STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525537	A. Building B. Wing	04/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lasata Care Center	W76 N677 Wauwatosa Rd Cedarburg, WI 53012

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42423 Based on staff interview and record review, the facility did not ensure all allegations of abuse and neglect were reported to the Nursing Home Administrator (NHA) or the State Agency (SA) for 3 residents (R) (R8, R9, and R10) of 11 sampled residents. In addition, the facility's Abuse/Mistreatment policy contained conflicting information related to reporting allegations of abuse/mistreatment. R8 reported to staff that a Certified Nursing Assistant (CNA) was short with R8 and would not allow R8 to have R8's face cream. The allegation of abuse was not reported to NHA-A or the SA. R9 reported to staff that it took 45 minutes for a CNA to respond to R9's toileting request and the CNA was rude, abrupt and unwilling to do (the CNA's) job. R9 also indicated the CNA would not give R9 a bath. The allegations of abuse and neglect were not reported to NHA-A or the SA. R10's daughter reported to staff that R10 was crying in R10's room and stated staff were mean and hurt R10. The allegation of abuse was not reported to NHA-A or the SA. The facility's Abuse/Mistreatment policy indicates the facility shall report all violations and substantiated incidents to the proper state agency, registry/licensing authorities, and local law enforcement as required; however, regulatory requirements indicate all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property be reported. Findings include: The facility's Grievance policy, dated July 2023, indicates: The Grievance Official or designee will: *Immediately report and take action pertaining to alleged violations involving neglect, abuse, mistreatment, exploitation, injuries of unknown source, and/or misappropriation of resident property in accordance with the facility's abuse policy. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Facility's Abuse/Mistreatment policy, dated April 2021, indicates: Each resident has the right to be free from abuse, neglect, misappropriation of resident property, exploitation, corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat residents' symptoms. Residents must not be subjected to abuse by anyone, including but not limited to facility staff, other residents, consultants, volunteers, staff of other agencies serving the resident, family members, legal guardians, friends, or other individuals. 5. The Administrator/designee will report to the DQA (Division of Quality Assurance) all alleged violations involving mistreatment, neglect, exploitation, or abuse .Reporting/Response: Facility shall report all violations and substantiated incidents to the proper state agency, registry/licensing authorities and local law enforcement as required .In the event of an alleged incident of abuse, neglect .1. All employees, contracted individuals, or volunteers are responsible for knowing about the facility's reporting procedures and requirements .All employees, contracted individuals and/or volunteers are required to report observations of abuse or mistreatment, resident complaints, concerns, allegations, injuries, incidents, and grievances immediately to their supervisor. Immediately means reporting should occur as soon as the safety of all residents are secured and all necessary emergency measures are taken, including removing the accused from services immediately. 1. On 4/8/24, Surveyor reviewed R8's medial record. R8 was admitted to the facility on [DATE] with diagnoses including pain, history of right hip arthroplasty, abnormalities of gait and mobility, muscle weakness, and history of falling. R8's Minimum Data Set (MDS) assessment contained a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R8 had intact cognition. R8's care plan indicated R8 had impaired mobility and loss of independence and required a full body mechanical lift with the assistance of two staff for transfers. The care plan also indicated R8 required set up assistance for grooming. On 4/7/24, Surveyor reviewed a grievance report for R8, dated 1/15/24, that indicated an aide was short with R8 the previous night. R8 stated R8 asked for R8's face cream and the aide said, No. You're in bed and that's where you're going to stay. R8 indicated the staff with the aide was nice and got R8's cream, but the aide said, No. The grievance was signed by Director of Nursing (DON)-B on 1/16/24. 2. On 4/8/24, Surveyor reviewed R9's medical record. R9 was admitted to the facility on [DATE] with diagnoses including brain cancer, polyneuropathy, syncope, and weakness. R9's MDS assessment contained a BIMS score of 10 out of 15 which indicated R9 had moderate cognitive impairment. R9's care plan indicated R9 had impaired mobility and required a full body lift and the assistance of two staff for transfers. R9's care plan also indicated R9 required assistance with bathing. R9's thought process care plan contained interventions to acknowledge R9's perspective, encourage R9 to express feelings regarding R9's current situation and anticipated changes, provide a structured environment, and provide reassurance. On 4/7/24, Surveyor reviewed a grievance report for R9, dated 12/21/23, that indicated R9 was upset with cares provided that AM by a CNA. R9 stated it took 45 minutes for the CNA to respond to R9's toileting request. R9 had loose stools due to recent antibiotic treatment, requested to use the bathroom, and was told, I said I can't help you right now. After waiting long enough, R9 stated R9 would take R9's self to the bathroom and the CNA stated, Fine, take yourself. R9 stated the CNA was rude, abrupt, and unwilling to do the CNA's job. The grievance also indicated the CNA would not give R9 a bath per R9's choice. The CNA said staff would give R9 a shower but only if R9 stopped acting like that (meaning weak). The grievance was signed by DON-B on 12/21/23. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. On 4/8/24, Surveyor reviewed R10's medical record. R10 was admitted to the facility on [DATE] and had diagnoses including dementia, multiple sclerosis, chronic pain, and anxiety disorder. R10's MDS assessment contained a BIMS score of 3 out of 15 which indicated R10 had severe cognitive impairment. R10's care plan indicated R10 required extensive assistance of staff for mobility and was able to verbalize pain and its location and intensity. R10's care plan contained interventions to anticipate and treat pain prior to transfer and movement, provide an explanation prior to moving, and to go slow and gentle because fast repositioning was alarming (dated 3/12/24). On 4/7/24, Surveyor reviewed a grievance initiated by R10's daughter, dated 2/20/24, that indicated R10 was crying in R10's room. Staff had just gotten R10 up via Hoyer lift for an appointment at 1:00 PM. R10 reported to R10's daughter that staff were mean to (R10) and hurt (R10). The grievance indicated Nurse Manager (NM)-C interviewed R10 for further clarification and R10 did not use the word mean. NM-C obtained witness statements from staff, dated 2/19/24. The grievance was signed by DON-B on 2/20/24 On 4/8/24 at 9:55 AM, Surveyor interviewed NM-C who confirmed NM-C received the initial allegation from R10's daughter, investigated the allegation, and reported the allegation to DON-B. NM-C stated the date on the grievance was incorrect and should be 2/19/24. NM-C confirmed the statements initially relayed to NM-C by R10's daughter would be considered abuse. On 4/8/24 at 9:58 AM, Surveyor interviewed DON-B who indicated allegations surface when R10's daughter visits. DON-B indicated DON-B believes this is attention-seeking and that R10 is trying to get a response from R10's daughter. DON-B stated the allegations were investigated. On 4/7/24 at 4:04 PM, Surveyor interviewed DON-B who confirmed the above allegations were not reported to the SA. On 4/8/24 at 9:45 AM, Surveyor interviewed NHA-A who confirmed the above allegations were not reported to NHA-A or the SA. NHA-A indicated DON-B is the first line of defense in terms of investigating situations.

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42423 Based on staff interview and record review, the facility did not ensure allegations of abuse and neglect were thoroughly investigated for 3 residents (R) (R8, R9, and R10) of 11 residents. R8 reported to staff that a Certified Nursing Assistant (CNA) was short with R8 and would not allow R8 to have R8's face cream. The allegation of abuse was not thoroughly investigated. R9 reported to staff that it took 45 minutes for a CNA to respond to R9's toileting request and that the CNA was rude, abrupt and unwilling to do (the CNA's) job. R9 also stated the CNA would not give R9 a bath. The allegations of abuse and neglect were not thoroughly investigated. R10's daughter reported to staff that R10 was crying in R10's room and stated staff were mean and hurt R10. The allegation of abuse was not thoroughly investigated. Findings include: The Facility's Abuse/Mistreatment policy, dated April 2021, indicates: Investigation: Whenever there is an incident, allegation or grievance reported to an employee, they shall immediately protect the resident and notify their supervisor who shall immediately notify the Administrator, or designee. The facility shall start an investigation of all incidents, allegations, concerns, complaints, and grievances immediately. Violations will be thoroughly investigated. Investigations will be thorough and conducted after any reported incident. Investigations must collect information that corroborates or disproves the incident and document the findings of each incident. A thorough investigation may include the following: ~Conduct observations of alleged victim, including identification of any injuries, the location where the alleged incident occurred, interactions and relationships between the staff and the alleged victim and/or other residents, and interactions/relationships between the resident and other residents, as appropriate. ~Interview alleged victims(s) and witness(es). ~Interview the accused individual(s) allegedly responsible for the mistreatment . ~Interview other residents to determine if they have been abused or mistreated. ~Interview staff who worked the same shift as the accused to determine if they ever witnessed any mistreatment by the accused. ~Interview staff who worked previous shifts to determine if they were aware of an injury or incident. ~Involve other regulatory authorities who may assist . (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In the event of an alleged incident of Abuse, Neglect, Exploitation, Mistreatment or Misappropriation of resident property: 1.After protecting the resident and all other residents from further incidents of misconduct or injury, the accused is removed from services immediately (if applicable) . 1. On 4/8/24, Surveyor reviewed R8's medial record. R8 was admitted to the facility on [DATE] with diagnoses including pain, history of right hip arthroplasty, abnormalities of gait and mobility, muscle weakness, and history of falling. R8's Minimum Data Set (MDS) assessment contained a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R8 had intact cognition. R8's care plan indicated R8 had impaired mobility and loss of independence and required a full body mechanical lift and the assistance of two staff for transfers. The care plan also indicated R8 required set up assistance for grooming. On 4/7/24, Surveyor reviewed a grievance report for R8, dated 1/15/24, that indicated a CNA was short with R8 the previous night. R8 asked for R8's face cream and the CNA said, No. You're in bed and that's where you're going to stay. The staff with the CNA got R8's face cream, but the CNA said, No. The grievance was signed by Director of Nursing (DON)-B on 1/16/24. The Action and Response Taken section of the grievance indicated: Include how resident was protected, how grievance was investigated, who was contacted, and how further potential violations will be prevented while the allegation is being investigated Provide and attach witness statements if appropriate. The grievance contained information that indicated DON-B contacted staff who worked that shift and what two of the staff stated. A wing assignment sheet was attached to the grievance. The Follow Up/Resolution/Conclusion section contained a note that indicated the grievance was unsubstantiated and staff would be re-educated and receive a discipline for not following the care plan. The grievance did not contain resident interviews, witness statements, written staff statements, or further information including how R8 was protected during the investigation. 2. On 4/8/24, Surveyor reviewed R9's medical record. R9 was admitted to the facility on [DATE] and had diagnoses including brain cancer, polyneuropathy, syncope, osteoarthritis, and weakness. R9's MDS assessment contained a BIMS score of 10 out of 15 which indicated R9 had moderate cognitive impairment. R9's care plan indicated R9 had impaired mobility and required a full body lift and the assistance of two staff for transfers. The care plan also indicated R9 needed staff assistance for bathing. R9's thought process care plan contained interventions to acknowledge R9's perspective, encourage R9 to express feelings regarding the current situation and anticipated changes, give structured environment, and provide reassurance. On 4/7/24, Surveyor reviewed a grievance for R9, dated 12/21/23, that indicated R9 upset with care provided that morning by a CNA. R9 stated it took 45 minutes for the CNA to respond to R9's toileting request. R9 had loose stools due to recent antibiotic treatment. R9 requested to use the bathroom and the CNA stated, I said I can't help you right now. After waiting long enough, R9 stated R9 would take R9's self to the bathroom and the CNA stated, Fine. Take yourself. R9 stated the CNA was rude, abrupt, and unwilling to do the CNA's job. The grievance also indicated the CNA would not give R9 a bath per R9's choice. The CNA said staff would give R9 a shower but only if R9 stopped acting like that (meaning weak). The grievance was signed by DON-B on 12/21/23. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Action and Response Taken section contained a note that indicated the CNA was escorted out of the building and sent home pending the investigation. DON-B and R9's representative were updated regarding the care concerns and start of the investigation. The Follow Up/Resolution/Conclusion section contained a note that indicated the CNA was immediately escorted from the building. DON-B and the Registered Nurse (RN) Manager met with R9. The investigation indicated the CNA was new to the facility and had a poor approach. R9's concern was substantiated and the CNA was terminated. The grievance did not contain resident interviews, witness interviews, written staff statements, or further investigation information. 3. On 4/8/24, Surveyor reviewed R10's medical record. R10 was admitted to the facility with diagnoses including dementia, multiple sclerosis, chronic pain, anxiety disorder, and palliative care. R10's MDS assessment contained a BIMS score of 3 out of 15 which indicated R10 had severe cognitive impairment. R10's care plan indicated R10 could verbalize the location and intensity of pain and required extensive assistance of staff for mobility. The care plan contained interventions to anticipate and treat pain prior to transfer/movement, explain what staff are doing prior to movement, and go slow and gentle because fast repositioning was alarming (dated 3/12/24). On 4/7/24, Surveyor reviewed a grievance initiated by R10's daughter, dated 2/20/24, that indicated R10 was crying in R10's room. Staff had just gotten R10 up via Hoyer lift for an appointment at 1:00 PM. R10 reported to R10's daughter that staff were mean to (R10) and hurt (R10). The Action and Response Taken section contained a note that indicated statements were collected from the CNAs who assisted with cares and the transfer. The statements were attached to the grievance form. The grievance form also indicated R10's care plan was reviewed and updated and an order was obtained for ibuprofen 400 mg (milligrams) for pain. A note indicated unit interviews were completed with no care or transfer concerns. The grievance did not contain resident interviews, witness interviews, or indicate how R10's safety was ensured pending the results of the investigation. On 4/8/24 at 9:58 AM, Surveyor interviewed DON-B who indicated allegations surface when R10's daughter visits. DON-B indicated DON-B believes this is attention-seeking and that R10 is trying to get a response from R10's daughter. DON-B stated, We investigated it. On 4/8/24 at 4:04 PM, Surveyor interviewed DON-B who indicated the above allegations were customer service situations and were not investigated as allegations of abuse or neglect. On 4/8/24 at 9:45 AM, Surveyor interviewed Nursing Home Administrator (NHA)-A who indicated the allegations were not reported to NHA-A. NHA-A indicated DON-B is the first line of defense in terms of investigating situations.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42423 Based on staff interview and record review, the facility did not ensure 1 resident (R) (R1) of 1 resident reviewed for hospitalization received a transfer notice that included the date of the transfer, the reason for the transfer, the location of the transfer, and appeal rights. R1 was transferred to the hospital on 3/27/24. R1 and/or R1's representative were not provided with a written transfer notice. Findings include: The facility's Transfer of Resident to the Hospital policy, with a review date of 5/2021, indicates: A written notification of transfer will be provided to the resident at the time of discharge with the date of discharge and where the resident is going. The nurse is to mark that the resident is being discharged because of a medical emergency. A copy of the discharge notification will be copied and placed in the medical record. The nurse will chart that the written notification of discharge was given. Note: The resident does not need to sign the form. On 4/7/24, Surveyor reviewed R1's medical record. R1 was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD), pressure injury on the left lower back, coronary artery disease (CAD), and memory impairment. On 3/27/24, R1 sustained a skin laceration during a transfer and was transported to the hospital for evaluation and treatment. R1's medical record did not contain a transfer notice. Surveyor requested a copy of the transfer notice from Director of Nursing (DON)-B which was not provided to Surveyor. On 4/8/24 at 10:30 AM, Surveyor interviewed Social Services (SS)-D who confirmed the facility did not provide a transfer notice other than a bed hold notice. On 4/8/24 at 10:35 AM, Surveyor interviewed DON-B who confirmed DON-B was not aware of the need to provide a written transfer notice to residents.