STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525548	A. Building B. Wing	12/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Peabody Manor	2600 S Heritage Woods Dr Appleton, WI 54915

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 0689 Level of Harm - 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** 47248 Based on staff interview and record review, the facility did not ensure the resident environment remained as free of accident hazards as possible for 1 resident (R) (R9) of 1 sampled resident. R9 fell during an EZ Stand transfer on 7/8/24. Following the fall, R9's care plan was updated with an intervention to transfer R9 with the assistance of two staff for all EZ Stand transfers. On 12/8/24, Certified Nursing Assistant (CNA)-G transferred R9 via EZ Stand without a second staff present. R9 fell during the transfer and sustained a right tibial plateau fracture. R9 was assessed by therapy and a recommendation was made to transfer R9 with two staff and a Hoyer lift. R9's care plan was not properly updated. Findings include: The facility's Resident Plan of Care Policy, revised 7/15/24, indicates: The purpose of this policy is to outline the standards and processes for providing high quality, person-centered care to all residents through a plan of care to promote continuity of care, communication among team members, resident safety, and safeguard against an adverse event .The following elements of a resident's plan of care may be kept in the resident's medical record: a. Nursing care (i.e., self-care deficit, restorative, fall prevention, skin injury, elimination, pain, and other specific needs as identified) .Documentation will include the following: .individualized interventions. The Interdisciplinary Team (IDT) will update/document a plan of care following an incident or event that causes a change in the plan of care or resident's condition . The facility's Resident Fall and Injury Prevention Policy, revised 10/22/24, indicates: The purpose of this policy is to outline the standards and processes to monitor long-term care environments and resident safety to prevent resident falls and injuries .Interventions will be assessed and added to the resident plan of care as needed .E. Post Fall Care and Post Fall Huddle: 1. If a resident fall occurs, team members will .d. Review the plan of care and update with new fall interventions . On 12/17/24, Surveyor reviewed R9's medical record. R9 had diagnoses including tibial plateau fracture-right (12/8/24), restless leg syndrome, lymphedema, and primary osteoarthritis of both knees. R9's Minimum Data Set (MDS) assessment, dated 11/15/24, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R9 was not cognitively impaired. R9 was R9's own decision maker. (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 0689 Level of Harm - Actual harm Residents Affected - Few	R9's medical record indicated R9 fell on [DATE] during an EZ Stand transfer. Nursing staff indicated R9 coughed, appeared to lose consciousness, and slid out of the EZ Stand. R9's care plan was updated with an intervention for the assistance of two staff during all EZ Stand transfers. The facility's EZ Stand slings were replaced to ensure the slings secured properly. R9 did not sustain an injury during the fall. R9's medical record indicated R9 fell on [DATE] during an EZ Stand transfer and sustained a right knee tibial plateau fracture. The facility's investigation indicated CNA-G transferred R9 with an EZ Stand lift without a second staff present. R9 indicated R9's knee buckled and R9 began to fall which caused the EZ Stand to tip over. R9 fell to the floor on R9's left side and the EZ Stand was in contact with R9's right knee. R9 had pain and bruising and was sent to the emergency room (ER). An X-ray identified the fracture. The facility's investigation indicated an intervention was initiated on 12/8/24 to use a Hoyer lift when R9 felt weak. A progress note, dated 12/11/24, indicated R9 was assessed by physical therapy staff for use of a lift. Documentation indicated R9 required a Hoyer lift with the assistance of two staff for all transfers. A Hoyer lift was determined to be the most appropriate and safest transfer technique due to R9's history of falls in the EZ Stand. On 12/17/24, Surveyor reviewed R9's care plan which stated the following, Please don (put on) my air splint on my L (left) ankle when I get up in the morning before using EZ stand lift .I transfer with assist of 2 people and Hoyer lift. I must have air splint on my L ankle to stand with the lift. Bathroom needs met with urinal and bed pan. I must have air splint on my L ankle to stand with the lift. On 12/17/24 at 1:24 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B. NHA-A and DON-B indicated a care plan intervention was added for two staff with all EZ Stand transfers following R9's fall on 7/8/24 because R9 had periods of unconsciousness during transfers. NHA-A indicated medical tests were completed to rule out ongoing medical issues and stated the intervention was initiated to ensure safety during transfers. DON-B indicated CNA-G did not follow R9's care plan on 12/8/24 and did not have a second staff present when CNA-G transferred R9 with the EZ Stand. During the investigation, CNA-G confirmed there was not a second staff present during the transfer. Following the fall, DON-B indicated R9's fall prevention care plan was updated on 12/11/24 with an intervention to use a Hoyer lift for all transfers following a physical therapy assessment of R9. DON-B confirmed R9's care plan should not include verbiage about donning a splint for EZ Stand lift use and indicated R9 should only be transferred with a Hoyer lift. DON-B indicated the EZ Stand portion of the care plan was forgotten and should have been removed. DON-B indicated R9's care plan would be revised to remove the verbiage that R9's left leg splint should be applied prior to EZ Stand transfers. On 12/17/24 at 3:00 PM, Surveyor interviewed NHA-A who indicated an investigation was completed following R9's fall on 12/8/24. NHA-A indicated staff were educated on transfers and following care plans and stated the lift manufacturer came to the facility to ensure all lifts were in proper working order. NHA-A indicated the facility provided staff training but possibly should have focused more time on the care plan to ensure R9's care plan was updated properly.

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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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50988 Based on staff and interview and record review, the facility did not ensure 1 resident (R) (R311) of 1 resident received appropriate dialysis care and services. R311 received dialysis services. R311 did not have a dialysis care plan and staff did not complete pre- and post-dialysis assessments. In addition, staff did not assess and monitor R311's fistula site. Findings include: The facility's Long-Term Care Dialysis Collaboration of Care Policy, revised 8/6/24, indicates: Nursing team members will assess residents pre-dialysis, as appropriate, and monitor them post-dialysis, including taking vital signs. From 12/16/24 to 12/18/24, Surveyor reviewed R311's medical record. R311 was admitted to the facility on [DATE] and had diagnoses including end stage renal disease (ESRD) with dependence on renal dialysis. R311's Admission Minimum Data Set (MDS) assessment, dated 12/10/24, had a Brief Interview for Mental Status (BIMS) score of 14 out of 15 which indicated R311 was not cognitively impaired. R311 had an order for hemodialysis every Tuesday, Thursday, and Saturday. In addition, R311 received intravenous (IV) antibiotic therapy at dialysis (dated 12/10/24). Surveyor noted R311's medical record did not contain a care plan for dialysis. Surveyor also noted R311's medical record did not contain documentation that R311's fistula site was assessed by nursing staff. On 12/16/24 at 9:33 AM, Surveyor interviewed R311 who indicated R311 received dialysis three times weekly and IV antibiotic therapy at dialysis. R311 indicated there was good communication with the dialysis center. On 12/18/24 at 8:50 AM, Surveyor interviewed Director of Nursing (DON)-B who indicated nursing staff should document daily on R311's fistula, but were not doing so at that time. DON-B indicated there was no paperwork sent with R311 to dialysis appointments. When Surveyor asked if R311 had a dialysis care plan, DON-B indicated R311 did not have a dialysis care plan. On 12/18/24 at 9:23 AM, Surveyor interviewed Registered Nurse (RN)-D who indicated staff did not do pre- or post-dialysis assessments for residents. RN-D indicated vital signs and a fistula assessment should be done after every dialysis procedure. On 12/18/24 at 9:29 AM, Surveyor reviewed the facility's dialysis policy with DON-B who indicated nursing staff were not following the policy and procedure for dialysis patients. DON-B indicated DON-B expects nursing staff to complete a pre- and post-dialysis assessment for all dialysis patients which includes a full set of vital signs and a fistula assessment on the days they receive dialysis.

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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** 32768 Based on observation, staff interview, and record review, the facility did not establish and maintain an infection prevention and control program designed to prevent the development and transmission of communicable disease and infection for 3 residents (R) (R22, R15, and R30) of 4 residents observed during the provision of cares. During an observation of wound, incontinence, and catheter care for R22 on 12/17/24, Registered Nurse (RN)-J, Certified Nursing Assistant (CNA)-K, and CNA-L did not wash or sanitize hands between glove changes. During an observation of peri-rectal care for R15 on 12/17/24, CNA-C did not wash or sanitize hands between glove changes. R30 was on enhanced barrier precautions (EBP). During an observation on 12/18/24, RN-I did not don a gown prior to administering R30's tube feeding. Findings include: The facility's Long Term Care Infection Prevention and Control Program Policy, revised 5/17/24, indicates: . to prevent, recognize and control the onset and spread of infection whenever possible .Hand Hygiene: the cleaning of hands by either handwashing (washing hands with soap and water) or antiseptic hand rub (i.e., alcohol-based hand sanitizer) .Team members will use an alcohol-based hand rub (ABHR): .Before and after resident contact .After contact with a resident's surroundings or equipment .Before donning sterile or non-sterile gloves or other personal protective equipment (PPE) .After removing gloves or other PPE .After contact with body fluids or excretions, mucous membranes, non-intact skin, or wound dressings, as long as hands are not visibly soiled .If moving from a contaminated body site to a clean body site during resident care .Enhanced Barrier Precautions (EBP) will be used .for residents with an infection or colonization with a novel or targeted multidrug-resistant organism (MDRO when contact precautions with room isolation do not apply, and for residents with chronic wounds or indwelling medical devices. Team members will use a gown and gloves for close contact activities .EBP will also be used when a resident has an infection with an MDRO that is not included on the list of targeted MDROs and contact precautions with room isolation do not apply . Close contact activities include: .Bathing/showering .Assisting with toileting or changing briefs .Manipulation or care of indwelling devices including central lines, urinary catheters, feeding tubes . 1. From 12/16/24 to 12/18/24, Surveyor reviewed R22's medical record. R22 was admitted to facility on 8/10/23 and had diagnoses including paraplegia, neurogenic bladder, neuralgia, and fecal incontinence. R22's Minimum Data Set (MDS) assessment, dated 10/1/24, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R22 was not cognitively impaired. The MDS also indicated R22 required partial/moderate assistance with hygiene and to roll left and right. R22 was dependent with toileting. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/17/24 at 10:16 AM, Surveyor observed RN-J, CNA-K, and CNA-L provide wound, incontinence, and catheter care for R22. RN-J, CNA-K, and CNA-L sanitized hands and donned gloves. CNA-L pulled R22's blanket back and opened R22's soiled brief. CNA-K wiped R22's perineal area from front to back twice with a wash cloth and removed gloves. Without washing or sanitizing hands, CNA-K donned clean gloves and again wiped R22's from front to back with a wash cloth and removed gloves. Without washing or sanitizing hands, CNA-K donned clean gloves and CNA-K and CNA-L rolled R22 on the right side. CNA-K handed R22's catheter bag to CNA-L who hung the catheter bag on the other side of the bed. CNA-K wiped R22's rectal area (which contained visible feces) from front to back and removed gloves. Without washing or sanitizing hands, CNA-K donned clean gloves, cleansed R22's Foley tubing with a wash cloth, and removed gloves. Without washing or sanitizing hands, CNA-K donned clean gloves, again cleansed R22's rectal area with a wash cloth, and removed gloves. Without washing or sanitizing hands, CNA-K donned clean gloves. CNA-K and CNA-L removed R22's soiled brief and placed a clean brief under R22. CNA-K removed gloves, but did not wash or sanitize hands before donning clean gloves. CNA-K then assisted RN-J with wound care. With the same gloved hands, CNA-K opened a 2 x 2 gauze package. RN-J removed R22's soiled dressing and removed gloves. Without washing or sanitizing hands, RN-donned clean gloves. CNA-K opened a container of saline and poured saline on a 2 x 2 gauze pad held by RN-J. RN-J cleansed R22's wound with the saline-soaked gauze. CNA-K again poured saline on a 2 x 2 gauze pad and RN-J continued to cleanse R22's wound. CNA-K then removed gloves. Without washing or sanitizing hands, CNA-K donned clean gloves, opened a 4 x 4 gauze package, and gave the gauze to RN-J. RN-J dried R22's wound with the gauze and removed gloves. Without washing or sanitizing hands, RN-J donned clean gloves, applied barrier cream to R22's reddened wound, and removed gloves. Without washing or sanitizing hands, RN-J donned clean gloves. CNA-K opened an Optifoam dressing and RN-J applied the dressing to R22's wound. RN-J and CNA-K then removed gloves and washed hands. On 12/17/24 at 10:52 AM Surveyor interviewed RN-J and CNA-K who verified they were trained to wash or sanitize hands between glove changes during wound and pericare. RN-J and CNA-K verified they did not wash or sanitize hands between glove changes during wound and pericare for R22. RN-J indicated RN-J knew better and taught infection control to CNAs. 45943 2. From 12/16/24 to 12/18/24, Surveyor reviewed R15's medical record. R15 was admitted to the facility on [DATE] and had diagnoses including diabetes, neurogenic bladder, multiple sclerosis, and blindness both eyes. R15's MDS assessment, dated 10/15/24, had a BIMS score of 15 out of 15 which indicated R15 was not cognitively impaired. R15 was R15's own decision maker. R15 was on EBP due to a suprapubic catheter. On 12/17/24 at 11:10 AM, Surveyor observed CNA-C complete peri-rectal care for R15. During the observation, CNA-C removed soiled gloves and donned clean gloves without completing hand hygiene. When Surveyor asked CNA-C if CNA-C had washed or sanitized hands between glove changes, CNA-C verified CNA-C did not do so but was aware CNA-C should complete hand hygiene between glove changes. 47248 (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 12/18/24, Surveyor reviewed R30's medical record. R30 had diagnoses including dysphagia and oropharyngeal-increased difficulties with chewing and swallowing leading to percutaneous endoscopic gastrostomy (PEG) placement (a medical procedure that involves inserting a feeding tube into a patient's stomach through the abdominal wall). R30's MDS assessment, dated 8/22/24, had a BIMS score of 8 out of 15 which indicated R30 had severely impaired cognition. R30 had an activated healthcare decision maker. R30's medical record contained the following tube feeding order: Jevity 1.2 via peg and bolus/syringe goal of 480 (milliliters) (three times daily)-60 ml five times daily. Flush 60 ml before and after. On 12/18/24 at 9:58 AM, Surveyor observed RN-I administer R30's tube feeding. Surveyor noted an EBP sign and a PPE cart outside R30's room. RN-I completed hand hygiene and donned gloves. Surveyor noted RN-I did not don a gown prior to administering the tube feeding. Surveyor observed RN-I administer the tube feeding with gloves and no gown. After RN-I completed the tube feeding and cleansed hands, Surveyor interviewed RN-I who indicated RN-I was not required to wear a gown when administering a tube feeding because there were no bodily fluids involved. On 12/18/24 at 10:10 AM, Surveyor interviewed Director of Nursing (DON)-B who confirmed the facility's policy and indicated DON-B expects staff to don PPE for residents on EBP prior to administering a tube feeding as well as during wound care and care for indwelling medical devices.