STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525520	A. Building B. Wing	08/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dove Healthcare - Lodi	700 Clark St Lodi, WI 53555

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. 29360 Based on observation and interview, the facility did not ensure each resident has the right to privacy and confidentiality for 7 of 9 residents (R) reviewed. (R3, R4, R5, R6, R7, R8, and R9) During the survey, a camera was observed to be used for surveillance in the facility dining room. The dining room is used throughout the day for meals and visits. Evidenced by: On 8/14/24 at 11:00 AM, Surveyor observed a camera in the dining room, just inside the doorway from the hallway. Surveyor noted the dining room is used throughout the day by residents for meals and visits. This includes R3, R4, R5, R6, R7, R8, and R9. Surveyor noted there was no signage or posted notification to any resident, family, or staff who may use the dining room that the room was under surveillance by a camera. On 8/14/24 at 12:00 PM, Surveyor interviewed NHA A (Nursing Home Administrator). Surveyor asked NHA A if there were any cameras in the dining room NHA A stated not to her knowledge. NHA A opened the camera feed on her computer. NHA A and Surveyor observed a video of the dining room with residents eating the noon meal. NHA A stated she did not know there was a camera in the dining room NHA A stated there should not be a camera in the dining room. NHA A stated the camera will be removed. Surveyor requested a copy of the facility's camera surveillance policy. On 8/14/24 at 4:00 PM, NHA A informed Surveyor she was unable to find a camera surveillance policy.

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39713 Based on observation, interview, and record review, the facility did not ensure each resident receives cares, consistent with professional standards of practice to prevent pressure injuries (PIs) for 2 of 3 residents (R) sampled out of a total sample of 9 (R2 and R8). R8 was admitted on [DATE], without a pressure injury or catheter. R8 was hospitalized on [DATE], returning on [DATE] with a foley catheter in place. The facility did not develop a care plan addressing the catheter until [DATE], after erosion to the penis was identified.The facility failed to ensure interventions to prevent medically related pressure injuries (PI) were implemented correctly to prevent PI development, failed to complete weekly measurements and assessments, and failed to get orders for treatments. R8 subsequently developed a full thickness wound that extended from the tip of the penis where the catheter is placed, through the meatus, and down to the shaft. These failures created a finding of immediate Jeopardy (IJ) which began on [DATE]. The NHA (Nursing Home Administrator) was notified of the IJ on [DATE] at 3:55 PM. The immediate jeopardy was removed on [DATE]; however, the deficient practice continues at a scope/severity of D (potential for more than minimal harm that is not immediate jeopardy/isolated) as evidenced by the following example: R2 was admitted to the facility on [DATE] without a pressure injury. The facility did not complete weekly skin checks and did not identify new pressure injuries. This is evidenced by: Example 1 An article from the National Library of Medicine (NIH) at pubmed.ncbi.nih.gov/21205992 from, [DATE] states in part . Medical devices often are overlooked as a potential cause of pressure ulcers. Indwelling urinary catheters have been described as a cause of urethral erosion. In men, the resultant partial-thickness or full-thickness wound can involve a small area of the glans penis or [NAME] the glans or penile shaft, requiring reconstructive surgery or urinary diversion. An article from the NIH at pubmed.ncbi.nih.gov/36493361 from [DATE] states in part . Urethral erosion secondary to a medical device-related pressure injury (MDRPI) is preventable, understudied , not well understood, and often overlooked. The facility document titled Pressure Injury Prevention Guidelines, dated 2023, states in part . Preventive Skin Care: 1. Inspect skin while providing care, paying close attention to bony prominences. 2. Inspect skin underneath medical devices at least twice daily. Keep skin clean and dry underneath. Adjust devices as needed for proper fit. Repositioning: Avoid positioning the resident directly onto medical devices (i.e., tubes, drainage systems). (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility policy titled, Pressure Injury Staging Guidelines, last reviewed ,d+[DATE], states in part . Purpose: To provide a common language for the description of the depth of pressure related injuries. These guidelines are to be utilized for pressure related injuries, no other wound should be utilized using this language. This common language is adopted from the National Pressure Ulcer Advisory Panel (NPUAP). National Pressure Ulcer Advisory Panel Pressure Injury Stages: Pressure Injury: A pressure injury is localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device. The pressure injury will present as intact skin and may be painful. A pressure injury will present as an open ulcer the appearance of which will vary depending on the stage and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by skin temperature and moisture; nutrition; perfusion; co-morbidities; and condition of the soft tissue. Stage 4 Pressure Injury: Full -thickness skin and tissue loss. Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage, or bone in the ulcer. Slough and/or eschar may be visible on some parts of the wound bed. Epibole (rolled edges), undermining and/or tunneling often occur. Depth caries by anatomical location. If slough or eschar obscures the wound bed, it is an Unstageable Pressure Injury. Medical Device Related Pressure Injury: Medical device related pressure injuries result from the use of devices designed and applied for diagnostic or therapeutic purposes. The resultant pressure injury generally conforms to the pattern or shape of the device. The injury should be staged using the staging system. The facility policy titled Catheter Care, last reviewed ,d+[DATE], states in part . Policy: It is the policy of this facility to ensure that residents with indwelling catheters receive appropriate catheter care and maintain their dignity and privacy when indwelling catheters are in use. Policy Explanation: 1. Catheter care will be performed every shift and as needed by nursing personnel. Compliance Guidelines: 7. Perform hand hygiene. 8. [NAME] gloves. Both: 20. Ensure the catheter tubing is secured by use of stat lock or leg secure device. The cath secure should be alternated each day. 21. Report abnormal findings to the nurse and document any care that needs to be in the resident record. 25. Perform hand hygiene. The facility policy titled, Hand Hygiene, last reviewed [DATE], states in part . Policy: All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. 2. Hand hygiene is indicated and will be performed under the conditions listed in, but not limited to, the attached hand hygiene table. 6. Additional considerations: a. 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. Hand Hygiene Table: - Before performed resident care procedures. - When, during resident care, moving from a contaminated body sit to a clean body site. - Before applying and after removing personal protective equipment (PPE), including gloves. - After handing items potentially contaminated with blood, body fluids, secretions, or excretions. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R8 was admitted to the facility on [DATE]. R8's diagnoses include Flaccid hemiplegia affecting right dominant side, diabetes mellitus type 2, cerebral infarction, benign prostatic hyperplasia, neuromuscular dysfunction of bladder, and urinary retention. R8's quarterly Minimum Data Set (MDS) assessment, with an assessment reference date of [DATE] indicates R8 has a Brief Interview of Mental Status (BIMS) of 11, indicating moderate cognitive impairment. R8 is dependent on staff for toileting hygiene, shower/bathe, upper and lower body dressing, bed mobility, and toilet transfers. R8 requires moderate/substantial assistance with upper body dressing, personal hygiene, sit to stand, and transfers from chair/bed to chair. Urinary continence is not rated due to urinary catheter in place and R8 is always incontinent of bowel. R8 was hospitalized on [DATE] and returned on [DATE] with foley catheter in place. R8's Braden Scores include in part . [DATE], indicates a 12, High Risk. [DATE], indicates 13, Moderate Risk [DATE], indicates 15, At Risk [DATE], indicates 14, Moderate Risk [DATE], indicates 15, At Risk [DATE], indicates 14, Moderate Risk [DATE], indicates 14, Moderate Risk [DATE], indicates 15, At Risk R8's care plan includes . Problem: The resident has Foley Catheter d/t (due to) retention of urine, neurogenic bladder. Date Initiated: [DATE]. Goal: The resident will be/remain free from catheter-related trauma through review date. Date Initiated: [DATE]. Interventions: Monitor Stat lock or catheter leg strap for tension on catheter. Catheter should be tension free. Date Initiated: [DATE]. Note: R8's catheter was placed at the hospital in ,d+[DATE] but his care plan was not initiated until [DATE], after erosion to the meatus was already identified. R8's Certified Nursing Assistant (CNA) Kardex, printed [DATE], states in part . Bladder/Bowel: Monitor stat lock or catheter leg strap for tension on catheter. Catheter should be tension free. Resident Care: Provide pericare after each incontinent episode. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Nurses Note from [DATE] at 12:29 PM states, catheter changed today clear yellow urine noted changed with DON (Director of Nursing), noted to have tip of penis split, NP (Nurse Practitioner) updated on this. Progress Note by NP (Nurse Practitioner) from [DATE] at 3:30 PM states in part . On exam, significant urethral erosion noted. Urology following, next scheduled appointment is in November but recommending patient to be seen sooner to discuss options. No S/S (signs or symptoms) infection, catheter draining dilute yellow urine. Physical Examination: GU (genitourinary) - indwelling Foley catheter, significant ureteral erosion with intermittent mild pain, no sign of infection. Assessment and Plan: Urethral erosion by catheter: Indwelling Foley catheter for urinary retention. Urology following, last seen ,d+[DATE]. Continue cath (catheter) exchanges as needed. Follow-up November, requesting sooner appointment given noted urethral erosion. Orders to monitor Stat Lock strap every shift to secure catheter but prevent tension on urethral meatus. Progress Note by NP from [DATE] at 1:00 PM states in part . Physical Examination: GU (genitourinary) - indwelling Foley catheter, significant ureteral erosion with intermittent mild pain, no sign of infection. Assessment and Plan: Urinary retention due to benign prostatic hyperplasia: Continue Flomax. Continue indwelling Foley catheter for retention. Urology following, last seen ,d+[DATE]. Continue cath exchanges as needed. Follow-up November, requesting sooner appointment given noted urethral erosion. Orders to monitor Stat Lock/leg strap every shift to secure catheter but prevent tension on urethral meatus. Urethral erosion by catheter: Indwelling Foley catheter for urinary retention. Urology following, last seen ,d+[DATE]. Continue cath (catheter) exchanges as needed. Follow-up November, requesting sooner appointment given noted urethral erosion. Orders to monitor Stat Lock strap every shift to secure catheter but prevent tension on urethral meatus. Of Note: Despite the nursing staff documenting tip of penis split and NP writing significant urethral erosion to the penis the facility did not implement weekly assessments, complete weekly measurements, or implement any treatments of this area. Urology HPI (History of Present Illness): ***On [DATE] at 2:17 PM, clinic staff wrote to MD, DON at [facility name] states she assisted in a foley exchange for R8 today and noticed his meatus is open the entire length of the tip of his penis. She states this has not be [sic] documented/noticed in the past. The meatus is red and inflamed. He is reporting no pain. There is no documentation of trauma or issues with his previous catheter exchanges. She does state R8 is confused at baseline, pulls at the catheter and has no knowledge of what could have happened. They are requesting an appointment. Exam Constitutional: GU: Penis: normal penis (urethral erosion due to tension from foley) and circumcised; no lesions. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Urology Clinic Visit Note from [DATE] states in part . Follow up incontinence: Patient with indwelling foley with recent issue noted of urethral erosion. Exam today showed that his Foley catheter was rerouted posteriorly underneath his depends undergarment creating tension on the Foley catheter. It was affixed to his inner thigh with a Stat Lock. We repositioned his Foley catheter in a manner to get off tension to prevent the ongoing urethral erosion. Tissue did not look infected. We did note the urethral erosion can be seen only back to the penoscrotal junction and some men [sic]. An additional option would be given that the nursing facility finds it difficult to maintain it off tension while riding into posteriorly underneath the depends undergarment they can create a small window within the depends and around the catheter out that was we can to drainage [sic]. Skilled Nursing Facility (SNF) Progress Note by NP from [DATE] at 1:45 PM states in part . Physical Examination: GU (genitourinary) - indwelling Foley catheter, significant ureteral erosion with intermittent mild pain, no sign of infection. SNF Monthly Compliance Note by Medical Doctor (MD) from [DATE] at 6:15 PM states in part . At the underlying obstructive uropathy with Foley catheter in place. Has urethral erosion secondary to chronic Foley catheter followed by urology. Additionally has significant issues with self-induced trauma recommend suprapubic but defer to urology for input. Care discussed with nursing staff EHR (electronic health record) is reviewed. SNF Progress Note by NP from [DATE] at 1:45 PM states in part . Physical Examination: GU (genitourinary) - indwelling Foley catheter, significant ureteral erosion with intermittent mild pain, no sign of infection. Wound Physician document titled, Wound Evaluation & Management Summary, dated [DATE], states in part . Unstageable (Due to A Device/Dressing) Penis Undetermined Thickness. Etiology: Pressure. Wound Size (L x W x D): 1 x 2 x 0.2 cm (centimeters). Exudate: Moderate Sero - sanguinous. Expanded Evaluation Performed: Reviewed off-loading surfaces and discussed surfaces care plan. Considered patient behavior as factor that is complicating wound healing and discussed it further with staff and/or family. Discussed wound healing trajectory and expectations with patient and/or family. Patient requiring an increase in the level of care. Rec to consider removal of cath vs if ongoing need, consult with urology for SP (suprapubic) placement. Dressing Treatment Plan: Triple antibiotic ointment apply twice daily for 30 days. Registered Nurse (RN) Weekly Wound Assessment, dated [DATE], states in part . A. Communication. 1a. Date MD/Alternate Notified/Last Updated: [DATE]. 1b. Details: NP. B. Observation/Data: 1. Location: penis. 2a. Indicate whether this site was acquired during the residents stay or whether it was present on admission: 2b. Acquired. Date acquired: [DATE]. 3a. Type: pressure. 4. Pressure Ulcer Stage. 4a. Original: SDTI (suspected deep tissue injury). Current: SDTI. 5. Visible Tissue. 5a. Overall Impression: First observation, no refence. 5f. Moist. 6. Drainage. 6a. Type: Serosanguinous. 6b. small. 8a. Length: 2. 8b. Width: 2. 8c. Depth(cm) or UTD (unable to determine): 0.2. C. Treatment. 2. Current treatment plan: TAO BID (triple antibiotic ointment twice a day). Evaluation. Wound Progress: Unstageable d/t (due to) device. Comments: Wound progress: exacerbated d/t pt (patient) seen by urology. Per wife declined void trial for cath removal or SP cath placement. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Wound Physician document titled, Wound Evaluation & Management Summary, dated [DATE], states in part . Unstageable (Due To A Device/Dressing) Penis Undetermined Thickness. Etiology: Pressure. Wound Size (L x W x D): 2 x 2 x 0.2 cm (centimeters). Exudate: Light Sero - sanguinous. Wound Progress: Exacerbated due to patient seen by urology, per report wife declined void trial for cath removal or SP cath placement. Expanded Evaluation Performed: Counseling offered to optimize wound healing regarding relevant conditions including Diabetes. Reviewed off-loading surfaces and discussed surfaces care plan. Discussed signs of atypical ulceration and consideration of biopsy with patient and/or family. Discussed wound healing trajectory and expectations with patient and/or family. Dressing Treatment Plan: Triple antibiotic ointment apply twice daily for 23 days. Recommendations: Reposition per facility protocol; Off-load wound: ensure foley is secured so cath is off tension and not placing tension along glans of penis. RN Weekly Wound Assessment, dated [DATE], states in part . A. Communication. 1a. Date MD/Alternate Notified/Last Updated: [DATE]. 1b. Details: NP. 3. Special Equipment/Preventative measures: ensure foley is secured so cath is off tension and not placing tension along glans of penis. B. Observation/Data: 1. Location: penis. 2a. Indicate whether this site was acquired during the residents stay or whether it was present on admission: 2b. Acquired. Date acquired: [DATE]. 3a. Type: pressure. 4. Pressure Ulcer Stage. 4a. Original: SDTI (suspected deep tissue injury). Current: SDTI. 5. Visible Tissue. 5a. Overall Impression: Unchanged. 5f. Moist. 6. Drainage. 6a. Type: Serosanguinous. 6b. small. 8a. Length: 2. 8b. Width: 2. 8c. Depth(cm) or UTD (unable to determine): 0.2. C. Treatment. 2. Current treatment plan: TAO BID (triple antibiotic ointment twice a day). Evaluation. Wound Progress: Unstageable d/t device (catheter). Comments: Wound progress: exacerbated d/t pt was seen by urology. Per wife declined void trial for cath removal or SP cath placement. Wound Physician document titled, Wound Evaluation & Management Summary, dated [DATE], states in part . Unstageable (Due To A Device/Dressing) Penis Undetermined Thickness. Etiology: Pressure. Wound Size (L x W x D): 2 x 2 x 0.2 cm (centimeters). This visit's measurements are noted by the clinician to be exactly the same as the previous visit. Exudate: Light Sero - sanguinous. Wound progress: Not at Goal. Dressing Treatment Plan: Triple antibiotic ointment apply twice daily for 16 days. Recommendations: Reposition per facility protocol; Off-load wound: ensure foley is secured so cath is off tension and not placing tension along glans of penis. RN Weekly Wound Assessment, dated [DATE], states in part . A. Communication. 1a. Date MD/Alternate Notified/Last Updated: [DATE]. 1b. Details: NP. 3. Special Equipment/Preventative measures: ensure foley is secured so cath is off tension and not placing tension along glans of penis. B. Observation/Data: 1. Location: penis. 2a. Indicate whether this site was acquired during the residents stay or whether it was present on admission: 2b. Acquired. Date acquired: [DATE]. 3a. Type: pressure. 4. Pressure Ulcer Stage. 4a. Original: SDTI (suspected deep tissue injury). Current: SDTI. 5. Visible Tissue. 5a. Overall Impression: Worsening. 5f. Moist. 6. Drainage. 6a. Type: Serosanguinous. 6b. small. 8a. Length: 2. 8b. Width: 3. 8c. Depth(cm) or UTD (unable to determine): 0.2. C. Treatment. 2. Current treatment plan: TAO BID (triple antibiotic ointment twice a day). Evaluation. Wound Progress: Unstageable d/t device (catheter). Comments: Expanded Evaluation Performed: Counseling offered to optimize wound healing and relevant conditions were addressed through management changes or investigations regarding conditions including patient with chronic foley, patient needs SP cath placed to offload however wife (poa [sic] (power of attorney)) declines pursuing this or even repeat voiding trial to assess ability to remove caths [sic]. Reviewed off-loading surfaces and discussed surfaces care plan. Considered patient healing trajectory and expectations with patient and/or family. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Wound Physician document titled, Wound Evaluation & Management Summary, dated [DATE], states in part . Unstageable (Due To A Device/Dressing) Penis Undetermined Thickness. Etiology: Pressure. Wound Size (L x W x D): 2 x 3 x 0.2 cm (centimeters). This visit's measurements are noted by the clinician to be exactly the same as the previous visit. Exudate: Light Sero - sanguinous. Wound progress: Not at Goal. Expanded Evaluation Performed: Counseling offered to optimize wound healing and relevant conditions were addressed through management changes or investigations regarding conditions including patient with chronic foley, patient needs SP cath placed to offload however wife (poa (power of attorney)) declines pursuing this or even repeat voiding trial to assess ability to remove caths [sic]. Reviewed off-loading surfaces and discussed surfaces care plan. Considered patient healing trajectory and expectations with patient and/or family. Dressing Treatment Plan: Triple antibiotic ointment apply twice daily for 30 days. Recommendations: Reposition per facility protocol; Off-load wound: ensure foley is secured so cath is off tension and not placing tension along glans of penis. R8's Medication Administration Record (MAR) states in part . - Shower weekly on Wednesday complete skin assessment. Only document (In Health Status) if skin issue found, every day shift every Wednesday. Start Date: [DATE]. - Monitor stat-lock or leg strap for indwelling catheter Q (every) shift. Ensure catheter is secure but relaxed, preventions of tension on urethral meatus due to urethral erosion noted. Every shift for monitor secure catheter, prevent tension to urethral meatus. Start Date: [DATE]. - Lidocaine HCl (low hydrochloric acid) External Gel 2 %. Apply to urethral meatus topically every 12 hours as needed for urethral erosion pain. (lidocaine uro-jet). Start Date: [DATE]. - Wound care to penis: Cleanse and dry, apply triple antibiotic ointment twice daily. May use equivalent. Every day and evening shift for wound care. Start Date: [DATE]. Of Note: Wound Physician Note from [DATE] states in part . Primary Dressing: Triple antibiotic ointment apply twice daily for 30 days. The facility did not start the treatment or place it on R8's MAR until [DATE]. On [DATE] at 8:45 AM, Surveyor observed CNA D (Certified Nursing Assistant) and CNA E completed catheter care with R8. Surveyor observed R8's stat lock on the right thigh with catheter connected. Surveyor observed the tubing to be slack and without tension at this time. Surveyor observed R8's penis to be open from the tip through the meatus, down to the shaft. CNA D washed hands and placed gloves, peri area cleansed, gloves changed. CNA D applied clean gloves and patted dry the area. Powder placed in groin per standing orders. On [DATE] at 9:00 AM, Surveyor interviewed CNA D. Surveyor asked CNA D if hands should be washed when going from dirty to clean and when changing gloves. CNA D stated, yes. On [DATE] at 9:08 AM, Surveyor interviewed NHA A and ADON C. Surveyor asked ADON C when it is appropriate to wash hands. ADON C stated, before cares, when changing gloves and before leaving a room. Surveyor asked ADON C if she would expect staff to wash hands when going from dirty to clean. ADON C stated, yes. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 10:55 AM, Surveyor interviewed NHA A and ADON C (Assistant Director of Nursing). Surveyor asked ADON C when R8's catheter was placed. ADON C stated, [DATE] during a hospitalization . Surveyor asked ADON C if R8 has always had a Stat Lock or strap in place to secure the catheter. ADON C stated, should always be a stat lock or securing device so would have/should have came back with that as well. There is a note when R8 returned from the hospital on [DATE] to follow up with Urology for irritation due to repeated cathing. Surveyor asked ADON C when R8 was seen by Urology. ADON C stated [DATE]. Surveyor asked ADON C if measurements and assessment should have been completed when the area was first discovered on [DATE]. ADON C stated, the area should have been assessed at the time of the note, [DATE]. The NP did see R8 on [DATE] and wrote a note but did not complete measurements. Surveyor asked ADON C if she would have expected this area to be assessed and measurements completed. ADON C stated, I would have hoped that would have been done but I can't speak on their behalf. Surveyor asked ADON C when R8 had measurements completed on the area. ADON C stated, the first measurements were completed by Wound MD G on [DATE]. Surveyor asked ADON C what the initial date of discovery was for R8's penile erosion. ADON C stated, [DATE] according to the nurses notes. Surveyor asked ADON C when on the RN Wound Assessment sheet from [DATE] it indicates the date of discovery or date acquired as [DATE]. ADON C stated, I used that date as Wound MD G put in his documentation that the wound duration was greater than 17 days. What I did was go off Wound MD G's estimated date not the actual charting that identified the area. This area should have been measured weekly from the time of discovery. On [DATE] at 12:00 PM, Surveyor interviewed Wound MD G. Surveyor asked Wound MD G about R8's wound. Wound MD G stated this area to the glans penis is considered a medical device related pressure injury which is common in long-term catheter use. Surveyor asked Wound MD G about staging of this area. Wound MD G states, the charting system we use for documentation locks out the depth but this is a full-thickness, stage 4 pressure injury to the penis. Surveyor asked Wound MD G if he considered this to be avoidable. Wound MD G stated, initially this would have been considered avoidable but R8's wife has declined other interventions, such as, SP catheter or voiding trial to remove the Foley. Since those things have been declined, I would say this is now unavoidable. There is usually some expected erosion from catheter placement but the extent of this is avoidable. Long-term catheter use will have some degree of erosion. On [DATE] at 12:15 PM, Surveyor interviewed NP F (Nurse Practitioner). Surveyor asked NP F if she would have expected the area on R8's penis to have been assessed and measured at time of discovery. NP F states, yes, they should have. I would have expected an assessment, measurements, and treatment. Surveyor asked NP F if she completed any measurements of the area when she assessed R8 on [DATE]. NP F stated, I did not do any measurements, but I placed orders for R8 to be seen on wound rounds and a Urology referral. Surveyor asked NP F if the pressure injury to R8's penis was avoidable. NP F states, the catheter puts R8 at risk, but the degree is likely avoidable. When I went to assess R8 on [DATE] his catheter was not in a good position. The catheter was tight, and the tubing was under his leg instead of over causing significant tension on the catheter. I did educated staff at that time about ensuring the tubing was loose and not tight. The facility's failure to implement interventions to ensure a medical device did not cause a pressure injury, failure to complete weekly assessments and measurements created a harm, leading to a finding of immediate jeopardy. The facility removed the immediacy on [DATE], when they completed the following: (continued on next page)

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	525520	A. Building B. Wing	08/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dove Healthcare - Lodi	700 Clark St Lodi, WI 53555

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- The facility conducted a sweep of all residents with an indwelling Foley catheter to ensure robust interventions are in place to prevent PI development. - The facility completed skin assessments on all residents with an indwelling Foley catheter. - Education will be provided to nursing staff prior to their next working shift on the following. - All Nursing Staff (nurses, nurse aides and ha (hospitality aides)): All residents with an indwelling foley will wear a leg strap or utilize a stat lock. Education and competency checks for nurses and nurse aides will be completed to ensure correct positioning to prevent tubing from being taunt or causing pressure on the urethra. - Monitoring of skin integrity on residents with catheters during cares paying special attention to skin impairment. Immediately reporting any skin impairment to licensed nurse. - Licensed Nurses: Documentation of any skin impairment. Wound documentation to include weekly measurements and assessments. - Obtain treatment orders upon discovery. - On [DATE] the Facility reviewed the Policy and Procedure for Prevention of Pressure Injury F686 - On [DATE] the Facility reviewed the Policy and Procedure for Change of Condition notification. - On [DATE] the Facility initiated re-education with all Licensed Nursing Staff and nurse aides on identifying and reporting Changes of Condition when newly identified changes in health status are identified. - On [DATE] the Facility initiated re-education with all Licensed Nursing Staff on completion of a comprehensive assessment on all skin events with a noted change in size, shape, and clinical presentation at the time of discovery. - On [DATE] the Licensed Nursing Staffand nurse aide were re-educated on catheter care including but not limited to pressure ulcer prevention and treatment. - The Facility will complete random audits 3x weekly with Licensed Nurses to gauge understanding related to completion of Changes of Condition. Remedial education will be provided at the time of completion of audits if indicated. - The Facility will complete random audits 3x weekly on catheters to ensure care is provided per clinical standards. To include proper placement of leg strap/stat loc to prevent pressure. Remedial education will be provided at the time of completion of audits if indicated. - The facility will complete random audits 3x weekly on pressure ulcers to ensure care is provided per clinical standards. Remedial education will be provided at the time of completion of audits if indicated. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- The facility will complete random audits 3x weekly on treatment records and weekly skin assessments to ensure care is provided per clinical standards. Remedial education will be provided at the time of completion of audits if indicated. - The facility will audit residents with medical device pressure injuries 3x weekly to ensure weekly assessments are documented in the medical record including measurements. - The results of the audits will be reported to the quality assurance and performance improvement (QAPI) committee and adjustments will be made to frequency of audits based on findings. Example 2: R2 was admitted to the facility on [DATE]. R2's diagnoses include hepatic encephalopathy, alcoholic cirrhosis of liver with ascites, chronic kidney disease (CKD), hepatic failure, degeneration of nervous system due to alcohol, splenomegaly, anesthesia of skin, and paresthesia of skin. R2's significant change Minimum Data Set (MDS) assessment, with an assessment reference date of [DATE] indicates R2 has a Brief Interview of Mental Status (BIMS) of 13, indicating R2 is cognitively intact. R2 is dependent on staff for toileting hygiene, shower/bathe self, upper and lower body dressing, personal hygiene, and transfers. R2 requires substantial/maximum assistance with rolling left to right. R2 is frequently incontinent of urine and always incontinent of bowel. R2's care plan includes . Problem: The resident has DTI (deep tissue injury) pressure ulcer of right heel (present on readmission [DATE]) r/t (related to) immobility secondary to cirrhosis of the liver. Date initiated: [DATE]. Interventions: Administer treatments as ordered and monitor for effectiveness. Date Initiated: [DATE]. Educate the resident/family/caregivers as to causes of skin breakdown; including: transfer/positioning requirements; importance of taking care during ambulating/mobility, good nutrition and frequent repositioning. Date Initiated: [DATE]. Follow facility policies/protocols for the prevention/treatment of skin breakdown. Date Initiated: [DATE]. Inform the resident/family/caregivers of any new skin breakdown. Date Initiated: [DATE]. Monitor nutritional status. Serve diet as ordered, monitor intake and record. Date Initiated: [DATE]. Monitor wound to ensure it is intact without bandage (open to air). Date Initiated: [DATE]. The resident needs partial/mod (moderate) assistance to turn/reposition routinely during waking hours, and as needed or requested. Date Initiated: [DATE]. The resident requires full alternating air mattress on bed and booties on bilateral feet when in bed with heels floated. Date Initiated: [DATE]. Weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate. Date Initiated: [DATE]. Admission Braden Scale from [DATE] indicating

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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** 39713 Based on interview and record review, the facility did not ensure that each resident receives adequate supervision and assistance devices to prevent accidents for 1 of 3 residents (R1) reviewed for fall concerns out of a total sample of 9 residents. R1 had a fall on [DATE] and the facility did not ensure that R1's fall was investigated or that care planned fall interventions were placed on R1's plan of care and implemented. This is evidenced by: The facility's policy titled, Fall Prevention Program, last reviewed [DATE], states, in part: . Purpose: Each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls. Definitions: A fall is an event in which an individual unintentionally comes to rest on the ground, floor, or other level, but not as a result of an overwhelming external force (e.g., resident pushes another resident). The event may be witnessed, reported, or presumed when a resident is found on the floor or ground, and can occur anywhere. Policy Explanation and Compliance Guidelines: 8. Each resident's risk factors, and environmental hazards will be evaluated when developing the resident's comprehensive plan of care. b. The plan of care will be revised as needed. 9. When any resident experiences a fall, the facility will: a. assess the resident. b. Complete a post-fall assessment. c. Complete an incident report. f. Document all assessments and actions. g. Obtain witness statements in the case of injury. R1 was admitted to the facility on [DATE] with diagnoses including, chronic obstructive pulmonary disease (COPD; a long-term lung condition that makes it difficult to breathe), malignant neoplasm right bronchus/lung, centrilobular emphysema (form of COPD that affects the upper lobes of the lungs), hypertension (HRN), and major depressive disorder. R1's quarterly Minimum Data Set (MDS) on [DATE] noted a Brief Interview for Mental Status (BIMS) score of 15, indicating R1 is cognitively intact. R1 required partial/moderate assistance for toileting hygiene, shower/bathe self, upper and lower body dressing. Set up, clean up assistance with oral hygiene, sit to stand and chair/bed-to-chair transfers. Supervision/touching assistance with toilet transfers. Independent with rolling left to right. R1's Fall Risk Assessment from [DATE] has a score of 12, indicating R1 is At Risk for falls. R1's Comprehensive Care Plan states in part . Problem: The resident is at risk for falls r/t (related to) Gait/balance problems d/t (due to) decline in status requiring admission to SNF (skilled nursing facility) for therapy secondary to lung cancer with COPD. Date Initiated: [DATE]. Interventions: Be sure 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. Date Initiated: [DATE]. Educate the resident/family/caregivers about safety reminders and what to do if a fall occurs. Date Initiated: [DATE]. Follow facility fall policy. Date Initiated: [DATE]. PT (physical therapy) evaluate and treat as ordered or PRN (as needed). Date Initiated: [DATE]. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Hospice Care Plan states in part . Fall Prevention Plan, starting [DATE]. Collaborate post fall with facility staff and determine if additional safety measures are needed and determine facility specific interventions which include frequent rounding, ensure walkway is clear, use of call light system, bed locked and in lowest position. Interventions: Fall Prevention Plan. Patient's fall prevention/harm reduction measures: Perform gait assessment. Reinforce bed in low position and wheels locked at all times. Of Note: The facility care plan did not include bed in low position as indicated in the hospice plan of care. R1 had a fall on [DATE] when she was found expired on the floor next to her bed. The bed at the time of the fall was at waist level. The facility completed a self-report following R1's death which includes a timeline. This document states in part . On [DATE] at approximately 4:20 AM R1 was found on the floor unresponsive without apparent injury; R1 is a DNR (Do Not Resuscitate). CNA H (Certified Nursing Assistant) checked on R1 at approximately 4:15 AM and observed R1 laying comfortably in her bed. Approximately 5 minutes later, while CNA H was making rounds, she observed R1 on the floor and immediately obtained the nurse. The nurse then call [sic] hospice, family, director of nursing, etc. On [DATE] at approximately 5:30 AM, RN (Registered Nurse) with Hospice pronounced (R1's death). All interviewable residents were interviewed they reported that no one has physically neglected or harmed them; no one has verbally neglected or harmed them; they feel safe in the facility; they know who to report abuse to; and they have not witnessed any abuse, neglect, or mistreatment. Of Note: The facility completed an investigation to ensure there was no abuse, neglect, or mistreatment to R1, but did not investigate the events of R1's fall. On [DATE] at 12:45 PM, Surveyor interviewed NHA A (Nursing Home Administrator) and ADON C (Assistant Director of Nursing). Surveyor asked NHA A and ADON C about R1's fall. ADON C stated, R1 was terminally restless. Surveyor asked ADON C where I could find documentation indicating R1 was terminally restless. ADON C stated, Staff should be documenting when giving medications for and follow up to ensure it was effective. Surveyor requested a copy of the facility fall investigation related to R1's fall. ADON C indicates she did not find anything in the risk management documentation that would show a fall investigation was done. Surveyor asked ADON C if a fall investigation should have been completed on R1. ADON C stated, yes, there should have been a risk management/fall investigation. Surveyor asked ADON C if care plan interventions in the hospice plan of care should be also added to the facility plan of care. ADON C stated, the hospice care plan should be tied to our care plan. If a low bed is on the hospice care plan it should also be on the facility care plan. On [DATE] at 1:32 PM, Surveyor interviewed CNA H. Surveyor asked CNA H about R1's fall on [DATE]. CNA H stated, R1's bed was at waist level at the time of the fall. No one ever said she should have had a low bed. Surveyor asked CNA H when she last saw R1 prior to finding her on the floor. CNA H stated, I rounded on her every 15 minutes due to her being at end of life. Surveyor asked CNA H if R1 was leaning in bed when she last saw her. CNA H stated, R1 was not leaning in bed at all the last time I saw her. I don't remember the exact time that I saw her prior to the fall. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1 had a fall while at the facility. The facility did not update R1's fall care plan with interventions identified in the hospice plan of care and did not investigate the fall.