STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525441	A. Building B. Wing	07/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Manitowoc Healthcare Center	2021 S Alverno Rd Manitowoc, WI 54220

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32768 Based on observation, staff interview, and record review, the facility did not provide the necessary care and services to prevent a pressure injury from developing and/or promote healing for 1 resident (R) (R161) of 5 sampled residents. R161 had a history of a stage 2 pressure injury on the sacral/coccyx area. R161's skin integrity care plan contained an intervention for a pressure reducing cushion while up in chair. During an observation on 7/24/24, R161 did not have a cushion in R161's recliner. Findings include: The facility's Pressure Injury Risk Assessment Policy, dated 6/23, indicates: It is our policy to perform a pressure injury risk assessment as part of our systemic approach to pressure injury prevention. A risk assessment does not always identify who will develop a pressure injury, but will determine which residents are more likely to develop a pressure injury .3. Each item on the standardized risk assessment will be considered, individually, to ensure risk factors are addressed appropriately, regardless of the total risk score . 5. Residents determined at risk for developing pressure injuries will have interventions documented in plan of care based on specific factors identified in the risk assessment. From 7/22/24 to 7/24/24, Surveyor reviewed R161's medical record. R161 was admitted to the facility on [DATE] on Hospice care with diagnoses including adult failure to thrive, pressure injury to sacral region stage 2, and protein calorie malnutrition. R161's Minimum Data Set (MDS) assessment, dated 7/14/24, indicated R161 required partial to moderate assistance of staff for toileting, hygiene, dressing, and transfers. R161's skin integrity care plan, dated 7/12/24, contained an intervention for a pressure reducing cushion to protect R161's skin while up in chair. A nursing note, dated 7/17/24, indicated R161's pressure injury had resolved and R161 had no open areas. A nursing note, dated 7/18/24, indicated R161's coccyx area re-opened and R161 had a stage 2 pressure injury that measured 0.2 cm (centimeters) (length) x 0.9 cm (width) x 0.3 cm (depth) that was facility-acquired. (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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/24/24 at 10:01 AM, Surveyor interviewed Director of Nursing (DON)-B who indicated R161 was admitted to the facility on Hospice services with a donut-type cushion. DON-B indicated the facility got rid of the cushion and ordered a new one. On 7/24/24 at 10:42 AM, Surveyor, DON-B, and Assistant Director of Nursing (ADON)-H observed R161's coccyx. DON-B and ADON-H assisted R161 up from R161's recliner and lowered R161's pants and brief. Surveyor noted a reddened open area on the upper portion of R161's coccyx. Surveyor also noted R161's recliner did not contain a pressuring reducing cushion. DON-B verified R161's recliner did not contain a cushion. ADON-H showed Surveyor a cushion in R161's wheelchair and indicated the cushion was from home and meant for a household chair. Following the observation, Surveyor interviewed Certified Nursing Assistant (CNA)-I who was in the nurses' station. CNA-I stated CNA-I had just transferred R161 from bed to recliner. When Surveyor asked CNA-I if R161 had a pressure reducing cushion for R161's recliner, CNA-I and other CNAs near the nurses' station indicated R161 did not have a pressure reducing cushion for R161's recliner since R161 was admitted to the facility, only the cushion brought from home in R161's wheelchair. On 7/24/24 at 11:01 AM, Surveyor interviewed DON-B who stated R161 should have a pressure reducing cushion in R161's recliner. DON-B indicated DON-B would look into a cushion for R161. On 7/24/24 at 11:21 AM, DON-B approached Surveyor and stated DON-B found a cushion that R161 could use in R161's recliner.

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45942 Based on observation, staff interview, and record review, the facility did not ensure it was free of a medication error rate of 5% or greater. During medication administration observations, 2 errors occurred during 25 opportunities which resulted in an 8% medication error rate that affected 1 resident (R) (R18) of 12 residents observed during medication pass. On 7/22/24, R18 was administered an incorrect dose of two eye drops. Findings include: The facility's Medication Administration policy, with a revision date of June 2024, indicates: .10. Ensure that the six rights of medication administration are followed: a. Right resident, b. Right drug, c. Right dosage, d. Right route, e. Right time, f. Right documentation. Compare medication source with Medication Administration Record (MAR) to verify resident name, medication name, form, dose, route, and time . On 7/22/24, Surveyor reviewed R18's medical record. R18 was admitted to the facility on [DATE] with diagnoses including unspecified macular degeneration and other chronic allergic conjunctivitis. R18's Minimum Data Set (MDS) assessment, dated 7/7/24, stated R18 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R18 had intact cognition. R18's medical record indicated R18 was responsible for R18's healthcare decisions. On 7/22/24 at 12:48 PM, Surveyor observed Registered Nurse (RN)-C prepare and administer R18's noon medication which included Ketotifen Fumarate 0.035% eye drop solution one drop in each eye. On 7/22/24 at 12:55 PM, RN-C administered Good Sense Artificial Tears (Polyethyl Glycol-Propyl Glycol) 0.5% -0.6% one drop in each eye. On 7/22/24 at 2:20 PM, Surveyor reviewed R18's medical record which contained the following physician orders: ~ Ketotifen Fumarate 0.025% eye drop solution, one drop in each eye in the afternoon for itchy eyes. ~ Systane Solution 0.4%-0.3% (Polyethyl Glycol-Propyl Glycol), instill one drop in both eyes in the morning for dry eyes, instill one drop in both eyes in the afternoon for dry eyes, and instill one drop in both eyes at bedtime for dry eyes. On 7/22/24 at 2:25 PM, Surveyor verified with RN-C that R18 was given Ketotifen Fumarate 0.035% but had an order for Ketotifen Fumarate 0.025%. RN-C verified RN-C should have clarified the strength of the eye drops. Per RN-C, the eye drops were the ones staff used because they were the only stock the facility had. On 7/22/24 at 2:27 PM, Surveyor observed Licensed Practical Nurse (LPN)-D asked R18's provider to change the prescribed strength from 0.025% to 0.035%. The provider agreed with the change. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/22/24 at 2:30 PM, Surveyor verified with LPN-D that LPN-D administered Good Sense Artificial Tears 0.5% -0.6%, but R18 had an order for 0.4%-0.3%. Surveyor observed LPN-D update R18's provider via phone and request to change medication to the facility's stock strength of 0.5%-0.6%. On 7/23/24 at 1:02 PM, Surveyor interviewed Director of Nursing (DON)-B who verified the above observations were considered medication errors. DON-B indicated if the facility's stock eye drop strengths are different than what is prescribed, staff should not administer the eye drops. DON-B stated staff should administer the correct strength or update the resident's provider.

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 43361 Based on observation and staff interview, the facility did not ensure food was stored and prepared in a safe and sanitary manner. This practice had the potential to affect 60 of 105 residents residing in the facility. On 7/23/24 and 7/24/24, beverages were not iced during meal service. The temperature of the milk at the end of meal service on 7/23/24 was 59 degrees Fahrenheit (F). Resident food was not heated in a microwave according to regulations or the facility's policy. Findings include: On 7/22/24 at 8:32 AM, Surveyor began an initial kitchen tour with Assistant Dietary Manager (ADM)-F who stated the facility follows the Wisconsin Food Code. Beverage Temperatures: The Wisconsin State Food Code documents at 3-501.16 Time/Temperature Control for Safety Food, Hot and Cold Holding: (A) .Time/Temperature Control for Safety Food shall be maintained: (2) At 41 degrees F or less. The facility's Record of Food Temperatures policy, dated January 2024, indicates: .4. Potentially hazardous cold food temperatures will be kept at or below 41 degrees F. On 7/23/24 at 11:22 AM, Surveyor observed Prep [NAME] (PC)-G temp cold beverages prior to meal service. Surveyor observed pitchers of juice and two half gallons of milk that were on a utility cart and not on ice. The temperature of the cold beverages was 40 degrees F. On 7/23/24 at 11:44 AM, Surveyor observed PC-G begin meal service for residents. PC-G started with residents who ate in the dining rooms and then served residents who ate in their rooms. During meal service, Surveyor observed Certified Nursing Assistant (CNA) staff pour milk and juice for residents as their trays were being delivered. On 7/23/24 at 12:05 PM, Surveyor observed PC-G plate the last lunch meal. On 7/23/24 at 12:06 PM, Surveyor requested PC-G re-temp the milk. PC-G opened a new half gallon because the previous half gallon was gone. PC-G opened the container, poured milk into a beverage cup, and placed a thermometer in the milk. Surveyor noted the temperature of the milk was 59 degrees F. On 7/23/24 at 12:06 PM, Surveyor interviewed PC-G who stated beverages are placed on a cart in the dining room until meal service is over and are not kept on ice. During the interview, Surveyor observed CNA staff put the beverages on the cart back in the refrigerator. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/24/24 at 8:15 AM, Surveyor observed breakfast beverages on the rehab unit that were not stored in ice to keep them chilled. On 7/24/24 at 10:43 AM, Surveyor interviewed Dietary Manager (DM)-E who confirmed beverages should remain below 41 degrees F through the end of meal service. Microwaved Food: The Wisconsin State Food Code documents at 3-403.11 Microwave Reheating for Hot Holding: (A) Time/Temperature Control for Safety Food that is cooked, cooled, and reheated for hot holding shall be reheated so that all parts of the food reach a temperature of at least 165 degrees F for 15 seconds. (B) Time/Temperature Control for Safety Food reheated in a microwave oven for hot holding shall be reheated so that all parts of the food reach a temperature of at least 165 degrees F and the food is rotated or stirred, covered, and allowed to stand covered for 2 minutes after reheating. (C) Ready to eat Time/Temperature Control for Safety Food that has been commercially processed and packaged in a food processing plant that is inspected by the regulatory authority that has jurisdiction over the plant shall be heated to a temperature of at least 135 degrees F when being reheated for hot holding. The facility's Use and Storage of Food Brought in by Family or Visitors policy, with a review date of 5/1/24, indicates: .4. Foods may be reheated in a microwave and should be stirred during the reheating process and reheated to at least 165 degrees F. 5. Ensure that reheated foods are cooled enough to a palatable temperature prior to consuming to prevent burns. The facility's Record of Food Temperatures policy, dated January 2024, indicates: .9. Ready to eat foods that require heating before consumption should be taken directly from a sealed container or an intact package from an approved processing source and heated to at least 135 degrees F for holding or hot service. On 7/23/24 at 11:35 AM, Surveyor observed PC-G complete hand hygiene and heat pre-packaged store bought soup containers for 2 residents. PC-G microwaved the soup containers per the instructions on the package. Surveyor noted PC-G did not stir or temp the soup prior to giving the soup to a CNA to serve. Surveyor observed PC-G state to the CNA to stir the soup prior to serving it. On 7/23/24 at 12:00 PM, Surveyor observed PC-G remove leftovers from the microwave and give them to a CNA to serve to a resident. PC-G stated to the CNA that PC-G microwaved the leftovers for 3-1/2 to 4 minutes. Surveyor did not observe PC-G temp the leftovers prior to service. On 7/23/24 at 12:08 PM, Surveyor interviewed PC-G who confirmed PC-G did not temp the microwaved items prior to serving them to residents. PC-G indicated PC-G did not know the exact temperature of the items but indicated the soup should have been heated to 135 degrees F. PC-G stated the resident who was served leftovers liked food scalding hot (at least 210 degrees F). During an interview on 7/23/24 at 1:23 PM, PC-G stated PC-G followed the instructions on the packaging for the soup that PC-G heated for residents. On 7/24/24 at 10:43 AM, Surveyor interviewed DM-E who confirmed staff should temp microwave heated food and should stir the food prior to service. DM-E stated DM-E would provide staff training on the process.