STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525353	A. Building B. Wing	05/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stevens Point Health Services	1800 Sherman Ave Stevens Point, WI 54481

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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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50479 Based on observation and staff interview, the facility did not ensure the right to personal privacy for 1 resident (R) (R21) of 19 sampled residents. During an observation on 5/6/24, staff did not ensure R21 had visual privacy and dignity during personal care. Findings include: On 5/6/24, Surveyor reviewed R21's medical record. R21 was admitted to the facility on [DATE] with a past medical history including Parkinson's disease and dementia. R21's Minimum Data Set (MDS) assessment, dated 4/8/24, indicated R21's Brief Interview for Mental Status (BIMS) score was 10 out of 15 which indicated R21 had moderately impaired cognition. R21's care plan, dated 4/29/24, with a target date of 5/30/24, indicated the following: ~ R21 had physical limitations, cognitive loss, and difficulty communicating. ~ R21 was dependent on staff for bathing, showing, dressing, and bed mobility. ~ R21's needs would be met with comfort and dignity. On 5/6/24 at 2:41 PM, Surveyor was standing in the lobby near the nurses' station and noted a window that contained a blind in the top portion of R21's door. The blind was open which allowed for an unobstructed view of R21's bed. While standing in the lobby, Surveyor observed Licensed Practical Nurse (LPN)-T and Certified Nursing Assistant (CNA)-V provide personal care to R21 in R21's bed. Surveyor observed R21's nude body with genitals exposed from the nursing station through R21's window. The open window blind allowed others in the common area around the nurses' station to view R21 receiving cares in R21's room. Two residents of the opposite gender were present near the nurses' station at the time of the observation. On 5/6/24 at 2:50 PM, Surveyor interviewed LPN-T who stated R21's blind should be closed and was typically closed for privacy during personal care. LPN-T stated LPN-T did not notice the window blind was open when LPN-T and CNA-V began personal care. (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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/8/24 at 10:17 AM, Surveyor interviewed CNA-W who stated it was CNA-W's practice to keep the window blind closed in R21's room to ensure privacy. On 5/8/24 at 10:50 AM, Surveyor interviewed Nursing Home Administrator (NHA)-A who stated NHA-A expects staff to provide visual privacy for residents during personal care. On 5/8/24 at 11:00 AM, Surveyor interviewed Director of Nursing (DON)-B who stated DON-B expects residents to have visual privacy during personal care. DON-B verified R21's window blind should be closed during personal care to ensure R21's privacy and dignity.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40342 Based on observation, staff and resident interview, and record review, the facility did not ensure adequate fall prevention interventions were in place for 3 residents (R) (R36, R10, and R291) of 3 sampled residents. R36 fell on [DATE] and 3/18/24. The facility did not implement new fall interventions to prevent future falls. R36 fell again on 3/22/24. R10 was admitted to the facility following a fall with a fracture at home. R10 had a rug in R10's room with curled edges. The facility did not develop a comprehensive falls care plan, including R10's preference and risk for keeping the rug in R10's room. R291's smoking materials were to be stored securely by staff. During an observation on 5/7/24, smoking materials were observed in R291's room. Findings include: The facility's Fall Prevention and Management Guidelines policy, with review date of 11/8/22, indicates: Each resident will be assessed for fall risk and will receive care and services in accordance with their individualized plan of care to minimize the likelihood of falls or reduce the possibility/severity of injury .7. When any resident experiences a fall, the facility will: a. Complete a post-fall assessment and review: .6) Contributing factors to the fall .d. Review the resident's care plan and update with any new interventions put in place to try to prevent additional falls . The facility's Accidents and Supervision policy, with a revised date of 7/14/22, indicates: The facility shall establish and utilize a systemic approach to address resident risk and environmental hazards to minimize the likelihood of accidents. a. All staff 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. i. Resident-directed approaches may include: implementing specific interventions as part of the plan of care. The facility's Smoking policy, with an effective date of 5/2019, indicates: 9. Residents who are assessed to require supervised smoking will have nicotine materials secured in a container that is maintained by the licensed nurse. 1. On 5/6/24, Surveyor reviewed R36's medical record. R36 was admitted to the facility on [DATE] with diagnoses including left femur (long bone in upper leg) fracture and unspecified dementia without behavioral disturbance. R36's Minimum Data Set (MDS) assessment, dated 4/4/24, stated R36's Brief Interview for Mental Status (BIMS) score was 7 out of 15 which indicated R36 had severely impaired cognition. R36's medical record indicated R36's Power of Attorney for Healthcare (POAHC) was responsible for R36's healthcare decisions. R36 was discharged from the facility on 4/30/24. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/7/24, Surveyor reviewed a fall investigation that indicated R36 was found on the floor on 3/14/24. The investigation indicated the facility added non-skid socks/shoes and auto-lock wheelchair brakes to R36's care plan. A fall investigation indicated R36 was found on the floor again on 3/18/24. The fall investigation indicated the facility again added non-skid socks/shoes and auto-lock wheelchair brakes to R36's care plan. In addition, a fall investigation indicated a nurse observed R36 start to stand up from R36's wheelchair on 3/22/24 but was unable to reach R36 before R36 slipped from the wheelchair onto the floor with the wheelchair cushion in R36's grip. The facility provided a non-slip pad and a better size cushion for R36's wheelchair. On 5/7/24, Surveyor reviewed R36's care plan which indicated non-skid socks/shoes were added on 1/2/24. In addition, the care plan indicated auto-lock brakes were added on 2/21/24. On 5/7/24 at 9:35 AM, Surveyor interviewed Director of Nursing (DON)-B who indicated the facility did staff training related to root cause analysis of falls and making sure new interventions make sense but did not document the education. DON-B verified the facility should have added new interventions to R36's care plan following R36's falls on 3/14/24 and 3/18/24. 43361 2. Between 5/6/24 and 5/8/24, Surveyor reviewed R10's medical record. R10 was admitted to the facility on [DATE] following a left femur fracture and hip surgery following a fall at home. R10 had a guardian and diagnoses including dementia and polyneuropathy. R10's MDS assessment, dated 3/1/24, stated R10 had a BIMS score of 3 out of 15 which indicated R10 had severely impaired cognition. R10's medical record contained a care plan, initiated on 12/8/23, with a focus statement that indicated R10 was at risk for falls due to a history of falls. The care plan contained one intervention that indicated: Fall Risk (FYI) (initiated on 12/8/23). During multiple observations between 5/6/24 and 5/8/24, Surveyor observed R10 ambulate independently throughout the unit and in R10's room. On 5/6/24 at 11:07 AM, Surveyor observed R10's room and noted R10's bed was placed in the middle of the room with the head of the bed against one of the walls. Surveyor observed a multicolored rug that was approximately 4 feet by 6 feet on the floor next to the bed. The corners of the rug were curled up. R10 was not in the room. On 5/8/24 at 10:03 AM, Surveyor observed R10 stand on the rug and attempt to make R10's bed. Surveyor observed a pile of blankets on the bed and watched R10 shuffle around the room. On 5/8/24 at 10:16 AM, Surveyor interviewed Registered Nurse (RN)-U who indicated RN-U previously expressed concern about the rug. RN-U indicated R10 was particular and would be upset if the rug was removed. On 5/8/24 at 11:34 AM, Surveyor interviewed DON-B who indicated staff tried to get the rug out of R10's room, but R10 was adamant that R10 wanted the rug. Surveyor asked if a risk versus benefit statement was completed, if staff consulted with R10's guardian, and if the rug should be noted on R10's care plan. When Surveyor showed DON-B R10's current falls care plan, DON-B confirmed the care plan should indicate more than that R10 was a fall risk. DON-B agreed R10's rug was a trip hazard and indicated staff would follow up about the rug. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	50479 3. Between 5/6/24 and 5/8/24, Surveyor reviewed R291's medical record. R291 was admitted to the facility on [DATE] with a past medical history including tobacco dependence, brain cancer, and epilepsy. A care plan, dated 5/2/24 with a target date of 7/31/24, indicated R291 opted to continue smoking cigarettes and R291's smoking safety was determined by a smoking assessment. A smoking assessment, dated 5/4/24, indicated R291 required supervision with nicotine products and R291's smoking materials should be stored with facility staff. On 5/7/24 at 1:02 PM, Surveyor observed R291 alone in R291's room. Surveyor observed a pack of cigarettes and a lighter on R291's bedside table. Surveyor interviewed R291 who stated staff escort R291 to the facility's designated smoking areas and supervise R291 when R291 smokes. R291 stated R291's cigarettes and lighter were stored in R291's room and indicated staff did not secure R291's smoking materials. On 5/7/24 at 1:10 PM, Surveyor interviewed Registered Nurse (RN)-S who confirmed R291 required staff supervision when smoking. On 5/7/24 at 1:33 PM, Surveyor interviewed Certified Nursing Assistant (CNA)-R who was unaware R291 smoked and was not familiar with the facility's smoking policy. On 5/7/24 at 1:15 PM, Surveyor interviewed Assistant Director of Nursing (ADON)-C who stated the facility's expectation is that smoking materials are kept locked in the medication cart.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45943 Based on observation, staff and resident interview, and record review, the facility did not provide the necessary respiratory care and services for 2 residents (R) (R8 and R144) of 2 residents reviewed for oxygen therapy. R8 used humidified oxygen from a concentrator. R8 did not have a physician's order for oxygen use. In addition, R8's care plan did not address oxygen use and R8's oxygen tubing was not labeled to indicate the date the tubing was last changed. R144 used oxygen from a concentrator. R144 did not have a physician's order for oxygen use or a care plan that addressed the use of oxygen. Findings include: The facility's Oxygen Cylinder Compressed Gas policy, with a reviewed/revised date of 6/27/22, indicates oxygen is a drug which must be ordered by a physician .Oxygen devices: Nasal cannula - change out weekly and as needed (PRN) 1. Between 5/6/24 and 5/8/24, Surveyor reviewed R8's medical record. R8 was admitted to the facility on [DATE] and had diagnoses including chronic acute and chronic respiratory failure, diabetes mellitus type 2, pneumonia, congestive heart failure (CHF), anxiety, obstructive sleep apnea (OSA), and dependence on supplemental oxygen. R8's Minimum Data Set (MDS) assessment, dated 5/1/24, indicated R8 had a Brief Interview for Mental Status (BIMS) score of 14 out of 15 which indicated R8 had intact cognition. The MDS also indicated R8 used continuous oxygen. On 5/6/24 at 12:28 PM, Surveyor interviewed R8 who used oxygen at 4 liters per minute (lpm) via nasal cannula. Surveyor noted R8's water reservoir chamber for humidification was empty and R8's oxygen tubing was not dated to indicate when the tubing was last changed. R8 could not recall the frequency of tubing changes or when R8's tubing was last changed. R8 indicated having the oxygen humidified helps so not so dry. On 5/6/24 at 12:33 PM, Surveyor interviewed Licensed Practical Nurse (LPN)-M who verified R8's water reservoir chamber was empty and stated the water was usually changed on night shift. Surveyor noted R8's medical record did not contain a physician's order for humidified oxygen, a care plan for oxygen use, or indicate how the facility monitored R8's oxygen use and ensured R8's oxygen tubing was changed. Surveyor noted an order, dated 10/30/23, for supplemental oxygen at 2-4 lpm into BiPAP (bilevel positive airway pressure)/CPAP (continuous positive airway pressure). R8's Treatment Administration Record (TAR) contained an order, dated 12/13/23, to change R8's BiPAP mask and tubing every Wednesday for BiPAP maintenance. On 5/7/24 at 3:10 PM, Surveyor interviewed Director of Nursing (DON)-B who confirmed R8 did not have an order for humidified oxygen or a care plan for oxygen use. In addition, DON-B indicated the facility did not have a policy that indicated R8's oxygen tubing should be labeled, but stated DON-B expects staff to label and change oxygen tubing weekly based on best practice. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	43361 2. Between 5/6/24 and 5/8/24, Surveyor reviewed R144's medical record. R144 was admitted to the facility on [DATE] with diagnoses including dependence on supplemental oxygen and CHF. R144's MDS assessment, dated 4/30/24, stated R144 had a BIMS score of 10 out of 15 which indicated R144 had moderately impaired cognition. The MDS also indicated R144 used oxygen. On 5/6/24 at 2:23 PM, Surveyor interviewed R144 and observed R144 use oxygen. When Surveyor asked if staff change R144's oxygen tubing and how many liters per minute of oxygen R144 uses, R144 stated R144 did not know. Surveyor noted R144's medical record did not contain an order for oxygen use, including the setting and when to test R144's oxygen saturation level, or to change R8's oxygen tubing. On 5/8/24 at 8:22 AM, Surveyor interviewed DON-B who verified R144 did not have an order for oxygen use, including care and management of the oxygen tubing, prior to 5/7/24. DON-B indicated staff spoke with R144's physician on 5/7/24 and obtained the orders. DON-B confirmed the orders should have been in place prior to 5/7/24.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49010 Based on staff interview and record review, the facility did not provide pharmacy services in accordance with the wishes of a resident/legal representative when the facility administered vaccines to 1 resident (R) (R11) of 5 sampled residents who declined the vaccines. The facility administered COVID 19 and influenza vaccines to R11 after R11 declined the vaccines. Findings include: 1. From 5/6/24 through 5/8/24, Surveyor reviewed R11's medical record. R11 was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD), multiple sclerosis, type 2 diabetes with neuropathy, and respiratory syncytial virus (RSV) pneumonia. R11 had a legal guardian for decision making. A progress note, dated 1/3/24 at 11:32 AM, indicated R11 declined the influenza and COVID-19 vaccines per a consent/declination sheet signed by R11's legal guardian on 1/3/24. A progress note, dated 1/3/24 at 13:37, indicated R11 received an influenza vaccine and a COVID-19 booster. R11's vaccination record indicated R11 received a COVID-19 vaccine (SARS-COV-2 COVID-19 Novavax Fall 2023) and an influenza (Flucelvax Quadrivalent) vaccine on 1/3/24. On 5/8/24 at 1:33 PM, Surveyor interviewed Director of Nursing (DON)-B who indicated residents should be offered vaccines upon admission and as needed per the Centers for Disease Control and Prevention (CDC) recommendations and residents' preferences. DON-B reviewed R11's medical record and stated R11 received COVID-19 and influenza vaccines on the same day R11's legal guardian signed a declination for the vaccines. DON-B reviewed the administration log and verified the vaccines were administered despite the signed declination forms and progress note that indicated R11 refused the vaccines. DON-B reviewed R11's immunization record which contained the lot number of the vaccines administered to R11 on 1/3/24. DON-B indicated staff who administer vaccines should carefully review the declination sheets. DON-B indicated administering vaccines despite a refusal is a serious issue and R11's legal guardian should be notified that R11 received the vaccines on 1/3/24. DON-B also indicated R11's physician should be notified and staff should monitor for issues and/or side effects. DON-B indicated a process evaluation and an improvement plan are needed for correction and prevention of future issues.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 43361 Based on staff interview and record review, the facility did not designate a person to serve as the food and nutrition services director who was a certified dietary manager, had a national certification for food service management and safety from a national accrediting body, or had an associates or higher level degree in food service management or hospitality. This practice had the potential to affect all 42 residents residing in the facility. Dietary Manager (DM)-H did not complete an approved dietary manager or food service manager certification course or other related education. Findings include: On 5/6/24 at 9:53 AM, Surveyor interviewed DM-H who indicated DM-H just started as a cook at the facility. DM-H indicated DM-H worked in maintenance and also worked as a cook in an assisted living facility. DM-H stated DM-H was enrolled in ServSafe (which is not an approved Dietary Manager certification course,) but had not yet completed the course. DM-H also indicated DM-H would enroll in a dietary manager course after DM-H finished the ServSafe course. DM-H stated the facility had a contracted dietician who was onsite every other week. On 5/8/24 at 10:53 AM, Surveyor interviewed Nursing Home Administrator (NHA)-A who confirmed DM-H was enrolled in the ServSafe course. NHA-A also confirmed when DM-H completed the ServSafe course, DM-H planned to enroll in a dietary manager course.

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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. 43361 Based on observation, staff interview, and record review, the facility did not ensure food was stored and prepared in a safe and sanitary manner. This practice had the potential to affect all 42 residents residing in the facility. Staff did not complete hand hygiene after washing dishes and prior to touching ready to eat food. The counter was not in clean condition when staff cut vegetables. The microwave was not in clean condition and the mixer was not covered. Staff did not maintain unit refrigerator and freezer temperature logs. Open items in the walk-in cooler and dry storage area did not contain open dates. Findings include: On 5/6/24 at 9:48 AM, Surveyor began an initial kitchen tour with Dietary Manager (DM)-H who stated the facility follows the Wisconsin Food Code. Hand Hygiene: The Wisconsin Food Code documents at Chapter 2 Personal Cleanliness 2-301.14 When to Wash: Food employees shall clean their hands and exposed portions of their arms as specified under 2-301.12 .(E) After handling soiled equipment or utensils; .(I) After engaging in other activities that contaminate the hands. The facility's General Food Preparation and Handling policy, with a revised date of 8/16/22, indicates: G. Bare hands should never touch ready to eat raw food directly. Disposable gloves are a single use item and should be discarded after each use. H. Food will be prepared and served with clean tongs, scoops, forks, spoons, spatulas, or other suitable implements to avoid manual contact of prepared foods. The facility's Employee Sanitary Practices-Food and Nutrition Services policy, with a revised date of 7/27/22, indicates: All employees will: .5. Use utensils to handle food .Disposable gloves are single use items and should be discarded after each use. Hands must be washed prior to using gloves and after removing gloves. 10. Use these guidelines in handling clean dishware, glasses, and flatware: Use clean hands. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 5/7/24 at 11:37 AM, Surveyor observed [NAME] (CK)-I plate food during tray line service in the kitchen. Surveyor observed CK-I pick up a plate, place it on the counter, and scoop potatoes onto the plate. CK-I touched the potatoes with the opposite gloved hand that touched plates, the counter, and scoops. CK-I then picked up a bun with the same gloved hand that touched the scoops, placed the bun on the plate, pushed the tray down the line, and prepared the next tray. Surveyor observed the same process for two trays. When Surveyor interrupted CK-I during the process and informed CK-I of the observation, CK-I stated CK-I was not aware CK-I should not touch the potatoes and use a tong to put buns on plates. On 5/8/24 at 9:34 AM, Surveyor observed Dietary Aide (DA)-J wash dishes in the dish room. DA-J wore green gloves while DA-J loaded breakfast dishes into a rack to go through the dishwasher. After DA-J pushed the rack through the dishwasher, Surveyor observed DA-J remove the gloves, unload the rack, and put away the clean dishes. Surveyor noted DA-J wore disposable gloves underneath the green gloves. DA-J used the same disposable gloves worn under the green gloves to put the clean dishes away. Surveyor interviewed DA-J who indicated DA-J thought it was okay to wear disposable gloves underneath the green gloves. Surveyor informed DA-J that DA-J touched the green gloves with the disposable gloves to take the green gloves off. On 5/8/24, Surveyor informed Nursing Home Administrator (NHA)-A of the observations. NHA-A confirmed NHA-A expected CK-I and DA-J to complete hand hygiene in the above instances. Cleanliness and Equipment Storage: The Wisconsin Food Code documents at 3-302.11 Packaged and Unpackaged Food Separation, Packaging, and Segregation: (A) Food shall be protected from cross contamination by: separating raw animal foods during storage, preparation, holding, and display from: (b) Arranging each type of food in equipment so that cross contamination of one type with another is prevented, and (c) Preparing each type of food at different times or in separate areas; (3) Cleaning equipment and utensils as specified under 4-602.11 (A) and sanitizing as specified under 4-703.11. The Wisconsin Food Code documents at 4-602.12 Cooking and Baking Equipment: (B) The cavities and door seals of microwave ovens shall be cleaned at least every 24 hours by using the manufacturer's recommended cleaning procedure. The Wisconsin Food Code documents at 4-903.11 Equipment, Utensils, Linens, and Single Service and Single Use Articles: (B) Clean equipment and utensils shall be stored .(2) Covered or inverted. The facility's General Food Preparation and Handling policy, with a revised date of 8/16/22, indicates: 1. The kitchen will be kept neat and orderly. The kitchen surfaces and equipment will be cleaned and sanitized as appropriate. The facility's Cleaning Instructions: Microwave Oven policy, with a revised date of 7/21/22 indicates: The microwave oven will be kept clean, sanitized and odor free. The microwave oven interior should be cleaned after each use as needed and at a minimum after each meal service. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stevens Point Health Services	1800 Sherman Ave Stevens Point, WI 54481

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 5/8/24 at 9:46 AM, Surveyor observed CK-K cut carrots on a cutting board. Surveyor observed splatters of blood and meat remnants on the counter and in the sink surrounding where CK-K cut the carrots. CK-K confirmed the counter should be cleaned between tasks when preparing food. During the initial kitchen tour on 5/6/24 with DM-H, Surveyor noted the Sharp microwave in the kitchen contained dried food and splatter on the inside surfaces. DM-H confirmed the microwave should be cleaned. Surveyor also noted the large mixer in the kitchen was uncovered. DM-H indicated DM-H was not aware the mixer should be covered. Refrigerator and Freezer Temperature Logs: The facility's Food Storage policy, with a revised date of 8/16/22, indicates: d. Each nursing unit with a refrigerator/freezer will be supplied with thermometers and monitored for appropriate temperatures. During the initial kitchen tour on 5/6/24, Surveyor asked DM-H about the unit refrigerators. DM-H indicated kitchen staff do not do maintain unit refrigerators. On 5/8/24 at 11:37 AM, Certified Nursing Assistant (CNA)-L showed Surveyor the unit refrigerator in the Bistro on one of two units. Surveyor and CNA-L could not locate a temperature log. CNA-L indicated there were also two refrigerators used to store resident food on another unit. Surveyor and CNA-L could not locate temperature logs for those refrigerators either. Dating: The Wisconsin Food Code documents at 3-501.17 Ready-to-Eat, Time/Temperature Control for Safety Food: (A) .refrigerated, ready to eat, time/temperature control for safety food prepared and held in a food establishment for more than 24 hours shall be clearly marked to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded when held at a temperature and time combination of 5 degrees Celsius (C) (41 degrees Fahrenheit (F)) or less for a maximum of 7 days. The day of preparation shall be counted as day 1. Commercially processed food open and hold .refrigerated, ready to eat, time/temperature control for safety food prepared and packaged by a food processing plant shall be clearly marked at the time the original container is opened in a food establishment and, if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded .(1) The day the original container is opened in the food establishment shall be counted as day 1 The facility's Food Storage policy, with a revised date of 8/16/22 indicates: 11. Leftover food will be stored in covered containers or wrapped carefully and securely. Each item will be clearly labeled and dated before being refrigerated. Leftover food is used within 3 days. 12. F. All foods should be covered, labeled, and dated. During the initial kitchen tour on 5/6/24 with DM-H, Surveyor observed the following: ~3 open and undated bags of cereal in the dry storage area not stored in their original containers. ~1 undated Ziploc bag of white American cheese slices in the walk-in cooler not stored in its original packaging. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	~1 undated Ziploc bag of cut onions in the walk-in cooler. ~1 open and undated container of liquid eggs in the walk-in cooler. DM-H confirmed the above items should contain open dates.

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F 0868 Level of Harm - Potential for minimal harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 49010 Based on staff interview and record review, the facility did not ensure the minimum required members of the Quality Assurance Performance Improvement (QAPI) committee met at least quarterly. This practice had the potential to impact all 42 residents residing in the facility. The facility did not hold two of four required QAPI meetings in the past year or six of twelve monthly meetings per their policy. For the two required QAPI meetings held, the facility was unable to provide verification of attendance for the required members. Findings include: The facility's Quality Assurance and Performance Improvement (QAPI) Committee policy, dated 7/11/22, indicates: The Executive Director and the Director of Nursing (DON) are responsible and accountable for the development, implementation, monitoring, and leadership of the center's QAPI program. A core team of individuals will be appointed to spearhead the QAPI program and will engage in monthly QAPI meetings which will include the creation/modification of performance improvement plans (PIPs). The center's QAPI committee may include the following team members: the Executive Director, Director of Nursing, Medical Director, Infection Preventionist, Life Enrichment Director, Social Services Director, Maintenance Director, Housekeeping Director, Business Office Manager, Human Resources Director, Dietary Manager/Registered Dietician, MDS Coordinator and at least one non-licensed direct care staff. On 5/6/24, Surveyor reviewed the QAPI committee meeting sign in sheets for the previous year (June 2023 through May 2024). The sign in sheets consisted of five pieces of paper labeled QAPI agenda and meeting minutes. The month and year was handwritten on the top of each page. The sheets were dated December 2023, January 2024, February 2024, March 2024, and April of 2024. The sheets did not contain signatures. There were no monthly QAPI sign in sheets provided for June 2023, July 2023, August 2023, September 2023, October 2023, and November 2023. On 5/7/24 at 4:46 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A who indicated NHA-A was unable to locate sign-in sheets for the June through November 2023 monthly QAPI meetings. NHA-A stated NHA-A was an interim NHA-A and attended NHA-A's first QAPI meeting in April 2024. NHA-A verified the facility did not have sign in sheets with committee member signatures for the December 2023 through April 2024 meetings. NHA-A indicated NHA-A expected the sheets to contain signatures of the QAPI meeting attendees. On 5/8/24 at 11:08 AM, Surveyor interviewed DON-B who provided Surveyor QAPI sign in sheets with attendee signatures for April 2024 and May 2024. DON-B stated DON-B just started at the facility and the sign in sheets were DON-B's personal copies of the sign in sheets from the meetings DON-B attended. DON-B indicated DON-B was aware the previous personnel marked x's for attendance on an online sign in sheet for the meetings. DON-B indicated DON-B understood the sheets should contain signatures to indicate who was in attendance.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43361 Based on observation, staff interview, and record review, the facility did not establish and maintain an infection control program designed to provide a safe and sanitary environment to help prevent the development and transmission of disease and infection for 2 residents (R) (R144 and R27) of 19 sampled residents. During on observation of care for R144 on 5/6/24, Certified Nursing Assistant (CNA)-R did not wear the proper personal protective equipment (PPE). During an observation of wound care for R144 on 5/6/24, Registered Nurse (RN)-S did not disinfect a pair of scissors or perform appropriate hand hygiene. During an observation of incontinence care for R27 on 5/8/24, CNA-P did not remove soiled gloves and cleanse hands before touching R27 and items in R27's room. Findings include: The facility's Infection Prevention and Control Program, with a revised date of 3/14/23, indicates: .5. Isolation Protocol (Transmission-Based Precautions): A resident with an infection or communicable disease shall be placed on transmission-based precautions as recommended by current Centers for Disease Control and Prevention (CDC) guidelines Equipment protocol: a. All reusable items and equipment requiring special cleaning or disinfection shall be cleaned in accordance with our current procedures governing the cleaning of soiled or contaminated equipment. d. Nursing staff /designee will decontaminate reusable equipment with a germicidal detergent prior to storing for reuse. The facility's Hand Hygiene policy, reviewed/revised on 11/2/22, indicates: All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. Hand Hygiene is a general term for cleaning your hands by handwashing with soap and water or the use of an antiseptic hand rub, also known as alcohol-based hand rub (ABHR). Hand hygiene is indicated and will be performed under the conditions listed in the hand hygiene table which includes: ~Before applying and after removing PPE including gloves ~Before and after handling clean or soiled dressings, linens, etc. ~After handling items potentially contaminated with blood, body fluids, secretions, or excretions ~When during resident care, moving from a contaminated body site to a clean body site ~After assistance with personal body functions (e.g., elimination, hair grooming, smoking) 6. Additional considerations: The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. R144 was admitted to the facility on [DATE] with diagnoses including osteomyelitis (bone infection) left ankle and foot and history of multi-drug resistant organism (MDRO) in nares (nostrils). R144's Minimum Data Set (MDS) assessment, dated 4/30/24, indicated R144 had a Brief Interview for Mental Status (BIMS) score of 10 out of 15 which indicated R144 had moderately impaired cognition. On 5/6/24 at 11:08 AM, Surveyor observed a contact precautions sign on R144's doorway. The sign indicated: Contact Precautions Everyone Must: Clean their hands, including before entering and when leaving room. Providers and staff must also: Put on gloves before room entry and put on gown before room entry. On 5/6/24 at 2:23 PM, Surveyor observed CNA-R enter R144's room with ice packs. CNA-R did not don a gown and gloves before CNA-R entered the room. CNA-R put a boot on R144's left foot and put the ice packs inside the boot wrapped around R144's left ankle and lower leg. R144 indicated the ice packs were for restless leg syndrome. CNA-R then exited the room. Upon exiting the room, Surveyor interviewed CNA-R. When Surveyor inquired about the contact precautions sign on R144's doorway, CNA-R stated CNA-R only needed to apply a gown and gloves if CNA-R provided care such as pericare. On 5/7/24 at 3:26 PM, Surveyor interviewed DON-B who confirmed contact precautions means staff should wear a gown and gloves any time they provide care that involves touching a resident. DON-B confirmed CNA-R should have worn a gown and gloves when CNA-R put the boot and ice packs on R144's left foot. DON-B indicated the facility was working on infection control education and ensuring proper signage was posted. 2. On 5/6/24 at 3:02 PM, Surveyor observed RN-S provide wound care for R144's left and right feet. During wound care, Surveyor observed RN-S change gloves three times without completing hand hygiene after removing soiled gloves and donning clean gloves. On 5/6/24 at 3:06 PM, Surveyor observed Licensed Practical Nurse (LPN)-T enter R144's room. RN-S asked LPN-T to get a scissors. LPN-T left the room and returned with a scissors. On 5/6/24 at 3:15 PM, Surveyor observed RN-S cut a bandage with the scissors. RN-S did not sanitize the scissors prior to use. On 5/6/24 at 3:21 PM, RN-S indicated RN-S wished there was hand sanitizer in R144's room and entered R144's bathroom to wash hands. On 5/6/24 at 3:25 PM, Surveyor interviewed RN-S who confirmed RN-S completed three glove changes without performing hand hygiene. RN-S also confirmed supplies should remain in a resident's room, including scissors. RN-S indicated it was RN-S' fourth day at the facility and RN-S was still getting used to where supplies were kept. On 5/7/24 at 3:27 PM, Surveyor interviewed DON-B who confirmed DON-B expects staff to complete hand hygiene between removing soiled gloves and donning clean gloves. DON-B also confirmed RN-S should have sanitized the scissors prior to use. 45943 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. On 5/8/24 at 11:02 AM, Surveyor observed CNA-P and CNA-Q provide care for R27. After performing hand hygiene and donning gloves, CNA-P and CNA-Q assisted R27 onto the commode via EZ stand. CNA-P removed R27's incontinence brief which was soiled with a small amount of stool. CNA-P performed hand hygiene, donned clean gloves, and washed R27's perineal area. Following perineal care, CNA-P did not remove gloves, cleanse hands, and don clean gloves before CNA-P touched R27's clean brief, clothing, wheelchair, and the EZ stand lift. On 5/8/24 at 11:10 AM, Surveyor interviewed CNA-P who verified CNA-P did not remove soiled gloves and perform hand hygiene after completing pericare and before touching the items mentioned above. On 5/8/24 at 12:57 PM, Surveyor interviewed DON-B who stated DON-B expects staff to complete hand hygiene prior to donning gloves for pericare and after cleansing the resident. DOB-B indicated moving from a dirty to clean task requires hand hygiene.

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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 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. 49010 Based on staff interview and record review, the facility did not ensure the designated Infection Preventionist (IP) completed infection prevention and control training and was employed at least part-time in the facility. This practice had the potential to affect all 42 residents residing in the facility. The facility's designated IP did not work in the facility at least part-time. Findings include: The Centers for Medicare & Medicaid Services (CMS) memo QSO-22-19-NH, last revised 6/29/22, indicates: In 2016, CMS overhauled the Requirements for Participation for Long-Term Care (LTC) facilities (i.e., nursing homes) which was implemented in three phases: .Phase 3 (11/28/19) regulations require nursing homes to have an Infection Preventionist who has specialized training onsite at least part-time to effectively oversee the facility's infection prevention and control program. During the entrance conference on 5/6/24 at 9:29 AM, Nursing Home Administrator (NHA)-A informed Surveyor that Director of Nursing Mentor (DONM)-E oversaw the IP role and mentored Assistant Director of Nursing (ADON)-C who was not yet certified as an IP. On 5/7/24 at 1:33 PM, Surveyor interviewed Director of Nursing (DON)-B who indicated DONM-E was the facility's IP, but did not work any scheduled hours in the facility. On 5/7/24 at 3:38 PM, Surveyor interviewed DONM-E who indicated DONM-E was the interim DON and IP for approximately three months before ADON-C was hired. DONM-E indicated DONM-E currently mentored ADON-C who was not IP certified, but was taking classes. DONM-E stated DONM-E did not have scheduled hours at the facility and was not considered a full time or part time staff. DONM-E stated DONM-E was more of a consultant who assisted ADON-C and DON-B. On 5/7/24 at 4:46 PM, Surveyor interviewed NHA-A who stated NHA-A was not aware the IP needs to work at least part time at the facility. On 5/8/24 at 9:00 AM, Surveyor interviewed ADON-C who indicated DONM-E was the facility's IP. ADON-C confirmed DONM-E did not work scheduled hours in the facility but was available to assist ADON-C and DON-B as needed. On 5/8/24, ADON-C provided Surveyor with ADON-C's registration for the Centers for Disease Control and Prevention (CDC) infection prevention and control training and proof of completion for seven of the 23 required training modules. ADON-C verified ADON-C has not completed all 23 modules of the IP course. On 5/8/24 at approximately 10:00 AM, DON-B indicated DON-B might have IP certification at DON-B's home. DON-B stated DON-B would look for and email the certification the following day. (continued on next page)

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 5/8/24 at 9:48 PM, DON-B emailed Surveyor and indicated DON-B could not find DON-B's IP training certification.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49010 Based on staff interview and record review, the facility did not ensure vaccinations were reviewed, offered, or administered for 3 residents (R) (R7, R11, and R21) of 5 residents reviewed for vaccines. The facility did not offer R7 the PCV20 (Prevnar 20(R)) vaccine. The facility did not offer R11 the PCV20(R) vaccine. The facility did not offer R21 the PCV20(R) vaccine. Findings include: Abbreviations (www.cdc.gov): PCV13: 13-valent pneumococcal conjugate vaccine (Prevnar13(R)) PCV15: 15-valent pneumococcal conjugate vaccine (Vaxneuvance(R)) PCV20: 20-valent pneumococcal conjugate vaccine (Prevnar 20(R)) PPSV23: 23-valent pneumococcal polysaccharide vaccine (Pneumovax23(R)) The most recent Centers for Disease Control and Prevention (CDC) recommendations for pneumococcal vaccinations indicate: For adults [AGE] years or older who have only received PPSV23, the CDC recommends: Give 1 dose of PCV15 or PCV20. The PCV15 or PCV20 dose should be administered at least 1 year after the most recent PPSV23 vaccination. Regardless of if PCV15 or PCV20 is given, an additional dose of PPSV23 is not recommended since they already received it. For those who have received PCV13 and 1 dose of PPSV23, the CDC recommends you give 1 dose of PCV20 at least 5 years after the last pneumococcal vaccine. For adults [AGE] years or older who have received PCV13, give 1 dose of PCV20 or PPSV23 at least 1 year after PCV13. Regardless of vaccine used, their vaccines are then complete. The facility's Pneumococcal Vaccine (Series) policy, with a revision date of 1/11/2024, indicates: It is our policy to offer residents and staff immunizations against pneumococcal disease in accordance with current CDC guidelines and recommendations .4. The resident /representative retains the right to refuse the immunization. Refusals should be documented in the medical record along with what education was provided and a risk versus benefit discussion. Notify Medical Doctor (MD) if vaccination is refused. 5. A consent form shall be signed prior to the administration of the vaccine and filed in the individual's medical record. 1. R7 was admitted to the facility on [DATE]. R7's diagnoses included congestive heart failure, chronic kidney disease, pneumonia (unspecified origin), and type 2 diabetes. R7 received a PPSV23 vaccine on 2/23/16 and a PCV13 vaccine on 12/17/19. R7's medical record did not indicate R7 was offered or administered the PCV20 vaccine. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. R11 was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD), multiple sclerosis, type 2 diabetes with neuropathy, and respiratory syncytial virus (RSV) pneumonia. R11 received a PPSV23 vaccine on 1/2/13 and a PCV13 vaccine on 2/25/22. R11's medical record did not indicate R11 was offered or administered the PCV20 vaccine. 3. R21 was admitted to the facility on [DATE]. R21's diagnoses included Parkinson's disease with dyskinesia, cancer, and dementia. R21 received a PPSV23 vaccine on 2/23/17 and a PCV13 vaccine on 2/12/16. R21's medical record did not indicate R21 was offered or administered the PCV20 vaccine. On 5/8/24 at 1:33 PM, Surveyor interviewed Director of Nursing (DON)-B who indicated residents should be offered vaccines upon admission and as needed per the CDC recommendations and residents' preferences. DON-B indicated the facility's vaccine policies and procedures need attention and stated DON-B was not aware the PCV20 vaccination information was not on the facility's consent/declination form. DON-B confirmed R7, R11, and R21 should have been offered the PCV20 vaccine and documentation should be in included in their medical records.