPN-LL on [DATE] at 6:19 PM documented: Staff informed writer that R83 was lowered to ground. Staff were able to get R83 back up her wheelchair. This was not immediately reported to this writer. Upon being notified, went to R83's room finding her in high back wheelchair. R83 was upset and informed me that her right ankle is always pronated inwards and this is baseline. She has trace pedal edema but no localized swelling. Acetaminophen and cold compress applied. Updated Manager on duty and Nurse Practitioner who will see her tomorrow. No redness or bruising noted at this moment. No acute distress or abnormal findings noted. Continuing to monitor per protocol.<br><br>On [DATE] at 10:49 AM, LPN-LL was interviewed and indicated he wad not been notified of R83's fall until several hours after. LPN-LL indicated he told the LPN-II, who was the house supervisor) of the fall and assumed she would take over the investigation. LPN-LL indicated he did not call the Administrator or suspend CNA-JJ and CNA-KK pending investigation and both completed their shifts.<br><br>On [DATE] at 10:28 AM, Nursing Home Administrator (NHA)-A was interviewed and indicated she was not notified of the incident with R83 until [DATE] about 9:30 AM and after that she proceeded to get statements and start an investigation. NHA-A indicated the nursing supervisor who was LPN-II should have informed her right away. NHA-A indicated CNA-JJ and CNA-KK were not suspended until [DATE] and should have been suspended immediately after the allegation.<br><br>The nursing schedule for [DATE] was reviewed and indicated CNA-JJ was scheduled till 3:00 PM ( LPN-LL documented she reported R83's fall to him at 3:30 PM and CNA-KK worked till 7:00 PM.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | On [DATE] at 1:39 PM, LPN-II was interviewed and indicated she doesn't remember much about R83's fall because that was too long ago. LPN-II indicated she was not sure if she documented anything on the incident or if she completed any investigation. (No documentation was found regarding LPN-II's involvement in the investigation and LPN-II is not mentioned in the facility investigation even though Administrator-A indicated LPN-II should have called her as she was the house supervisor).<br><br>On [DATE], R83 was interviewed and indicated that about a month ago 2 CNA's transferred her and dropped her because they didn't use the lift like she told them too. R83 also indicated that one of the CNA's swore at her and it greatly upset her. R83 did not know the CNA's name and did not see either CNA after the day of the fall.<br><br>R83's nursing note written by LPN-NN dated [DATE] documented: R83 is complaining of increased pain to right ankle. Ankle is swollen and bruising purple in color. Third eye (virtual doctor) updated about R83 wanting to go to the hospital for evaluation. Third eye physician gave orders to send to emergency room for evaluation ambulance called.<br><br>R83's emergency room report dated [DATE] documented: a diagnosis of a closed displaced bimalleolar fracture of the right ankle. A short leg splint was applied to R83's right leg and a consultation with orthopedic surgery was ordered in one week. R83 was ordered oxycodone 10 milligrams (MG) every 6 hours as needed.<br><br>R83's medication administration record (MAR) was reviewed for her oxycodone use from [DATE] to [DATE] and she received it per request approximately ,d+[DATE] times a day.<br><br>R83's orthopedic consult notes dated [DATE] which indicated R83 underwent an outpatient closed reduction and casting of the right leg for the right ankle fracture.<br><br>R83's current care plan for activities of daily living dated [DATE] was reviewed and documented: Intervention: Transfers, resident requires Hoyer lift with 2 assist started [DATE].<br><br>R83's CNA care sheet dated [DATE] was reviewed and documented: Transfers R83 requires Hoyer lift with 2 assist.<br><br>The above findings were shared with the NHA-A and Director of Nurses-B on [DATE]. Additional information was requested if available, none was provided as to why CNA-JJ and CNA-KK did not follow R83's care plan for transfers and an investigation into the fall was not started immediately.<br><br>49011<br><br>The Facility Policy titled, Proper Use of Bed Rails Date Implemented: [DATE], Date Reviewed/Revised: [DATE], documents in part:<br><br>Policy Explanation and Compliance Guidelines:<br><br>Resident Assessment<br><br>1. As part of the resident's comprehensive assessment, the following components will be considered when determining the resident's needs, and whether or not the use of bed rails meets those needs:<br><br>(continued on next page) |

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