STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525019	A. Building B. Wing	09/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Deerfield Care Center, LLC	575 Hospital Rd New Richmond, WI 54017

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47284 Based on interview and record review, the facility failed to notify the resident's practitioner of the delay in obtaining a chest x-ray (CXR) and failure to immediately consult with the resident's practitioner concerning a change in the condition of a resident for 1 of 2 residents (R39). R39 was prescribed blood thinners and started to have hematuria (blood in the urine) with nickel size blood clots, an adverse consequence of taking blood thinners. The facility neglected to notify R39's practitioner until almost 5 hours later after the symptoms started. Findings include: The facility policy, entitled Communication and Notification - Staff, Practitioners, and Resident Representatives, dated November 2022, states: .Staff will notify the practitioner any time there is a significant change in clinical condition; including but not limited to a need to discontinue or change an existing form of treatment due to adverse consequences, or to initiate a new form of treatment .Any significant change in status must be reported to the practitioner team immediately which may be life threatening in nature or risk to self or others . R39 was admitted to the facility on [DATE], and had diagnoses including in part Alzheimer's disease, dementia, gross hematuria, malignant neoplasm of prostate, benign prostatic hyperplasia with lower urinary tract symptoms, acute embolism, and thrombosis of DVT (deep vein thrombus) right lower extremity (blood clot), fracture of right femur. On 9/19/23, Surveyor reviewed R39's medical record and identified the following: R39's Physician's Orders: Aspirin EC (enteric coated) 81 mg (milligram) Give 2 tablet by mouth one time a day for blood clot prevention. Start date: 5/25/23 End date: 6/08/23. Enoxaparin sodium injection solution prefilled syringe 40 mg/0.4ml (milliliter) (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Inject 0.4 ml subcutaneously every 24 hours for blood clot prevention for 9 administrations. Start date: 5/25/23 End date: 6/03/23. Xarelto oral tablet Give 15 mg by mouth two times a day for DVT. Start date: 6/08/23 End date: 6/09/23. Per Medication Administration Record (MAR), R39 started on Xarelto 15mg 6/09/23 two doses and one dose given 6/10/23 at am dose. R39's Progress Notes: 6/10/23 at 5:16 AM Resident [R39] had several nickel sized clots in catheter bag with 400ml bloody urine, and blood in pad. Started on Xarelto 6/9/23 for DVT in right leg . 6/10/23 at 12:32 PM .Change in Condition-situation .Resident [R39] had significant amount of blood in catheter bag with nickel sized clots present. On-Call contacted and wanted resident to be seen in ER [emergency room] for further evaluation. Cather is patent and still draining bladder, bladder scan showed 27mL. Concerns with bleeding due to resident starting Xarelto 15mg BID [twice a day] on Thursday [6/08/23] for DVT .Notification of MD/NP: On- call provider notified at 10:00 [AM] . Surveyor noted R39 was prescribed blood thinners and started to have hematuria (blood in the urine) with nickel size blood clots, complications of taking blood thinners. The facility neglected to notify R39's practitioner until almost 5 hours later after the symptoms started. On 9/19/23 at 9:13 AM, Surveyor spoke with Registered Nurse (RN) H to ask if a resident on an anticoagulant (blood thinner) starts to have hematuria with blood clots in the urine, what is the expectation to notify the provider. RN H said we need to notify the provider immediately as there could be something serious going on and the resident would need intervention right away. Surveyor asked RN H where the nurses would document this conversation with the provider. RN H said it would be documented in our progress notes. On 9/19/23 at 12:32 PM, Surveyor spoke with Director of Nursing (DON) B to ask what the expectation would be for when the nurse needs to notify the provider if a resident on an anticoagulant started with hematuria with blood clots. DON B said the provider should be notified as soon as possible.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47807 Based on observation, interview and record review, the facility did not ensure that the facility used the least restrictive alternative for the least amount of time and documented ongoing re-evaluations of the need for restraints for 1 of 1 resident (R15) using restrictive devices. The facility did not assess the use of a tray attached to R15's wheelchair for use as a restraint. This is evidenced by: The facility policy, entitled Physical Restraint Policy, dated November 2022, states: Procedure for Use of Restraints: 1. An assessment will be reviewed quarterly, and a new assessment will be completed annually, with significant change, with use of a new device, and with discontinuation of and existing device. R15 was admitted to the facility on [DATE] and has been diagnosed with Amyotrophic Lateral Sclerosis (ALS) and has a Brief Interview for Mental Status (BIMS) of 15. On 09/18/23 at 11:19 AM, Surveyor observed R15 in their room with a tray attached to his electric wheelchair. The tray was attached to both arms of the chair and in front of R15 while sitting in a wheelchair. On 09/18/23 at 11:19 AM, Surveyor asked R15 if they could remove the tray attached to the electric wheelchair, to which R15 replied they could not. However, they had no issues asking one of the nurses or Certified Nursing Assistants (CNAs) to remove it when they wanted it removed. Surveyor attempted to locate an assessment related to the restraint observed on R15's electric wheelchair and could not locate one. On 09/19/23 at 12:12 PM, Surveyor interviewed Registered Nurse (RN) I about the tray on R15's Chair. RN I said the chair is relatively new, and they work with a company specializing in ALS; the chair should help R15 as the disease progresses. The tray is nice and allows R15 to read, and if R15 ever needs it off, he knows to ask any of the aides on the floor. R15 can communicate well with staff. When Surveyor asked if RN I had seen any assessments related to the tray on R15's chair, RN I said they did not know of any. On 09/19/23 at 12:26 PM, Surveyor asked Director of Nursing (DON) B for a copy of an assessment related to the attached tray on R15's electric wheelchair. No assessment related to the tray was received. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/19/23 at 2:45 PM, Surveyor interviewed Clinical Coordinator (CC) G regarding a restraint assessment. CC G presented Surveyor with a copy of the assessment created on 09/19/23 and said they had not started it until that day. There was no assessment completed prior to the one presented. They believed it had been missed due to working with a different company providing R15 with ALS-specific equipment, including the electric wheelchair and the attached tray. Surveyor asked how long R15 had had the electric wheelchair, and CC G said that R15 had applied for the chair with the tray in the spring and received the new electric chair in the middle of the summer but could not remember the exact dates. Surveyor asked CC G what their expectations would be if someone had added a possible restraint to their wheelchair. CC G said they would expect an assessment to be created for the restraint.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47807 Based on observation, interview and record review, the facility did not ensure that the comprehensive care plan was implemented for 1 of 13 residents (R) reviewed, R15. R15 did not have a care plan regarding the tray attached to R15's wheelchair which R15 could not physically remove. This is evidenced by: The facility policy and procedure entitled Physical Restraint Policy, last revised in November 2022, states in part, Procedures for use of restraints: . 3. The care plan will be updated to include the following: a. Least restrictive type of restraint. b. Length of time the restraint will be used. c. Medical symptom requiring the use of the restraint. d. Who may apply the restraint. e. The time and frequency the restraint should be restraint f. When/how direct monitoring and supervision would be provided when the restraint is in use . R15 was admitted to the facility on [DATE] and has been diagnosed with Amyotrophic Lateral Sclerosis (ALS) and has a Brief Interview for Mental Status (BIMS) of 15 indicating intact cognition. On 09/18/23 at 11:19 AM, Surveyor observed R15 in their room with a tray attached to his electric wheelchair. The tray was attached to both arms of the chair and was located in front of R15 while sitting in wheelchair. On 09/18/23 at 11:19 AM, Surveyor asked R15 if they could remove the tray attached to the electric wheelchair, to which R15 replied they could not. However, they had no issues asking one of the nurses or Certified Nursing Assistants (CNA) to remove it when they wanted it removed. Surveyor attempted to locate a care plan related to the restraint observed on R15's electric wheelchair and could not locate one. On 09/19/23 at 12:26 PM, Surveyor asked Director of Nursing (DON) B for a copy of the care plan related to the attached tray on R15's electric wheelchair. No care plan related to the tray was provided. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/19/23 at 2:45 PM, Surveyor interviewed Clinical Coordinator (CC) G regarding the care plan. CC G presented Surveyor with a new copy of the care plan created on 09/19/23 and said they had not created it until that day. No care plan relating to restraints was completed prior to the one presented. They believed it had been missed due to working with a different company providing R15 with ALS-specific equipment, including the electric wheelchair and the attached tray. Surveyor asked how long R15 had had the electric wheelchair, and CC G said that R15 had applied for the chair with the tray in the spring and received the new electric chair in the middle of the summer but could not remember the exact dates. Surveyor asked CC G what their expectations would be if someone had added a possible restraint to their wheelchair. CC G said they would expect a care plan to be created.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 47807 Based on observation and interview, the facility failed to prepare and distribute food under sanitary conditions. This has the ability to affect all 45 residents in the facility. The dietary staff did not restrain hair under hair nets in the kitchen and serving areas. The dietary staff did not allow time, after using an alcohol swab on a thermometer, for the thermometer to dry off before inserting the thermometer into the food. This is evidenced by: Example 1: The facility policy and procedure entitled Infection Prevention and Control Manual Dietary - F812 Regulation - Food Safety Requirements, last revised in 2020, states in part, Dietary Staff must wear hair restraints (e.g., hairnet, hat, and/or beard restraint) to prevent hair from contacting food. On 09/18/23 at 9:00 AM, Surveyor performed an initial tour of facility's kitchen. During the initial tour, Surveyor observed Dietary Aide (DA) D with a hair net on their head, but bangs were protruding from the hairnet. DA D's hair was not contained in the hair net. On 09/18/23 at 12:05 PM, Surveyor observed DA E dishing up plates from the dry heat table in the kitchen on the third floor. DA E had on a hair net, but hair was protruding from the hairnet below where the hairnet would cover DA E's neck. DA E's hair was not contained in the hair net. On 09/19/23 at 7:57 AM, Surveyor observed DA F taking food temperatures before breakfast. DA F had on a hair net, but hair was protruding below the hair net near the base of the neck. DA F's hair was not contained in the hair net. On 09/20/23 at 8:44 AM, Surveyor interviewed Dietary Manager (DM) C about DM C's expectations for hair restraints in the kitchen. DM C said they would expect staff always to have hair nets on; if hair were out, they would need to get larger hair nets. They plan to look into larger hair nets for staff with more hair. Example 2: The facility policy and procedure entitled Proper Use and Calibration of Food Thermometers, last revised in July 2020, states in part, Proper Use: Sanitize the stem of the thermometer upon each use with an alcohol wipe or 5 seconds in a sanitizer solution. Allow to probe to air dry completely before next use. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 09/19/23 at 7:57 AM, Surveyor observed DA F checking food temperature before serving residents on the third floor. DA F first wiped the thermometer with a sanitation wipe, and after 7 seconds, they put the thermometer in the oatmeal. DA F then wiped the thermometer with a sanitation wipe, and after a count of 5 seconds, they checked the temperature of the pancakes. DA F then wiped the thermometer with a sanitation wipe and, after a count of 2 seconds, put the thermometer into the eggs. DA F took the thermometer out of the eggs, wiped the thermometer off with the sanitation wipe, and immediately put the thermometer into the pureed eggs. On 09/19/23 at 7:57 AM, Surveyor interviewed DA F about checking food temperature at the point of service. Surveyor asked if DA F knew what type of wipes were being used to clean the thermometer, and DA F responded by saying they are alcohol wipes. Surveyor then asked if she knew of an allotted time that DA F should wait after wiping off the thermometer before taking the temperature of the following food item. DA F did not know of a time they should wait after wiping off a thermometer with an alcohol swab. On 09/20/23 at 8:44 AM, Surveyor interviewed DM C about DM C's expectations for checking food temperature before serving. DM C would expect the thermometer to be cleaned each time. Surveyor asked about the time it might take for alcohol to dry on the thermometer, and DM C said they did not think about the time it would take for the alcohol to dry off the thermometer and possibly contaminate food with alcohol.