STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525586	A. Building B. Wing	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Health Services	1119 N Wisconsin St Port Washington, WI 53074

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 40342 Based on staff interview and record review, the facility did not implement their written policies and procedures that prohibit and prevent abuse for 3 of 8 facility and contracted staff reviewed for caregiver background checks. The facility did not ensure a thorough and timely background check was completed for Licensed Practical Nurse (LPN)-K, LPN-I, and Certified Nursing Assistant (CNA)-L. Findings include: The facility's Abuse, Neglect and Exploitation policy, with a revision date of 7/15/22 indicates: It is the policy of the facility to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property .Potential employees will be screened for a history of abuse, neglect, exploitation, or misappropriation of resident property. 1. Background, reference, and credentials checks shall be conducted on potential employees, contracted temporary staff, students affiliated with academic institutions, volunteers, and consultants. Background checks, including re-checks, will be completed consistent with applicable state laws and regulation. On 9/12/24, Surveyor reviewed background check information for 8 facility and contracted staff, including LPN-K, LPN-I, and CNA-L. LPN-K was hired on 10/1/17. LPN-K's Background Information Disclosure (BID) form was dated 9/27/17. LPN-K's Department of Justice (DOJ) and Integrated Background Information System (IBIS) letters were dated 6/12/19. LPN-I was hired on 8/3/18. LPN-I's BID form and DOJ and IBIS letters were dated 3/14/16. CNA-L was hired on 8/5/24. CNA-L's BID form was dated 6/12/23. (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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/12/24 at 2:27 PM, Surveyor interviewed Business Manager (BOM)-E who indicated BOM-E started at the facility on 5/6/24. BOM-E indicated BID forms were part of the application process and the facility obtained DOJ and IBIS letters prior to an employee's hire date. Following a discussion of the above findings, BOM-E indicated CNA-L most likely applied to the facility but was not hired until over a year later. BOM-E verified the facility should have had CNA-L fill out a new BID form prior to hire because CNA-L could have lived out of state during the previous year. BOM-E could not explain why background checks were not obtained for LPN-K and LPN-I prior to their hire dates. On 9/12/24 at 3:16 PM, Surveyor interviewed Regional Manager (RM)-C who indicated the facility had no other background check information for LPN-K, LPN-I, or CNA-L related to their hire dates.

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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 - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 42423 Based on staff interview and record review, the facility did not ensure an allegation of neglect was reported to the State Agency (SA) when the facility was without a licensed nurse for approximately 2.5 hours on 4/14/24. This had the potential to affect 14 of 23 residents. On 4/14/24, the facility was without a licensed nurse on the PM shift from approximately 3:02 PM until 5:35 PM. Three residents (R10, R16, and R7) did not receive blood glucose monitoring in accordance with physician orders. Fourteen residents (R1, R3, R5, R7, R8, R9, R10, R11, R12, R13, R14, R15, R16, and R17) did not receive medication in accordance with physician orders or the facility's policy. One resident (R5) was transported by ambulance to the emergency room (ER) without a nurse assessment to determine R5's medical needs. Findings include: The facility's Abuse, Neglect and Exploitation policy, with a revision date of 7/15/22, indicates: Neglect is the failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress .2. The facility will designate a leadership position in the facility who is responsible for reporting allegations or suspected abuse, neglect, or exploitation to the State Survey Agency and other officials in accordance with state law. Reporting/Response: 1. Reporting of all alleged violations to the Administrator, State Agency, Adult Protective Services and to all other required agencies (e.g., law enforcement when applicable) within specified timeframes: b. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury .B. The Administrator will follow up with government agencies to report the results of the investigation when final within 5 working days of the incident, as required by state agencies. On 9/12/24, Surveyor reviewed a police department report, dated 4/19/24, that indicated on 4/14/24 the facility was without staff for several hours when an agency staff could not get ahold of anyone and left the facility. The report also indicated an ambulance was called for an unresponsive resident and the only person at the facility was a maintenance staff who called 911. The officers who responded to the call indicated there were 3 employees at the facility in addition to the maintenance staff. Surveyor reviewed an ambulance report, dated 4/14/24, that indicated there was a 911 call from the facility at 5:10 PM that R5 was unresponsive. R5 had abnormal breathing and was still unconscious at 5:10 PM and was transported to the hospital 5:38 PM. On 9/12/24 at 12:10 PM, Surveyor interviewed Regional Manager (RM)-C who confirmed there was a timeframe on the 4/14/24 PM shift when the facility was without a licensed nurse. RM-C provided Surveyor with an investigation that was completed by a former Nursing Home Administrator (NHA) who was employed by the facility at that time. (continued on next page)

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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 - Some	Surveyor reviewed the investigation which included a written statement from Maintenance Manager (MM)-H that indicated at 1:48 PM, MM-H called the NHA, Scheduler and on-call Unit Manager (all of whom are no longer employed at the facility) to notify them there was no nurse for the PM shift. At 4:01 PM, the NHA first responded to the calls and text messages sent by MM-H. MM-H's statement indicated [NAME] President of Success (VPS)-J later contacted the facility and advised staff to not serve diabetic residents supper; however, the 300 wing residents had already been served. The investigation included a Critical Event Analysis and Action Plan Worksheet that indicated the facility was without a licensed nurse from approximately 3:02 PM until 5:35 PM when VPS-J arrived. On 9/12/24, Surveyor interviewed MM-H by phone. MM-H no longer worked at the facility but recalled the events of 4/14/24. MM-H confirmed there was no licensed nurse in the facility on the PM shift and MM-H called 911 to send R5 to the hospital. Surveyor reviewed medical records for diabetic residents who resided at the facility on 4/14/24. R10, R16, and R7's medical records indicated R10, R16, and R7's PM shift blood sugars were not obtained and their insulin was not administered timely or in accordance with their physician orders. Surveyor also reviewed a Medication Administration Audit report for residents who resided at the facility on 4/14/24. The report indicated 14 residents (R1, R3, R5, R7, R8, R9, R10, R11, R12, R13, R14, R15, R16, and R17) received medications outside their designated timeframes and/or not in accordance with their physician orders. On 9/12/24 at 4:08 PM, Surveyor interviewed RM-C who confirmed the facility did not report the allegation of neglect to the SA.

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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 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42423 Based on staff interview and record review, the facility did not have a licensed nurse on duty to meet the needs of residents for approximately 2.5 hours on the [DATE] PM shift. This had the potential to affect 23 of 23 residents (R) residing in the facility. On [DATE], an agency nurse who worked the AM shift left the facility without licensed nurse coverage for the PM shift. The facility was without a nurse for approximately 2.5 hours. Due to not having a licensed nurse on duty, 3 residents (R10, R16, and R7) did not receive blood glucose monitoring in accordance with physician orders. Fourteen residents (R8, R9, R10, R11, R12, R5, R1, R13, R14, R15, R16, R7, R3, and R17) did not receive medication in accordance with physician orders. One resident (R5) was transported by ambulance to the emergency room (ER) without a nurse assessment. Seven residents (R7, R11, R12, R14, R16, R18, and R19) were full-code status and without a cardiopulmonary resuscitation (CPR)-certified nursing staff in the facility. The facility indicated Maintenance Manager (MM)-H was in the building and CPR certified; however, the facility and MM-H were unable to provide proof of CPR certification. All residents in the facility were at risk due to not having a licensed nurse available to assess their healthcare needs. The facility's failure to ensure there was licensed nurse coverage at all times created a finding of immediate jeopardy that began on [DATE]. Nursing Home Administrator (NHA)-A and Regional Manager (RM)-C were notified of the immediate jeopardy on [DATE] at 4:07 PM. The immediate jeopardy was removed and corrected on [DATE]. Findings include: The facility's Cardiopulmonary Resuscitation (CPR) policy, dated [DATE], indicates in part: .2. If a resident experiences a cardiac arrest, facility staff will provide basic life support including CPR prior to the arrival of emergency medical services, and: a. In accordance with the resident's advance directives, or B. In the absence of an advance directive or a Do Not Resuscitate order, and c. If the resident does not show obvious signs of clinical death .3. CPR-certified staff will be available at all times. 4. Staff will maintain current CPR certification for healthcare providers through a CPR provider who evaluates proper technique through in-person demonstration of skills. CPR certification, which includes an online knowledge component yet still requires an in-person skills demonstration to obtain certification or recertification, is also acceptable. On [DATE], Surveyor reviewed R5's medical record. R5 was admitted to the facility on [DATE] with a diagnosis of Parkinson's disease. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On [DATE] at 10:22 AM, Surveyor interviewed night (NOC) shift Licensed Practical Nurse (LPN)-I who confirmed there was a date in April in which there was no licensed nurse on duty. LPN-I indicated LPN-I heard that an agency nurse walked out of the facility and left the medication cart keys at the nurses' station. LPN-I indicated MM-H called 911 for R5 when R5 had an episode of unresponsiveness. LPN-I indicated R5 had episodes before and if MM-H would have waited awhile, R5's episode would have resolved. LPN-I indicated R5 slept through parts of shifts due to Parkinson's flare ups and would likely not have needed to be transferred to the hospital. Surveyor reviewed an ambulance report, dated [DATE], that indicated the facility called 911 at 5:10 PM when R5 was not responding. At 5:10 PM, R5's breathing was abnormal and R5 was still unconscious. R5 was transported to the hospital at 5:38 PM. Surveyor reviewed a Police Department report, dated [DATE], that indicated on [DATE] the facility was without staff for several hours because an agency staff left the facility when the agency staff could not get ahold of anyone. An ambulance was called for an unresponsive resident and the only person at the facility was a maintenance staff who called 911. The police officer who wrote the report indicated the officers who responded to the 911 call on [DATE] indicated there were 3 employees at the facility in addition to the maintenance staff. Surveyor reviewed hospital records for R5 which indicated there were no significant medical findings. R5 returned to the facility on the evening of [DATE]. On [DATE] at 11:45 AM, Surveyor interviewed former [NAME] President of Success (VPS)-J who indicated VPS-J was a Registered Nurse (RN) and was employed as the VPS on [DATE]. VPS-J indicated VPS-J lived 15 minutes from the facility and was notified on [DATE] around dinner time that there was no licensed nurse in the facility. VPS-J contacted the facility and instructed staff to hold dinner trays for diabetic residents so VPS-J could check blood sugars when VPS-J arrived. VPS-J confirmed there was not a nurse on duty when VPS-J arrived at the facility. VPS-J arranged for an agency nurse to join VPS-J approximately 20 minutes later. VPS-J and the agency nurse finished the shift. VPS-J verified MM-H and 2 or 3 Certified Nursing Assistants (CNAs) were in the facility when VPS-J arrived. VPS-J confirmed R5 was sent to the hospital by MM-J prior to VPS-J's arrival. On [DATE] at 12:10 PM, Surveyor interviewed Regional Manager (RM)-C who confirmed there was a timeframe on the [DATE] PM shift where there was no licensed nurse in the facility. RM-C provided Surveyor with an investigation that was completed by a former Nursing Home Administrator (NHA) who was employed by the facility at that time. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On [DATE] at 12:15 PM, Surveyor reviewed the facility's investigation which included a written statement from MM-H that indicated MM-H made calls/texts to the NHA, Scheduler, and on-call Unit Manager (UM)-Q (all of whom are no longer employed at the facility) at 1:48 PM to alert them that there was no nurse for the PM shift. The facility's investigation also contained a log of text messages within a group text that started with MM-H indicating, There is no nurse for 2 PM; ED (Executive Director (aka NHA)) did not respond. At 2:06 PM, on-call UM-Q responded, I'm not going in .I have been on call 10 out of the last 14 days and I did not take this job to be a floor RN in a long term care center. There are 3 other people that can come up with something. None of them responded to my text either. At 4:01 PM, the NHA first responded to the calls and text messages sent by MM-H and at 4:48 PM, NHA notified VPS-J of the situation. VPS-J contacted the facility and advised staff not to serve supper to diabetic residents; however, the supper trays were already served on the 300 wing per MM-H's statement. The investigation included a Critical Event Analysis and Action Plan Worksheet that indicated both AM shift nurses left the facility without a PM shift nurse replacement and the facility was without a licensed nurse from approximately 3:02 PM until 5:35 PM when VPS-J arrived. The facility's investigation contained a written statement from agency RN-N that indicated LPN-O and RN-N became aware at 1:00 PM that there was no nurse coming in on the PM shift to relieve them. Attempts to call facility management started with no response/resolution. RN-N indicated LPN-O left the facility prior to the end of LPN-O's scheduled shift which left RN-N as the only nurse. RN-N indicated LPN-O did not count narcotics or give report to PM CNA staff. RN-N indicated LPN-O also left the medication cart keys on the counter by the CNAs. RN-N indicated RN-N left the keys on the counter and left the facility at 3:03 PM. There was no nurse to give report to or count narcotics with. RN-N indicated there were 3 CNAs (one agency CNA, one CNA on orientation, and one long-term employee of the facility). RN-N indicated if a resident needed a medication, they would have to wait until a nurse was there. On [DATE] at 12:30 PM, Surveyor interviewed MM-H via phone. MM-H indicated MM-H no longer worked at the facility. MM-H recalled the events from [DATE] and confirmed there was no licensed nurse in the facility. MM-H also confirmed MM-H contacted 911 to send R5 to the hospital. On [DATE] at 3:10 PM, Surveyor reviewed the medical records of R10, R16, and R7 who had diagnoses of diabetes and resided at the facility on [DATE]. R10, R16, and R7's medical records confirmed R10, R16, and R7 did not have their blood sugar checked nor did they receive insulin in accordance with their physician orders on [DATE]. On [DATE] at 3:30 PM, Surveyor reviewed a Medication Administration Audit Report for residents residing at the facility on [DATE]. The report indicated 14 residents (R8, R9, R10, R11, R12, R5, R1, R13, R14, R15, R16, R7, R3, and R17) received their medications outside the range specified in the facility's medication administration policy and/or not in accordance with their physician orders. The facility's undated Liberalized Medication Pass Times policy, indicates: It is the policy of the company to administer medications to residents in a safe manner that coincides with their daily activities of living and normal schedule. The administration window will be one hour prior to the scheduled dose and one hour past the scheduled dose .Any physician orders for specific medication times will supersede the facility's policy for liberalized medication pass times. The following medications were administered between 1.5 and 4 hours outside of the acceptable administration window: (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	R8: ~ Albuterol sulfate 4 mg (milligrams) for shortness of breath ~ Acetaminophen 500 mg for pain ~ Potassium chloride solution 20 mEq (milliequivalents)/15 ml (milliliters) R9: ~ Senna 8XXX,d+[DATE] mg for constipation ~ Simethicone 80 mg for gastroesophageal reflux disease (GERD) R10: ~ Oxybutynin chloride 2.5 mg for bladder spasms ~ Pro Med oral liquid nutritional supplement ~ Boost Plus nutritional supplement ~ A blood sugar check for diabetes scheduled for 4:00 PM was obtained 2 hours and 36 minutes late ~ Insulin aspart 10 units with meals for diabetes scheduled for 5:00 PM was administered 1 hour and 36 minutes late R11: ~ Acetaminophen 325 mg (3 tabs) for pain ~ Flomax 0.4 mg for benign prostatic hypertrophy (BPH) ~ Clozaril 200 mg for schizoaffective disorder ~ Nubeqa 300 mg for malignant neoplasm of prostate ~ Calcium-Vitamin D3 600 mg-10 mcg (micrograms) supplement R12: ~ Gabapentin 600 mg for pain related to diabetes R5: ~ Carbidopa-Levodopa extended release (ER) ,d+[DATE] mg (3 tabs) for Parkinson's disease scheduled for 3:00 PM (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	~ Carbidopa-Levodopa ER ,d+[DATE] mg (3 tabs) for Parkinson's disease scheduled for 4:00 PM R5 was hospitalized from approximately 5:00 PM to 8:00 PM on [DATE]. Both doses were administered at 8:26 PM. R1: ~ Acetaminophen 650 mg for knee pain ~ Gabapentin 100 mg for polyneuropathy ~ Ocuvite multivitamin for polyneuropathy R13: ~ Vitamin C supplement ~ Baclofen 20 mg for muscle spasm/pain R14: ~ Buspirone HCL (hydrochloride) 10 mg for anxiety ~ Gabapentin 800 mg for pain ~ Pantoprazole 40 mg for stomach protection ~ Apixaban 2.5 mg for history of pulmonary embolism ~ Gabapentin 800 mg for pain ~ Buspirone 10 mg for anxiety R15: ~ Multivitamin supplement ~ Glipizide 2.5 mg for diabetes R16: ~ Fluticasone-salmeterol inhaler for chronic obstructive pulmonary disease (COPD) ~ Blood sugar monitoring for diabetes ~ Insulin lispro 6 units with meals for diabetes ~ Insulin lispro SS (sliding scale) with meals for diabetes (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	R7: ~ Hydralazine HCL 50 mg for hypertension ~ Pantoprazole DR 40 mg for GERD ~ A blood sugar check for diabetes was obtained 1 hour and 31 minutes late ~ Insulin lispro SS for diabetes was administered 2 hours and 31 minutes late R3: ~ Acetaminophen 1000 mg for pain R17: ~ Senna 8.6 mg for constipation ~ Collectable 1000 units for vitamin D deficiency ~ Protein supplement ~ Reguloid oral for constipation ~ Carbidopa-Levodopa 61XXX,d+[DATE] mg for Parkinson's disease ~ Magnesium oxide 400 mg supplement On [DATE], Surveyor reviewed a list of residents who resided in the facility on [DATE] and were full-code status. Seven residents (R7, R11, R12, R14, R16, R18, and R19) were full-code status and without a CPR-certified nursing staff in the facility. On [DATE] at 4:00 PM, Surveyor interviewed RM-C who indicated all nurses who work in the facility are CPR certified. RM-C showed Surveyor a CPR certification on RM-C's phone for CNA-M and indicated CNA-M worked the [DATE] PM shift. When NHA-A later provided Surveyor with CNA-M's timecard, Surveyor noted CNA-M worked the [DATE] AM shift and left the facility at 2:08 PM. RM-C indicated CNA-P worked the [DATE] PM shift and was CPR-certified; however, Surveyor was not provided proof of CNA-P's certification. NHA-A provided CNA-P's timecard which indicated CNA-P worked from 2:00 PM to 10:00 PM on [DATE]. Surveyor also reviewed time sheets provided by Business Office Manager (BOM)-E that did not indicate CNA-M and CNA-P worked the [DATE] PM shift. When Surveyor showed RM-C the time sheets, RM-C confirmed CNA-M and CNA-P were not listed. The time sheets indicated two nurses worked the [DATE] PM during the time frame when there was no nurse in the facility. RM-C was unsure why the time sheets indicated that and confirmed the facility did not have a nurse during the times listed. RM-C later provided an attestation from MM-H that indicated MM-H was CPR-certified, however, proof of certification was not provided. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On [DATE] at 4:14 PM, Surveyor interviewed Director of Nursing (DON)-B who was working as a floor nurse on the [DATE] PM shift and confirmed DON-B was covering the shift because there was not a licensed nurse assigned to work the floor that day. DON-B confirmed the facility's plan was to have DON-B cover the floor assignment in the absence of another licensed nurse and indicated DON-B frequently covered floor assignments. The facility's failure to have a licensed nurse for approximately 2.5 hours on the [DATE] PM shift created a reasonable likelihood for serious harm, thus leading to a finding of immediate jeopardy. The facility removed the jeopardy on [DATE] when it completed the following: 1. Reeducated staff of the requirement to have a licensed nurse on duty 24 hours per day. 2. Reeducated nurses to remain on assignment until relieved by another nurse. 3. Reeducated nursing staff that only licensed nursing staff have access to medication cart keys. 4. Educated staffing agencies used by the facility of the responsibility of nurses to remain on assignment until another nurse arrives on duty. 5. Clarified with staffing agencies used by the facility the need for notification when agency staff cancel shifts. 6. Developed an agency nurse orientation packet that indicates nurses may not leave the facility until care is handed off to another nurse. 7. Incorporated a process in which there is a designated charge nurse each shift when the DON is not in the facility. The charge nurse or DON will cover any shifts that do not have a nurse.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 42423 Based on staff interview and record review, the facility did not ensure the nurse staffing posting accurately reflected the number of nursing staff working in the facility. This had the potential to affect all 23 residents who resided in the facility on 4/14/24. The nurse staffing posting and payroll record did not accurately reflect the actual nursing staff who worked on 4/14/24. Findings include: The facility's Nurse Staffing Posting Information policy, with a revision date of 10/13/22, indicates: It is the policy of the facility to make nurse staffing information readily available in a readable format to residents and visitors at any given time .1. The Nurse Staffing Sheet will be posted on a daily basis and will contain the following information: .d. The total number and actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for the resident care per shift: .i. Registered Nurses; ii. Licensed Practical Nurses/Licensed Vocational Nurses; iii. Certified Nursing Aides. 2. The facility will post the Nurse Staffing Sheet daily .4. A copy of the schedule will be available to supervisors to ensure the information posted is up-to-date and current .a. The information shall be updated to reflect staff absences on that shift due to call-outs and illness. After the start of each shift, actual hours will be updated to reflect such. On 9/12/24 at 10:00 AM, Surveyor interviewed Business Office Manager (BOM)-E who confirmed part of BOM-E's duties included nursing department scheduling. BOM-E indicated BOM-E or the night (NOC) shift nurse was responsible for posting and updating the nurse staffing information for the upcoming shifts. Surveyor requested the nurse staffing posting and payroll punches for 4/14/24, including agency staff. On 9/12/24 at 10:22 AM, Surveyor interviewed Licensed Practical Nurse (LPN)-I who indicated LPN-I worked the NOC shift with one Certified Nursing Assistant (CNA) on 4/14/24 and there was an issue on the PM shift when there was no licensed nurse in the facility for a period of time. On 9/12/24 at 12:15 PM, Surveyor reviewed the facility's investigation which indicated a nurse did not report to work on the 4/14/24 PM shift and an LPN left early on the AM shift. An AM shift Registered Nurse (RN) left the facility at 3:02 PM which left the residents without a licensed nurse until approximately 5:35 PM when former [NAME] President of Success (VPS)-J arrived. On 9/12/24 at 1:00 PM, Surveyor reviewed a nurse staffing posting for 4/14/24 which indicated the AM shift started at 6:00 AM, the PM shift started at 2:00 PM, and the NOC shift started at 10:00 PM. The census was 23 residents on 4/14/24. The posting indicated an RN worked 7.5 hours and an LPN worked 8 hours on the AM shift. The posting did not indicate the LPN left early (prior to 2:00 PM) or the RN stayed late (3:02 PM). A payroll document provided by BOM-E indicated there was an RN on the AM shift from 5:55 AM to 2:31 PM. The nurse staffing posting indicated 1.88 CNAs worked the AM shift. The payroll document indicated 3 CNAs worked the full AM shift and 2 CNAs worked a partial AM shift. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525586	A. Building B. Wing	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Health Services	1119 N Wisconsin St Port Washington, WI 53074

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	The nurse staffing posting indicated an RN and an LPN (for a 1/2 hour) worked the PM shift. The payroll document indicated an RN worked from 1:56 PM to 10:32 PM and an LPN worked from 1:54 PM to 11:36 PM. The facility's investigation and Surveyor's interviews with staff indicated a licensed nurse did not show up for work for the PM shift until VPS-J arrived after 5:30 PM to cover the shift and an agency nurse arrived to assist approximately 20 minutes later. The nurse staffing posting indicated 2.81 CNAs worked the PM shift. The payroll document indicated 3.5 CNAs worked the PM shift. The nurse staffing posting for the NOC shift indicated there was a licensed nurse on duty for a 1/2 hour and no CNAs. The payroll document indicated an LPN and 1 CNA worked the NOC shift. On 9/12/24 at 1:31 PM, Surveyor interviewed Regional Manager (RM)-C who confirmed the nurse staffing posting was not accurate. When shown the payroll entries for 4/14/24, RM-C was not sure why the payroll entries also were inaccurate.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50467 Based on staff interview and record review, the facility did not ensure the accurate acquiring, receiving, dispensing, and/or administering of drugs and biologicals to meet the needs of 1 resident (R) (R2) of 1 sampled resident. R2 did not have a physician's order for alprazolam (a sedative medication used to treat anxiety) from 8/30/24 to 9/3/24. R2 received alprazolam 6 times during that time period. Findings include: The facility's Medication Administration under General Guidelines policy, dated 1/2024, indicates: . Medications are administered as prescribed in accordance with manufacturers' specifications, good nursing principles and practices and only by persons legally authorized to do so .Medication Administration: .3. Prior to administration, review and confirm medication orders for each individual resident on the Medication Administration Record (MAR). Compare the medication and dosage schedule on the resident's MAR with the medication label. If the label and MAR are different, and the container is not flagged indicating a change in directions, or if there is any other reason to question the dosage or directions, the prescriber's orders are checked for the correct dosage schedule. Apply a direction change sticker to the label if the directions have changed from the current label. On 9/12/24, Surveyor reviewed R2's medical record. R2 was admitted to the facility on [DATE] and had diagnoses including chronic pain syndrome, major depressive disorder, and anxiety disorder. R2's Minimum Data Set MDS) assessment, dated 6/22/24, had a Brief Interview for Mental Status (BIMS) score of 14 out of 15 which indicated R2 had intact cognition. R2's medical record indicated an order for alprazolam 0.25 mg (milligrams) every 8 hours as needed (PRN) was discontinued via a verbal order on 8/30/24 by Medical Doctor (MD)-F. An order for alprazolam 0.25 mg every 12 hours PRN was entered on 8/30/24 at 2:45 PM. On 9/12/24 at 1:49 PM, Surveyor interviewed Director of Nursing (DON)-B who could not locate the 8/30/24 order for the change in alprazolam to every 12 hours. DON-B confirmed the physician discontinued the alprazolam 0.25 mg every 8 hours PRN order on 8/30/24. DON-B indicated the facility would have needed a new order for alprazolam 0.25 mg every 12 hours PRN. DON-B stated DON-B would call the pharmacy for the order. On 9/12/24 at 2:30 PM, DON-B gave Surveyor a faxed copy of the order which indicated the start date of alprazolam 0.25 mg every 12 hours was 9/3/24 at 9:35 AM. Surveyor reviewed R2's August and September 2024 Medication Administration Records (MARs) which indicated from 8/30/24 at 2:39 PM to 9/3/24 at 9:33 AM, 6 doses of alprazolam were administered to R2 without a valid script for the medication. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525586	A. Building B. Wing	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Health Services	1119 N Wisconsin St Port Washington, WI 53074

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/12/24 at 4:33 PM, Surveyor called MD-F's office and spoke with Nurse Practitioner (NP)-G who confirmed there was a verbal order to discontinue R2's alprazolam on 8/30/24 and an order to restart alprazolam 0.25 mg every 12 hours PRN on 9/3/24. Surveyor requested copies of the alprazolam orders and communications with the facility from NP-G on 9/12/24 and 9/16/24. The information was not provided as of this writing.