STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525595	A. Building B. Wing	12/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Francis Home	33 Everett St Fond Du Lac, WI 54935

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50467 Based on observation, staff and resident interview, and record review, the facility did not ensure call lights were in reach for 5 residents (R) (R44, R10, R60, R38, and R285) of 21 sampled residents. R44, R10, R60, R38, and R285 were dependent on staff for mobility and cares. During observations on 12/16/24 and 12/17/24, R44, R10, R60, R38, and R285's call lights were not within reach. Findings include: On 12/17/24, Surveyor requested the facility's call light policy. The policy was not provided to Surveyor. 1. From 12/16/24 to 12/18/24, Surveyor reviewed R44's medical record. R44 was admitted to the facility on [DATE] and had diagnoses including Alzheimer's disease, palliative care, right and left hand contractures, and visual disturbance. R44's most recent Minimum Data Set (MDS) assessment, dated 11/22/24, indicated R44 was rarely/never understood. The MDS also indicated R44 had highly impaired vision. R44's care plan indicated R44 had right and left hand contractures with splints to both hands and was completely dependent on staff for cares. On 12/16/24 at 10:22 AM, Surveyor observed R44 in bed. Surveyor noted R44's call light was wrapped around R44's nightstand handle and R44 could not reach the call light from R44's position in bed. On 12/16/24 at 10:28 AM, Surveyor asked Certified Nursing Assistant (CNA)-K if R44's call light should be within reach. CNA-K indicated yes and attached the call light to R44's blanket. On 12/16/24 at 2:03 PM, Surveyor observed R44's call light hanging over the drawer of R44's nightstand. Surveyor asked CNA-K if R44's call light should be within reach. CNA-K confirmed R44's call light should be within reach and attached the call light to R44's blanket. 2. From 12/16/24 to 12/18/24, Surveyor reviewed R10's medical record. R10 was admitted to the facility on [DATE] and had diagnoses including Alzheimer's disease, palliative care, and spinal stenosis. R10's most recent MDS assessment, dated 11/7/24, indicated R10 was rarely/never understood. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/16/24 at 2:10 PM, Surveyor observed R10 in bed. Surveyor noted R10's call light was hanging on the drawer of R10's nightstand and not within R10's reach. When Surveyor asked CNA-K if R10's call light should be within reach, CNA-K indicated yes and gave the call light to R10. 3. From 12/16/24 to 12/18/24, Surveyor reviewed R60's medical record. R60 was admitted to the facility on [DATE] and had diagnoses including fracture to olecranon process (portion of the elbow), Meniere's disease (condition that occurs when fluid builds up in the inner ear), hallucinations, irritable bowel syndrome (IBS), and radiculopathy of the cervical region of the spine (neuropathy that causes radiating pain when nerve/nerves are not working properly). R60's most recent MDS assessment, dated 9/27/24, had a BIMS score of 9 out of 15 which indicated R60 had moderate cognitive impairment. R60's care plan, with a revision date of 10/2/24, indicated R60 required the assistance of one staff to transfer and ambulate and should have a call light within reach. On 2/17/24 at 9:15 AM, Surveyor observed R60 in bed and noted R60's call light was across the room in a chair. Surveyor asked CNA-L if R60's call light should be within reach. CNA-L indicated yes and moved the call light within R60's reach. 4. From 12/16/24 to 12/18/24, Surveyor reviewed R38's medical record. R38 was admitted to the facility on [DATE] and had diagnoses including Alzheimer's disease, palliative care, IBS, and stage 3 pressure injury to the sacral region. R38's most recent MDS assessment, dated 11/26/24, indicated R38 was rarely/never understood. On 12/17/24 at 9:20 AM, Surveyor observed R38 sitting in a Broda chair. Surveyor noted R38's call light was hanging on R38's nightstand drawer approximately 3 feet away. When Surveyor asked CNA-L if R38's call light should be within reach, CNA-L indicated yes. CNA-L moved R38 closer to the nightstand and put the call light in R38's lap. 5. From 12/16/24 to 12/18/24, Surveyor reviewed R285's medical record. R285 was admitted to the facility on [DATE]. R285's BIMS score had not been determined yet because R285 was a new admission and an MDS assessment had not been completed yet. R285's care plan indicated (under Safety/Falls) that R285's call light should be positioned for easy access. On 12/17/24 at 9:23 AM, Surveyor observed R285 sitting in a recliner. Surveyor noted R285's call light was on the bed and not within reach. When Surveyor asked if R285 was able to reach the call light, R285 indicated no. R285 indicated R285 was not able to get up independently and get the call light. On 12/17/24 at 9:29 AM, Surveyor interviewed CNA-N who indicated R285 should have a call light within reach and provided the call light to R285. On 12/17/24 at 10:25 AM, Surveyor interviewed Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B who confirmed residents should have call lights on their person or within reach.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45942 Based on staff interview and record review, the facility did not ensure a physician was notified when 1 resident (R) (R186) of 1 sampled resident had a blood sugar outside the parameters of a physician's order. R186 had an order to notify the physician if R186's blood sugar was higher than 400 mg/dL (milligrams per deciliter) or less than 60 mg/dL. On 12/15/24, R186's blood sugar was 409 mg/dL. R186's physician was not notified. Findings include: The facility's Notification of Change policy, revised 11/2022, indicates: The community will consult the resident's Physician, Nurse Practitioner, or Physician Assistant and notify the resident representative or an interested family member when there is: .acute illness or a significant change in the resident's physical, mental, or psychosocial status (i.e., deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications) .A need to alter treatment significantly means a need to stop a form of treatment because of adverse consequences .or commence a new form of treatment to deal with a problem. Notification: Depending on the nursing assessment, appropriate notification may be immediate to 48 hours. From 12/16/24 to 12/18/24, Surveyor reviewed R186's medical record. R186 was admitted to the facility on [DATE] with diagnoses including diabetes and cellulitis of left limb. R186's Minimum Data Set (MDS) assessment, dated 12/16/24, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R186 was not cognitively impaired. R186 did not have an activated healthcare decision maker. R186 had a physician's order that indicated to notify the physician if R186's blood sugar reading was higher than 400 mg/dL or less than 60 mg/dL. On 12/17/24, Surveyor reviewed R186's blood sugar results and noted on 12/15/24, R186 had a blood sugar level of 409. R186's medical record did not indicate R186's physician was notified of the result. On 12/17/24 at 1:05 PM, Surveyor interviewed Registered Nurse (RN)-I who verified R186's blood sugar level on was 409 on 12/15/24. RN-I indicated if R186's blood sugar level was greater than 400, R186's physician should be notified. RN-I confirmed R186's medical record did not contain documentation of physician notification. On 12/17/24 at 3:55 PM, Surveyor interviewed Director of Nursing (DON)-B who indicated the physician should have been notified when R186's blood sugar level was over 400 per R186's order.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 48794 Based on staff interview and record review, the facility did not ensure a written transfer notice was provided for 1 resident (R) (R11) of 6 residents reviewed for hospitalization . In addition, the facility did not ensure the Ombudsman was notified of hospital transfers for 6 (R11, R33, R21, R30, R59, and R82) of 6 residents. R11 was transferred to the hospital on 2/22/24 and 5/1/24. Neither R11 or R11's Power of Attorney (POA) were provided with a written transfer notice for R11's 5/1/24 hospital transfer. In addition, the facility did not notify the Ombudsman of R11's hospital transfers. R33 was transferred to the hospital on 8/7/24. The facility did not notify the Ombudsman of R33's hospital transfer. R21 was transferred to the hospital on 12/11/24. The facility did not notify the Ombudsman of R21's hospital transfer. R30 was transferred to the hospital on 6/30/24. The facility did not notify the Ombudsman of R30's hospital transfer. R59 was transferred to the hospital on 11/2/24 and 11/13/24. The facility did not notify the Ombudsman of R59's hospital transfers. R82 was transferred to the hospital on 9/22/24 and 10/21/24. The facility did not notify the Ombudsman of R82's hospital transfers. Findings include: The facility's Admission, Transfer and Discharge policy, dated 10/2022, indicates: It is the policy to follow all state and federal regulations regarding admission, transfer, and discharge to and from the skilled nursing facility, and the transfer or discharge includes appropriate information that is communicated to the receiving health care provider or institution .7. Residents are notified in writing of their right to appeal this action. Written notification includes the name, email, and telephone number of the state long-term care Ombudsman, as well as information on how to obtain an appeal form. 1. From 12/16/24 to 12/18/24, Surveyor reviewed R11's medical record. R11 was admitted to the facility on [DATE] and had diagnoses including congestive heart failure and type 2 diabetes. R11 had an activated POA. R11's medical record indicated R11 had a change in condition on 2/22/24 and was transferred to the hospital. R11 returned to the facility on [DATE]. R11 had another change in condition on 5/1/24 and was transferred to the hospital. R11 returned to the facility on [DATE]. R11's medical record did not indicate R11 or R11's POA were provided with a written transfer notice for R11's 5/1/24 hospital transfer. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/17/24, Surveyor reviewed the facility's Ombudsman Notification for transfers/discharges and noted R11's 2/22/24 and 5/1/24 hospital transfers were not listed on the report provided to the Ombudsman. 2. From 12/16/24 to 12/18/24, Surveyor reviewed R33's medical record. R33 was admitted to the facility on [DATE] and had diagnoses including cardiomyopathy, cardiomegaly, and type 2 diabetes. R33's medical record indicated R33 had a change in condition on 8/7/24 and was transferred to the hospital. R33 returned to the facility on [DATE]. On 12/17/24, Surveyor reviewed the facility's Ombudsman Notification for transfers/discharges and noted R33's 8/7/24 hospital transfer was not listed on the report provided to the Ombudsman. 45942 3. From 12/16/24 to 12/18/24, Surveyor reviewed R21's medical record. R21 was admitted to the facility on [DATE] and had diagnoses including hemiplegia (paralysis) and hemiparesis (weakness) following nontraumatic intracranial hemorrhage affecting the left non-dominant side and Parkinson's disease. R21's Minimum Data Set (MDS) assessment, dated 10/29/24, had a Brief Interview for Mental Status (BIMS) score of 7 out of 15 which indicated R21 had severely impaired cognition. R21 had an activated Power of Attorney for Healthcare (POAHC). R21's medical record indicated R21 was transferred to the hospital on 12/11/24. On 12/17/24, Surveyor reviewed the facility's Ombudsman Notification for transfers/discharges and noted R21's 12/11/24 hospital transfer was not listed on the report provided to the Ombudsman. 4. From 12/16/24 to 12/18/24, Surveyor reviewed R30's medical record. R30 was admitted to the facility on [DATE] and had diagnoses including arthritis and malnutrition. R30's MDS assessment, dated 10/8/24, had a BIMS score of 15 out of 15 which indicated R30 was not cognitively impaired. R30's medical record indicated R30 was transferred to the hospital on 6/30/24. On 12/17/24, Surveyor reviewed the facility's Ombudsman Notification for transfers/discharges and noted R30's 6/30/24 hospital transfer was not listed on the report provided to the Ombudsman. 5. From 12/16/24 to 12/18/24, Surveyor reviewed R59's medical record. R59 was admitted to the facility on [DATE] and had diagnoses including acute embolism (obstruction in blood vessel) and thrombosis (formation of blood clot) of right femoral (thigh) vein, Parkinson's disease, and obesity. R59's MDS assessment, dated 11/8/24, had a BIMS score of 12 out of 15 which indicated R59 had moderately impaired cognition. R59 did not have an activated healthcare decision maker. R59's medical record indicated R59 was transferred to the hospital on 11/2/24 and 11/13/24. On 12/17/24, Surveyor reviewed the facility's Ombudsman Notification for transfers/discharges and noted the Ombudsman was not notified of R59's 11/2/24 and 11/13/24 hospital transfers. 43361 (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6. From 12/16/24 to 12/28/24, Surveyor reviewed R82's medical record. R82 was admitted to the facility on [DATE] and had diagnoses including L1 compression fracture and acute cystitis. R82's medical record indicated R82 was hospitalized on [DATE]. R82 returned to the facility on [DATE] with diagnoses including aspiration pneumonia, acute hypoxic respiratory failure, and acute on chronic congestive heart failure (CHF). R82 was hospitalized again on 10/21/24 due to weakness and did not return to the facility. On 12/17/24, Surveyor reviewed the facility's Ombudsman Notification for transfers/discharges and noted the Ombudsman was not notified of R82's hospital transfers. On 12/17/24 at 2:13 PM, Surveyor interviewed Health Information Manager (HIM)-C who indicated HIM-C sent a monthly report to the Ombudsman. HIM-C indicated HIM-C used to include hospitalization s on the report, however, the Ombudsman only wanted to be notified of residents that had been discharged and not residents who had gone back and forth to the hospital. On 12/18/24 at 11:05 AM, Surveyor interviewed Ombudsman (OM)-D who indicated when OM-D speaks with facilities, OM-B encourages facilities to speak with the State Agency and consult the regulations regarding what information should be sent to the Ombudsman regarding transfers and discharges. OM-D did not recall telling the facility not to send hospital transfer information.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48794 Based on staff and resident interview and record review, the facility did not ensure 2 residents (R) (R11 and R33) of 6 residents reviewed for hospitalization received written notification of the facility's bedhold policy when they were transferred to the hospital. R11 was transferred to the hospital on 2/22/24. The facility did not obtain written bedhold confirmation from R11 or R11's Power of Attorney (POA). In addition, R11 was transferred to the hospital on 5/1/24. Neither R11 or R11's POA were provided with a written bedhold notification for R11's 5/1/24 hospital transfer. R33 was transferred to the hospital on 8/7/24. The facility did not obtain written bedhold confirmation from R33 or R33's emergency contact. Findings include: The facility's undated Bedhold Policy and Notification/Acknowledgement policy indicates prior to a resident being transferred to a hospital .a notice is given concerning the facility's bedhold policy. 1. From 12/16/24 to 12/18/24, Surveyor reviewed R11's medical record. R11 was admitted to the facility on [DATE] and had diagnoses including congestive heart failure, type 2 diabetes, and major depression. R11 had an activated POA. R11's medical record indicated R11 had a change in condition on 2/22/24 and was transferred to the hospital. R11 returned to the facility on [DATE]. R11 had another change in condition on 5/1/24 and was transferred to the hospital. R11 returned to the facility on [DATE]. On 12/17/24, Surveyor reviewed the Bedhold Notification/Acknowledgment for R11's 2/22/24 hospital transfer which did not include a signature of acknowledgement from R11 or R11's POA. In addition, the facility did not provide R11 or R11's POA with a written bedhold notice for R11's 5/1/24 hospital transfer. 2. From 12/16/24 to 12/138/24, Surveyor reviewed R33's medical record. R33 was admitted to the facility on [DATE] and had diagnoses including cardiomyopathy, cardiomegaly, type 2 diabetes. R33 did not have an activated POA. R33's medical record indicated R33 had a change in condition on 8/7/24 and was transferred to the hospital. R33 returned to the facility on [DATE]. On 12/17/24, Surveyor reviewed the Bedhold Notification/Acknowledgment for R33's 2/22/24 hospital transfer which did not include a signature of acknowledgement from R33 or R33's emergency contact. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/18/24 at 1:44 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A who indicated it is the nurse's responsibility to ask the resident or their representative if they want a bedhold and the Social Worker's responsibility to follow-up and obtain responses and signatures. NHA-A confirmed signatures should have been obtained for R11 and R33's hospitalization s. NHA-A stated the facility did not complete a bedhold for R11's 5/1/24 hospital transfer because R11 did not want a bedhold and the facility discharged R11 from the record.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48794 Based on staff interview and record review, the facility did not ensure Minimum Data Set (MDS) assessments were coded correctly for 2 residents (R) (R11 and R19) of 21 sampled residents. R11 was prescribed lorazepam (an anti-anxiety medication) and oxycodone (an opioid medication). R11's MDS assessments, dated 5/21/24, 6/24/24 and 9/20/24, did not indicate R11 received anti-anxiety or opioid medication. R19 had a diagnosis of mental illness (MI). R19's MDS assessment, dated 8/6/24, indicated R19 did not have a serious mental illness. Findings include: 1. From 12/16/24 to 12/18/24, Surveyor reviewed R11's medical record. R11 was admitted to the facility on [DATE] and had diagnoses including major depression disorder, altered mental status, and psychophysiologic insomnia. R11's MDS assessment, dated 9/20/24, had a Brief Interview for Mental Status (BIMS) score of 6 out of 15 which indicated R11 had severely impaired cognition. R11 had an activated Power of Attorney (POA) to assist with healthcare decisions. R11 had physician's orders for lorazepam (with a start date of 5/15/24) and oxycodone (with a start date of 5/15/24). R11's MDS assessments, dated 5/21/24, 6/24/24, and 9/20/24 did not indicate R11 received anti-anxiety or opioid medication. 2. From 12/16/24 to 12/18/24, Surveyor reviewed R19's medical record. R19 admitted to the facility on [DATE] from another skilled nursing facility (SNF) and had diagnoses including schizoaffective disorder and anxiety disorder. R19's MDS assessment, dated 11/1/24, had a BIMS score of 15 out of 15 which indicated R19 was not cognitively impaired. R19's Preadmission Screening and Resident Review (PASRR) Level I, dated 9/12/17, indicated R19 was at another SNF at the time of completion and had an MI with corresponding medication. R19's PASRR Level II, dated 10/12/17, confirmed R19's MI diagnosis. R19 transferred to the facility on [DATE]. R19's MDS assessment, dated 8/6/24, indicated R19 was not evaluated by PASRR Level II and determined to have a serious MI (section A1500). On 12/18/24 at 1:21 PM, Surveyor interviewed Director of Nursing (DON)-B who stated the facility had been in transition with an MDS coordinator and had an outside company completing MDS assessments in the interim, therefore, DON-B was unable to confirm the MDS coding errors. On 12/18/24 at 2:32 PM, Surveyor interviewed Social Worker (SW)-G who stated SW-G was responsible for completion of section A1500 of the MDS. SW-G indicated R19's MDS should have been coded to indicate R19 had a serious MI.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48794 Based on staff interview and record review, the facility did not ensure the appropriate care and treatment were provided for 1 resident (R) (R54) of 1 resident reviewed for weight monitoring. The facility did not ensure R54's physician was notified when R54 had a significant weight gain. In addition, the facility did not consistently monitor R54's weight per the physician's order. Findings include: The facility's Nutrition Policy, dated 2/2023, indicates the facility maintains acceptable parameters of nutritional status such as body weight or desirable body weight range .unless the resident's clinical condition demonstrates that this is not possible, or the resident's preferences indicates otherwise. From 12/16/24 to 12/18/24, Surveyor reviewed R54's medical record. R54 was admitted to the facility on [DATE] and had diagnoses including atrial fibrillation, personal history of other venous thrombosis and embolism, and chronic kidney disease, stage 3 unspecified. R54's Minimum Data Set (MDS) assessment, dated 10/17/24, had a Brief interview for Mental Status (BIMS) score of 14 out of 15 which indicated R54 was not cognitively impaired. R54's medical record contained the following information: ~ R54 had a physician's order for weights to be completed daily for 3 days and then weekly and to update the physician if R54's weight increased or decreased by 3 lbs in 1 day or 5 lbs in 1 week. ~ R54 was first weighed on 10/13/24 and was 151.2 lbs. ~ R54 weighed 152 lbs on 10/23/24. ~ On 11/5/24, R54 had a weight gain of 8.4 lbs in 23 days. R54's medical record did not indicate the physician was notified. ~ On 11/26/24, R54 had an additional weight gain of 7.2 lbs. R54's medical record did not indicate the physician was notified. ~ On 12/9/24, R54 had an additional weight gain of 9.7 lbs. R54's medical record did not indicate physician was notified. ~ On 12/11/24, R54 weighed 176.5 lbs (which was a 16.73% weight gain). The Dietitian documented R54 was up 20 lbs since admission. R54's medical record did not indicate the physician was notified. ~ On 12/11/24, R54's physician order was changed to daily weights due to edema and changes in medication and to update the physician if R54's weight increased or decreased by 3 lbs in 1 day or 5 lbs in 1 week. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	~ R54's medical record did not contain weights after 12/11/24. On 12/18/24 at 1:01 PM, Surveyor interviewed Infection Preventionist (IP)-E who confirmed R54 was not weighed for the first 3 days following admission but should have been weighed per the physician's order. IP-E stated IP-E changed R54's order on 12/11/24 to daily weights because R54's weights had been off and R54 was started on a diuretic. IP-E confirmed R54's weights were not consistently obtained and should have been completed per the physician's order. IP-E confirmed R54's physician was not updated per the order or of R54's significant weight gain. IP-E indicated R54 was placed on isolation precautions on 12/11/24 due to illness. IP-E stated staff do not complete weights on residents who are on isolation precautions. IP-E confirmed staff should have updated R54's physician on the facility's inability to obtain R54's weight.

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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** 45942 Based on observation, staff and resident interview, and record review, the facility did not provide pharmaceutical services to ensure the safe administration of drugs and biologicals for 2 residents (R) (R27 and R78) of 21 sampled residents. On 12/16/24, Surveyor observed two inhalers on R27's bedside table. R27 indicated R27 self-administered the inhalers as needed. A self-administration of medication assessment, dated 9/24/24, determined R27 was unable to self-administer medication. On 12/17/24, R78's 500 milligram (mg) ranolazine (used to treat chest pain) tablet was administered late. Findings include: The facility's Medication Administration policy, revised 11/2024, indicates: This community supervises or administers all medications a resident receives as ordered by their physician. The community provides appropriate methods and procedures for obtaining, dispensing, and administering drugs approved by the resident's physician and consulting pharmacist .Staff members responsible for administering medications review the physician's order prior to administering medications .Medication Administration Record (MAR) is reviewed to obtain correct medication, time, dosage, and route of administration as ordered by the physician for each individual resident .Resident Medication Agreement: .3) When a resident's drugs are obtained from another pharmacy, it is the resident/responsible party's responsibility to see that all drugs brought in are in compliance with policy and state regulations. 4) To meet policy and state regulations, all medications must have a doctor's order and a proper label .If drugs are purchased from another pharmacy, it becomes the responsibility of the person obtaining the drugs to see that they are properly labeled. 5) Labels should include the name of the pharmacy, pharmacy's address and telephone number, name of the resident, name of the prescribing physician or dentist, date and prescription number, directions for use of the drug, dosage unit of the medication, quantity of the drug, expiration date, and other auxiliary statements as required by the drug and as determined by the pharmacist .7) When a resident moves in, the community requires a doctor's order in writing. Only those drugs listed on the order will be administered to the resident .9) No drugs are allowed in resident rooms unless specifically ordered by the physician. If a resident does self-administer medications, they must have a locked box or cabinet in their room. The resident will have a key to the box or cabinet and one key is kept in the medication room. 1. On 12/16/24, Surveyor reviewed R27's medical record. R27 was admitted to the facility on [DATE] and had diagnoses including spinal stenosis, wheezing, and congestive heart failure. R27's Minimum Data Set (MDS) assessment, dated 10/8/24, had a Brief Interview for Mental Status (BIMS) score of 12 out of 15 which indicated R27 had moderate cognitive impairment. R27 did not have an activated healthcare decision maker. On 12/16/24 at 11:27 AM, Surveyor observed two inhalers on R27's bedside table. The first inhaler was Spiriva 2.5 micrograms (mcg) with no open date. The second inhaler was albuterol sulfate 200 metered inhalation with no open date. R27 indicated both inhalers were brought from home. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R27's medical record contained a physician's order for Albuterol Sulfate HFA Inhalation Aerosol Solution 108 (90 base) mcg/act (micrograms/actuation), 2 puffs inhale orally every 4 hours as needed for wheezing. R27 did not have a physician's order for Spiriva. R27's medical record contained a self-administration of medication assessment, dated 9/24/24, that indicated R27 was unable to self-administer medication. On 12/17/24 at 1:29 PM, Surveyor interviewed Registered Nurse (RN)-I who confirmed both inhalers were on R27's bedside table but should not be in R27's room. RN-I verified R27 had a physician's order for albuterol sulfate but did not have an order for Spiriva. RN-I also verified R27 did not have an order to self-administer medication or an assessment that indicated R27 could safely and accurately do so. Surveyor also interviewed Assistant Director of Nursing (ADON)-J who indicated R27 was unable to use a locked drawer and was, therefore, not able to self-administer medication. On 12/17/24 at 2:23 PM, Surveyor interviewed Director of Nursing (DON)-B who verified R27's self-administration of medication assessment indicated R27 was unable to self-administer medication. DON-B indicated R27 should not have inhalers in R27's room. 2. On 12/17/24, Surveyor reviewed R78's medical record. R78 was admitted to the facility on [DATE] and had diagnoses including pulmonary embolism (obstruction in blood vessel), pressure ulcer stage 3 to left heel, and after care following surgical amputation to right leg. R78's MDS assessment, dated 10/4/24, had a BIMS score of 9 out of 15 which indicated R78 had moderately impaired cognition. R78 did not have an activated healthcare decision maker. On 12/17/24 at 9:07 AM, Surveyor observed Licensed Practical Nurse (LPN)-O prepare and administer R78's AM medication, including a 500 mg tablet of ranolazine. Surveyor reviewed R78's physician orders and noted R78 had an order for ranolazine 500 mg to be given by mouth every 12 hours at 8:00 AM and 8:00 PM. On 12/17/24 at 10:47 AM, Surveyor interviewed LPN-O who verified R78's ranolazine was scheduled for 8:00 AM and there was an hour window to administer. On 12/17/24 at 11:08 AM, Surveyor interviewed DON-B who indicated if a medication is ordered to be administered at 8:00 AM, there is a one hour window for administration. DON-B indicated if an 8:00 AM medication is administered at 9:07 AM, the medication is considered late.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43361 Based on staff interview and record review, the facility did not ensure monitoring for high risk medications was in place for 3 residents (R) (R30, R69, and R11) reviewed for unnecessary medications. R30 was prescribed hydrocodone-acetaminophen (an opioid medication) for pain. R30 was not monitored for adverse reactions or side effects of the high-risk medication. R69 was prescribed oxycodone (an opioid medication) for pain. R69 was not monitored for adverse reactions or side effects of the high-risk medication. R11 was prescribed oxycodone and torsemide (a diuretic medication) for congestive heart failure (CHF). R11 was not monitored for adverse reactions or side effects of the high-risk medications. Findings include Per the Federal Food and Drug Administration (FDA), opioid medications have a black box warning. A black box warning is the FDA's strongest safety warning given to medications. These medications have the potential for severe side effects. The facility's Pain Management policy, dated 4/1/08, indicates: There is a system in place to identify, monitor and evaluate residents' pain .12. Potential side effects related to pain medications will be identified in the person-centered care plan. 1. On 12/17/24, Surveyor reviewed R30's medical record. R30 was admitted to the facility on [DATE] and had diagnoses including right femur fracture, gout, muscle spasms, rheumatoid arthritis, and generalized discomfort. R30's Minimum Data Set (MDS) assessment, dated 10/8/24, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R30 was not cognitively impaired. R30's medical record indicated R30 was prescribed one 5-325 milligram (mg) tablet of hydrocodone-acetaminophen two times daily and as needed (PRN) every 6 hours for pain. Surveyor noted R30's pain care plan (initiated on 8/9/23) and medical record did not contain monitoring interventions for opioid use. On 12/18/24, Surveyor reviewed R30's plan of care and noted R30's pain care plan was updated on 12/17/24 to indicate R30 received opioid medication. The care plan indicated staff should monitor/notify for side effects of opioid use such as: sedation, dizziness, nausea, vomiting, constipation, and respiratory depression. 2. On 12/17/24, Surveyor reviewed R69's medical record. R69 was admitted to the facility on [DATE] and had diagnoses including spondylosis without myelopathy or radiculopathy, cervical region and osteoarthritis of the hip. R69's MDS assessment, dated 11/15/24, had a BIMS score of 1 out of 15 which indicated R69 had severely impaired cognition. R69 received Hospice services. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R69's medical record indicated R69 was prescribed 5 mg of oxycodone every 2 hours as needed for pain 4-10/10 or terminal and 2 tablets by mouth 3 times daily. R69 had a pain care plan. Surveyor neither R69's pain care plan or medical record contained monitoring interventions for opioid use. On 12/18/24, Surveyor reviewed R69's plan of care and noted the facility had revised R69's pain care plan on 12/17/24 to indicate R69 received opioid medication and to monitor/notify for side effects of opioid use such as: sedation, dizziness, nausea, vomiting, constipation, and respiratory depression. On 12/18/24 at 12:47 PM, Surveyor interviewed Director of Nursing (DON)-B who confirmed R30 and R69 did not have opioid side effect monitoring in their care plans prior to 12/17/24 but should have. 48794 3. From 12/17/24 to 12/18/24, Surveyor reviewed R11's medical record. R11 was admitted to the facility on [DATE] and had diagnoses including CHF, chronic kidney disease, stage 3, and type 2 diabetes. R11's MDS assessment, dated 9/20/24, had a BIMS score of 6 out of 15 which indicated R11 had severely impaired cognition. R11 had an activated Power of Attorney for Healthcare (POAHC) to assist with healthcare decisions. R11's medical record contained physician orders for one 5 mg oxycodone tablet every 2 hours as needed for pain and one 10 mg torsemide tablet once daily for CHF. R11 had a pain care plan. Surveyor noted R11's pain care plan and medical record did not contain monitoring interventions for opioid or diuretic use. On 12/18/24, Surveyor reviewed R11's plan of care and noted R11's pain care plan was updated on 12/17/24 to indicate R11 received opioid medication and to monitor/notify for side effects of opioid use such as: sedation, dizziness, nausea, vomiting, constipation, and respiratory depression. R11's plan of care still did not contain monitoring interventions for diuretic use. On 12/18/24 at 10:18 AM, Surveyor interviewed DON-B who confirmed R11 did not have side effect monitoring in place for opioid medication (prior to 12/17/24) or diuretic medication but should have.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45942 Based on observation, staff interview, and record review, the facility did not ensure it was free of a medication error rate of 5% or greater. During medication administration observations, 3 errors occurred during 32 opportunities which resulted in a 9.37% medication error rate that affected 1 resident (R) (R21) of 3 residents observed during medication administration. On 12/17/24, R21 was administered two medications in the wrong form and one incorrect medication. Findings include: The facility's Medication-Crushing policy, revised 4/1/08, indicates: Only appropriate medications will be crushed with physician orders .1) Only medications approved to be crushed by the manufacturer are crushed. 2) All crushed medications are documented with a physician's order. According to Carbidopa and Levodopa Extended-Release Tablets-Drugs.com: .How is this medicine best taken? .Swallow whole. Do not chew or crush. According to Potassium Chloride: Uses, Dosage & Side Effects-Drugs.com: .How Should I take Potassium Chloride? .Do not crush, chew, or suck on a tablet or capsule. The facility's Medication Administration policy, revised 11/2024, indicates: The community provides appropriate methods and procedures for obtaining, dispensing, and administering drugs approved by the resident's physician and consulting pharmacist .Staff members responsible for administering medications review the physician's order prior to administering medications .Procedure: .5) Medication Administration Record (MAR) is reviewed to obtain correct medication, time, dosage, and route of administration as ordered by the physician for each individual resident . 1. On 12/17/24, Surveyor reviewed R21's medical record. R21 was admitted to the facility on [DATE] and had diagnoses including hemiplegia (paralysis) and hemiparesis (weakness) following nontraumatic intracranial hemorrhage (brain bleed) affecting the left non-dominant side and Parkinson's disease. R21's Minimum Data Set (MDS) assessment, dated 10/29/24, had a Brief Interview for Mental Status (BIMS) score of 7 out of 15 which indicated R21 had severely impaired cognition. R21 had an activated Power of Attorney for Healthcare (POAHC). On 12/17/24 at 8:44 AM, Surveyor observed Licensed Practical Nurse (LPN)-O prepare and administer R21's AM medication. Surveyor observed LPN-O crush R21's medications, including carbidopa/levodopa (used to treat Parkinson's disease) 25-100 milligrams (mg) extended release and potassium chloride (supplement) 20 milliequivalents (mEq) extended release. Surveyor also observed LPN-O administer an 8.6 mg tablet of senna (used to treat constipation). Surveyor reviewed R21's physician orders and noted R21 did not have an order for senna 8.6 mg. R21 had an order for senna plus oral tablet 8.6-50 mg (which contained docusate, another laxative). (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/17/24 at 9:05 AM, Surveyor interviewed LPN-O who indicated extended release medications should not be crushed. LPN-O indicated LPN-O crushed R21's extended release medications due to R21's swallowing issues. LPN-O indicated LPN-O should call a resident's physician prior to crushing extended release medications. On 12/17/24 at 9:18 AM, Surveyor interviewed Assistant Director of Nursing (ADON)-J who indicated extended release medications should not be crushed. On 12/17/24 at 10:47 AM, Surveyor interviewed LPN-O who verified LPN-O administered senna 8.6 mg to R21 instead of senna plus 8.6-50 mg.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43361 Based on observation, staff and resident interview, and record review, the facility did not maintain an infection prevention and control program designed to prevent the transmission of communicable disease and infection for 8 residents (R) (R57, R28, R54, R186, R73, R30, R44, and R38) of 8 sampled residents. This practice had the potential to affect all 74 residents residing in the facility. The facility's line list for a current gastrointestinal outbreak (GI) of Norovirus was inaccurate for R57, R28, R54, R186, and R73. R30 was on enhanced barrier precautions (EBP) and had an EBP sign posted on R30's door. On 12/16/24, Certified Nursing Assistant (CNA)-P repositioned R30 without wearing the appropriate personal protective equipment (PPE). R44 was on EBP related to wounds and had an EBP sign posted on R44's door. On 12/17/24, CNA-L and Medication Technician (MT)-M repositioned R44 without wearing the appropriate PPE. R38 was on EBP and had an EBP sign posted on R38's door. On 12/16/24, CNA-K exited R38's room with a lift used to transfer R38. CNA-K did not sanitize the lift after use. In addition, PPE was not available in or near R38's room. Findings include: The Centers for Disease Control and Prevention (CDC) defines Norovirus as a very contagious virus that causes vomiting and diarrhea. The CDC document titled Guidelines for the Prevention and Control of Norovirus Gastroenteritis Outbreaks in Healthcare Settings, dated 2/2017, indicates: During outbreaks, place patients with Norovirus gastroenteritis on contact precautions for a minimum of 48 hours after the resolution of symptoms to prevent further exposure of susceptible patients .Wait at least 2 days (48 hours) after symptoms resolve .Begin active case-finding when a cluster of acute gastroenteritis cases is detected in the healthcare facility. Use a specified case definition, and implement line lists to track both exposed and symptomatic patients and staff . The facility's Infection Prevention and Control Program Policy, revised 2/2024, indicates: The Infection Preventionist (IP) .conducts surveillance for community-associated infections .to identify opportunities to prevent and/or reduce the rate of infection in our residents .surveillance includes use of a data collection tool . Collected by concurrent and/or retrospective chart review, review of microbiological reports, reports from resident care providers and review of other documents . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility's Infection Prevention binder includes the Wisconsin Department of Health Services' Recommendations for Prevention and Control of Acute Gastroenteritis Outbreaks in Wisconsin Long-Term Care Facilities, dated 12/2017, which recommends: .Develop and implement routine surveillance for gastrointestinal infection in residents and staff to more rapidly identify illnesses and outbreaks .A line list is a log of ill staff and residents with similar signs and symptoms. It should be used as a tool to track illnesses within a facility when an outbreak is suspected and while an outbreak is occurring in real time . The facility's Enhanced Barrier Precautions (EBP) policy, revised 4/1/24, indicates: .For EBP, signage should clearly indicate the high-contact resident care activities that require the use of a gown and gloves (dressing, showering, transferring, providing hygiene, changing linens, changing briefs, device care, or wound care) .3. Make PPE, including gowns and gloves, available immediately outside of the resident's room, including a mask for cares that might generate splash or spray. Per facility signage posted on residents' doors, contact precautions indicates the use of patient-dedicated, single-use disposable or shared equipment that should be cleaned and disinfected between patients. 1. When Surveyor entered the facility on the morning of 12/16/24, Surveyor noted signage at the entrance and throughout the building that indicated the facility had an outbreak of Norovirus. At the entrance, Nursing Home Administrator (NHA)-A confirmed the facility was in an active Norovirus outbreak. On 12/17/24 at 1:45 PM, the facility provided Surveyor with infection prevention line lists, including a line list for the Norovirus outbreak. Surveyor reviewed the Norovirus line list and noted the first resident had a symptom onset date of 12/6/24. There were 25 residents on the line list some of which still had active infections. Surveyor also reviewed resident charting, including CNA bowel charting, and noted the following: ~ R57 was added to the line list due to GI symptom onset (diarrhea) on 12/12/24. The line list indicated R57's last symptom of diarrhea was on 12/13/24. R57's well date was listed as 12/16/24. R57's CNA bowel charting indicated R57 last had diarrhea on 12/15/24 at 7:26 PM which indicated R57's well date was incorrect and R57 should have still been on precautions. ~ R28 was added to the line list due to GI symptom onset (diarrhea) on 12/7/24. The line list indicated R28's last symptom of diarrhea was on 12/15/24. R28's CNA bowel charting indicated R28 last had diarrhea on 12/16/24 at 4:37 PM. ~ R54 was added to the line list due to GI symptom onset (diarrhea) on 12/11/24. The line list indicated R54's last symptom of diarrhea was on 12/15/24. R54's CNA bowel charting indicated R54 last had diarrhea on 12/16/24 at 1:55 PM. ~ R186 was admitted to the facility on [DATE]. R186 had a contact precautions sign on R186's door and a PPE cart outside R186's room. A progress note, dated 12/17/24 at 2:02 AM, indicated R186 had loose stools on 12/16/24 and was placed on contact isolation precautions. Surveyor noted R186 was not on the line list for GI symptoms. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	~ R73 was added to the line list due to GI symptom onset (diarrhea and abdominal cramping) on 12/6/24. The line list indicated R73's last symptom of diarrhea was on 12/8/24. R73's well date was listed as 12/11/24. R73's CNA bowel charting indicated R73 last had diarrhea on 12/16/24. On 12/17/24 at 3:51 PM, Surveyor interviewed Director of Nursing (DON)-B who indicated DON-B maintained the line list since Infection Preventionist (IP)-E had been out ill. DON-B indicated DON-B reviewed the 24-hour report daily which included progress notes, medication changes, and physician communication. DON-B indicated staff and shift huddles occurred daily and staff contacted DON-B if a resident had symptoms. When Surveyor reviewed the above discrepancies between the line list and CNA bowel charting, DON-B indicated the 24-hour report did not pull bowel documentation. DON-B confirmed R186 started symptoms yesterday and should be on the line list. DON-B also confirmed R57 should still be on precautions if R57's last documented bout of diarrhea was on 12/15/24. DON-B and NHA-A acknowledged that by not accurately tracking residents' last episodes of diarrhea on the line list, staff could be removing symptomatic residents from precautions too early which could cause continued spread of the illness. DON-B also confirmed the line lists should be accurate. On 12/18/24 at 8:51 AM, Surveyor observed a contact isolation precaution sign (which indicated anyone entering the room needed to wear a gown and gloves) on R73's door and a PPE cart outside R73's room. Surveyor interviewed MT-F who indicated R73 was on contact precautions. On 12/18/24 at 1:04 PM, Surveyor interviewed IP-E who indicated on 12/17/24, Social Worker (SW)-G called the staff who documented R73 had diarrhea on 12/16/24 and was told R73's bowel movement was a loose stool, not diarrhea. IP-E indicated the loose stool was not watery which indicated it was not Norovirus. IP-E indicated there should not have been a contact precautions sign on R73's door. IP-E stated staff were updated about precaution changes on the 24-hour board at the nurses' station, via daily communication, and during staff huddles. IP-E indicated either DON-B or IP-E calls the nurse on the floor to update them on precaution changes and the nurse either posts or removes precaution signs and PPE carts from outside residents' rooms. On 12/18/24 at 1:41 PM, Surveyor interviewed Registered Nurse (RN)-H who stated R73 was not on contact precautions at that time. When Surveyor asked how RN-H knew if a resident was on contact precautions, RN-H stated it was in the resident's care plan. RN-H and Surveyor looked at R73's care plan which did not indicate R73 was on contact precautions. RN-H and Surveyor looked at the 24-hour board in the facility's electronic medical record which did not indicate R73 was on contact precautions. RN-H did not know why R73's door had a contact precautions sign or why a PPE cart was located outside R73's room. At that time, MT-F stated R73 was supposed to be on contact precautions because R73 had a loose stool on 12/16/24. 45942 2. On 12/16/24, Surveyor reviewed R30's medical record. R30 was admitted to the facility on [DATE] and had diagnoses including right femur fracture, gout, and rheumatoid arthritis. R30's Minimum Data Set (MDS) assessment, dated 10/8/24, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R30 was not cognitively impaired. On 12/16/24 at 11:00 AM, Surveyor observed an EBP sign on R30's door. Surveyor did not observe a PPE cart outside or inside R30's room. Surveyor observed CNA-P enter R30's room to reposition R30 prior to morning cares. (continued on next page)

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 12/16/24 at 11:38 AM, Surveyor interviewed CNA-P who indicated CNA-P was not sure why R30 was on EBP. CNA-P indicated R30 did not have wounds or an infection, therefore, CNA-P did not don PPE. CNA-P also indicated RN-I was unsure why there was an EBP sign on R30's door. On 12/16/24 at 1:15 PM, Surveyor noted the EBP sign was removed from R30's door. Surveyor interviewed R30 who indicated staff told R30 that since R30 was positive for methicillin-resistant Staphylococcus aureus (MRSA) a few years ago and was now colonized, the EBP sign was removed. R30 confirmed staff did not wear the appropriate PPE during cares. On 12/17/24 at 1:37 PM, Surveyor interviewed RN-I who indicated RN-I removed the EBP sign from R30's room because R30's wounds were healed. RN-I indicated R30 informed RN-I that R30's MRSA was colonized. RN-I indicated an EBP sign should have been in place per the facility's policy. On 12/17/25 at 1:45 PM, Surveyor interviewed Assistant Director of Nursing (ADON)-J who indicated an EBP sign should be posted on or near R30's door and staff should wear the appropriate PPE during cares. On 12/17/24 at 2:00 PM, Surveyor observed an EBP sign on R30's door. Surveyor did not observe a PPE cart outside or near R30's room. 50467 3. On 12/17/24 at 9:30 AM, Surveyor observed CNA-L and MT-M enter R44's room to reposition R44. CNA-L and MT-M did not wear PPE during repositioning. Surveyor noted there was not a PPE cart inside or outside R44's room. When Surveyor asked if R44 was on EBP due to the EBP sign posted on R44's door, MT-M indicated gowns and gloves only had to be worn during wound care. When Surveyor inquired about PPE, MT-M stated PPE could be at the CNA desk or in storage. CNA-L then assisted R44 with dining and MT-M resumed medication pass. No PPE was brought to R44's room at that time. 4. On 12/16/24 at 10:28 AM, Surveyor observed CNA-K exit R38's room with a lift. CNA-K rolled the lift to a storage area and walked away. Surveyor interviewed CNA-K and asked if the lift should be sanitized after use. CNA-K indicated lifts only needed to be sanitized when the facility was on precautions which had been lifted. Surveyor noted R38 was on EBP due to a sign posted on R38's door Surveyor noted there was not a PPE cart inside or outside R38's room. CNA-K confirmed PPE should be available and went to a storage closet at the end of the hall. CNA-K returned with gowns and put them on a dresser next to the entrance to R38's room. On 12/17/24 at 10:25 AM, NHA-A and DON-B confirmed staff should wear PPE during high-contact cares for residents on EBP. DON-B indicated PPE carts should be outside the rooms of residents on precautions. DON-B also confirmed lifts should be wiped with cleaner and air dried for 1 minute before use on the next resident.