STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525482	A. Building B. Wing	08/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Burlington Health and Rehabilitation Center	677 E State St Burlington, WI 53105

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. 40533 Based on observation, interview and record review, the facility did not ensure that 1 (R1) of 3 sampled residents was free of from accident hazards and provided supervision and assistive devices to prevent avoidable accidents. R1 was admitted to the facility after a hospital stay for falls. R1 had multiple falls during his stay at the facility. In June and July 2021 R1 had 14 falls including 6 on the patio, 4 in his room and 3 in his bathroom. The facility did not perform a root cause analysis for falls, did not put an immediate intervention in place for some falls and did not put a new intervention in place for some falls. On 6/16/21 R1 was sent to the hospital post fall and returned with a soft cast and on 712/21 R1 required transfer to the hospital for stitches to his head with lacerations. During the survey R1 was observed without safety care planned interventions in place including a body pillow in bed, gripper socks and lids on cups. Findings include: Surveyor reviewed facility's Falls and Fall Risk, Managing policy with a revision date of March 2018. Documented was: Policy Statement Based on previous evaluations and current date, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and try to minimize complications from falling. Policy Interpretation and Implementation Definition According to the [Minimum Data Set (MDS)], a fall is defined as: (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	Unintentionally coming to rest on ground, floor or other lower level, but not as a result of an overwhelming external force (e.g., a resident pushes another resident). An episode where a resident lost her/his balance and would have fallen, if not for another person or if he or she had not caught him/herself, is considered a fall. A fall without injury is still a fall. Unless there is evidence suggesting otherwise, when a resident is found on the floor, a fall is considered to have occurred . Resident-Centered Approaches to Managing Falls and Fall Risks 1. The staff, with the input of the attending physician, will implement a resident-centered fall prevention plan to reduce the specific risk factor(s) of falls for each resident at risk or with a history of falls. 2. If a systematic evaluation of a resident's fall risk identifies several possible interventions, the staff may choose to prioritize interventions (i.e., to try one or a few at a time, rather than many at once) . 5. If falling recurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant. 6. If underlying causes cannot be readily identified or corrected, staff will try various interventions, based on assessment of the nature or category of falling, until falling is reduced or stopped, or until the reason for the continuation of the falling is identified as unavoidable . Monitoring Subsequent Falls and Fall Risk 1. The staff will monitor and document each resident's response to interventions intended to reduce falling or the risks of falling . 3. If the resident continues to fall, staff will re-evaluate the situation and whether it is appropriate to continue or change current interventions. As needed, the attending physician will help the staff reconsider possible causes that may not previously have been identified . Surveyor reviewed facility's Assessing Falls and Their Causes policy with a revision date of March 2018. Documented was: Purpose The purpose of this procedure are to provide guidance for assessing a resident after a fall and to assist staff in identifying causes of the fall . Defining Details of Falls: 1. After an observed or probable fall, clarify the details of the fall, such as when the fall occurred and what the individual was trying to do at the time the fall occurred . Identifying Causes of a Fall or Fall Risk: (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	1. Within 24 hours of a fall, begin to try to identify possible or likely causes of the incident. Refer to resident-specific evidence including medical history, known functional impairments, etc. 2. Evaluate chains of events or circumstances preceding a recent fall, including: a. Time of day of the fall; b. Time of the last meal; c. What the resident was doing; d. Whether the resident was standing, walking, reaching, or transferring from one position to another; f. Whether the resident was trying to get to the toilet; g. Whether any environmental risk factors were involved (e.g., slippery floor, poor lighting, furniture or objects in the way); and/or h. Whether there is a pattern of falls for this resident . R1 was admitted to the facility 10/28/20 with diagnoses that included Alcohol Abuse with Intoxication Delirium, Constipation, Acute Kidney Failure, Encephalopathy and Protein-Calorie Malnutrition. Surveyor reviewed R1's hospital Discharge Summary with a date of 10/28/21. Documented was On [7/14/20], 3 days prior to admission, he was brought to [hospital] after reportedly falling down several stairs at the motel he was living at. He had trauma workup which included head CT which revealed bilateral chronic subdural hematoma (SDH) which possible acute component to bleed. The rest of his trauma workup was negative. He was admitted to neurosurgery service for observation. Repeat head CT 4 hours later revealed stable SDH. He unfortunately left [against medical advice (AMA)] from that admission. Later in day of admission he was found down on the ground lying in the middle of the street so he was brought to the ED for further evaluation . [R1] had multiple minor falls while in the hospital. His last fall was unwitnessed on the afternoon of 10/27/20 and resulted in a small laceration above his right eye and an area of swelling on the right side of his forehead . Surveyor reviewed R1's Comprehensive Care Plan with an initiation date of 10/29/20. Documented was: Focus: Resident has the potential for falls, accidents and incidents [related to (r/t)] [history (hx)] of falls, unaware of safety needs. Goal: Injuries will be minimized through the next review. Interventions: - Encourage resident to ask for assistance. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	- Fall assessment to be completed upon admission, after falls, quarterly, with [significant change of condition (SCOC)] and PRN - Follow therapy recommendations for transfers and mobility. - Review information on past falls and attempt to determine cause of falls. Surveyor reviewed R1's Comprehensive Care Plan with revision dates of 11/7/20, 12/25/20, 12/27/20, 12/30/20, 1/2/21, 1/3/21, 1/4/21, 1/11/21, 1/18/21, 1/20/21, 2/17/21, 3/5/21, 5/12/21, 5/14/21 and 5/27/21. Documented was: .Interventions: - 1/11/21 - Send to ER, staples left side of head, (staples removed) Low bed - 1/12/21 - staff to check floor for spills and if resident needs water. - 2/17/21 - change to 30 minute checks d/c'ed - 3/5/21 - 60 minute checks - 1/18/21 - body pillow in bed . - 1/18/21 - lids on drinks - 1/2/21 - night light in room - 1/3/21 - sign in room - 1/4/21 - staff to remove tray when meal is over and assess floor for spills . - 1/6/21 - gripper strips on floor when available - 11/7/20 - all plastic patio chairs removed from outdoor seating area - 12/25/20 - prompt to toilet [every (Q)] 2-3 hours and [PRN (as needed)] - 12/27/20 - knife removed - 12/30/20 - slippers removed, encourage gripper socks at all times - 5/12/21 - night light - 5/14/21 - returned from ER with soft cast to right arm - 5/27/21 - continue current safety interventions. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Surveyor reviewed Unwitnessed Fall Reports for R1 from June and July 2021. R1 had falls on 6/2/21, 6/3/21, 6/9/21, 6/13/21, 6/14/21, 6/16/21, 6/18/21, 6/26/21, 7/1/21, 7/8/21, 7/12/21 AM, 7/12/21 PM, 7/15/21 and 7/17/21. Surveyor reviewed Unwitnessed Fall Report for fall on 6/2/21. R1 had a fall on the patio with no injury. There was no documentation under Immediate Action Taken. The Comprehensive Care Plan was updated to include 6-2-21, Therapy eval and screen, pt re-education on self transferring with risk of injury to self. There was no Root Cause Analysis completed to investigate the fall on the patio. Surveyor reviewed Unwitnessed Fall Reports for R1 from 6/3/21. R1 had a fall on the patio with no injury. Documented under Immediate Action Taken was Resident was assessed and assisted off the ground. The Comprehensive Care Plan was not updated with any added interventions. There was no Root Cause Analysis completed to investigate 2 falls in 2 days on the patio. Surveyor reviewed Unwitnessed Fall Reports for R1 from 6/9/21. R1 had a fall in his bathroom and sustained a 7 cm scratch to right buttock. Documented under Immediate Action Taken was Resident was assessed and assisted. The Comprehensive Care Plan was updated with new intervention for Meclizine for vertigo. There was no Root Cause Analysis completed to investigate the fall in the bathroom. Surveyor reviewed Unwitnessed Fall Reports for R1 from 6/13/21. R1 had a fall on the patio with no injury. Documented under Immediate Action Taken was a head to toe assessment and R1 was brought back to his room. The Comprehensive Care Plan was updated with 6/14/21 - dining room chair placed out on courtyard for residents use. Resident provided verbal understanding. There was no Root Cause Analysis completed to investigate 3 falls in 10 days on the patio. Surveyor reviewed Unwitnessed Fall Reports for R1 from 6/14/21. R1 had a fall in his room with no injury and reported the floor was wet. Documented under Immediate Action Taken was [Patient (pt)] assisted to low bed. The Comprehensive Care Plan was not updated with any added interventions. There was no Root Cause Analysis completed to investigate the fall in his room. Surveyor reviewed Unwitnessed Fall Reports for R1 from 6/16/21. R1 had a fall on the patio and was sent to the hospital after his right elbow preexisting wound opened. Documented under Immediate Action Taken was a head to toe assessment and R1 was provided emotional support. The Comprehensive Care Plan was updated with [6/17/21] - Labs and [urinalysis (UA)] completed at hospital evaluation. UA negative. New soft cast applied to arm. Resident removed soft cast upon return. There was no Root Cause Analysis completed to investigate 4 falls in 13 days on the patio. Surveyor reviewed Unwitnessed Fall Reports for R1 from 6/18/21. R1 had a fall in his room with no injury. Documented under Immediate Action Taken was Resident assessed and started getting up off the floor himself not wanting assistance. The Comprehensive Care Plan was updated with new intervention for Clonidine for anxiety. There was no Root Cause Analysis completed to investigate 2 falls in 4 days in his room. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Surveyor reviewed Unwitnessed Fall Reports for R1 from 6/26/21. R1 had a fall in the dining room with no injury. Documented under Immediate Action Taken was RN called to assess, [vital signs] taken, neuro checks initiated, [Nurse Practitioner] notified, spouse present and witnessed fall, witness statement taken from spouse. The Comprehensive Care Plan was updated with no new interventions and stated Fall interventions reviewed and continue to be appropriate. There was no Root Cause Analysis completed to investigate the fall in the dining room. Surveyor reviewed Unwitnessed Fall Reports for R1 from 7/1/21. R1 had a fall coming inside from the patio with no injury. Documented under Immediate Action Taken was resident assessed and hoyered off ground. The Comprehensive Care Plan was updated with no new interventions and stated 7/2/21 - Safety interventions reviewed, continue appropriate. There was no Root Cause Analysis completed to investigate the fall coming in from the patio. Surveyor reviewed Unwitnessed Fall Reports for R1 from 7/8/21. R1 had a fall attempting to go outside onto the patio with no injury. Documented under Immediate Action Taken was resident assessed and assisted up with hoyered and 2 assist. The Comprehensive Care Plan was updated with no new interventions and stated 7/8/21 - remove slip on slippers, gripper socks on at all times. This intervention was already in place as of 12/30/20. There was no Root Cause Analysis completed to investigate the fall going out to the patio. Surveyor reviewed Unwitnessed Fall Reports for R1 from 7/12/21 AM. R1 had a fall on the patio and was sent to the hospital. Per hospital documentation R1 suffered laceration to head, left elbow skin tear and nosebleed and required stitches to left forehead. Documented under Immediate Action Taken was Dressing applied to laceration above left eye, resident refused [vital signs] and neuro assessment, [hospital] notified and send for eval and treat. The Comprehensive Care Plan was updated with an increase to meclizine for vertigo. There was no Root Cause Analysis completed to investigate 5 falls in June and July on the patio. Surveyor reviewed Unwitnessed Fall Reports for R1 from 7/12/21 PM. R1 had a fall in his room with no injury. Documented under Immediate Action Taken was Resident assessed and assisted off floor. The Comprehensive Care Plan was updated with no new interventions and stated 7/12/21 - continue current interventions. There was no Root Cause Analysis completed to investigate the 3 falls in June and July in resident's room. Surveyor reviewed Unwitnessed Fall Reports for R1 from 7/15/21 PM. R1 had a fall in his room with no injury. Documented under Immediate Action Taken was an assessment and assisted to bed. The Comprehensive Care Plan was updated with new intervention of Physical Therapy to treat R1. There was no Root Cause Analysis completed to investigate the 4 falls in June and July in resident's room. Surveyor reviewed Unwitnessed Fall Reports for R1 from 7/17/21. R1 had a fall in his bathroom and sustained a scratch to left buttock. Documented under Immediate Action Taken was Cleanse with [normal saline followed by] bordered gauze. The Comprehensive Care Plan was updated with no new interventions and stated 7/18/21 - safety interventions reviewed and remain appropriate at this time. There was no Root Cause Analysis completed to investigate the 3 falls in the bathroom in June and July. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Surveyor reviewed Unwitnessed Fall Reports for R1 from 7/19/21. R1 had a fall on the patio with no injury. Documented under Immediate Action Taken was a head to toe assessment. The Comprehensive Care Plan was updated with 7/19/21 - Hospice eval and treat. There was no Root Cause Analysis completed to investigate 6 falls in June and July on the patio. On 8/12/21 at 8:52 am, 9:19 am, 9:32 am, 10:50 am, 12:04 pm, and 2:18 pm Surveyor observed R1 in his bed. The surveyor observed no body pillow was in the bed with the resident. R1's Comprehensive Care Plan noted an intervention for a body pillow while in bed. On 8/12/21 at 12:04 pm and 2:18 pm Surveyor observed a drink in a Styrofoam cup with a straw with no lid on it next to the resident on R1's bedside table. R1's Comprehensive Care Plan noted an intervention for lids on cups. On 8/12/21 at 2:18 pm Surveyor observed R1 in bed with white and gray plain socks and not gripper socks on as indicated per his plan of care. R1's Comprehensive Care Plan noted an intervention for gripper socks on at all times. On 8/12/21 at 2:22 pm Surveyor interviewed Certified Nursing Assistant (CNA)-C. Surveyor asked what interventions were in place for R1 to prevent falls. CNA-C stated low bed, no mat on floor, 15 minute checks and gripper socks. CNA-C did not mention the body pillow or covers on cups. On 8/12/21 at 3:00 pm Surveyor interviewed Director of Nursing (DON)-B. Surveyor asked what the facility's process was if a resident has a fall. DON-B stated the resident is assessed by a nurse, an immediate intervention is put in place, incident report is completed, pain assessment completed, neuro checks completed, family updated and MD updated. DON-B stated with 24 hours the interdisciplinary team reviews and comes up with a new intervention for the care plan. Surveyor asked DON-B what interventions are in place for R1 to prevent falls. DON-B reviewed Comprehensive Care Plan and reviewed interventions including body pillow, gripper socks and lids on cups. Surveyor noted observations made on survey of R1. DON-B stated those interventions should have been in place. Surveyor asked if a new intervention is put in place for each fall. DON-B stated yes. Surveyor noted to DON-B the interventions that only stated current interventions are appropriate. DON-B stated all interventions should be reviewed to make sure they are appropriate after a fall but also a new intervention should be added.

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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. 40533 Based on interview and record review the facility did not ensure 1 (R1) of 3 residents reviewed for weight loss had their nutritional care needs recognized, evaluated, and addressed to provide adequate parameters of nutritional status. R1 was admitted to the facility at 163 pounds taken on 11/3/20. The facility did not reweigh R1 until 3/31/21 when R1 weighed 140 pounds and had lost 14.1% of his body weight. The facility did not weigh the resident monthly, put interventions in place to prevent weight loss and did not accurately assess the resident's nutritional status in a timely manner. Findings include: The facility's Weight Assessment and Intervention policy and procedure, revised September 2008, documents The multidisciplinary team will strive to prevent, monitor, and intervene for undesirable weight loss for our residents .the Nursing staff will measure resident weights within two days of admission, then per dietician recommendation or monthly .The threshold for significant unplanned and undesired weight loss will be based on the following criteria .a. 1 month- 5% weight loss is significant, greater than 5% is severe. R1 was admitted to the facility 10/28/20 with diagnoses that included Alcohol Abuse with Intoxication Delirium, Constipation, Acute Kidney Failure, Encephalopathy and Protein-Calorie Malnutrition. Surveyor reviewed R1's hospital Discharge Summary with a date of 10/28/21. Documented was a weight of 159 pounds on 9/22/21. Surveyor reviewed the Admission Minimum Data Set (MDS) with an assessment reference date of 11/1/20 for R1. Documented under Section K, Swallowing/Nutritional Status was Height: 72 inches. Weight: 150 pounds. Surveyor also reviewed R1's Care Area Assessments (CAA) from this MDS with an assessment date of 11/1/19. There was no CAA for Nutritional Status. Surveyor reviewed R1's weights. R1's weight was documented as 163 pounds on 11/3/20. Surveyor reviewed R1's Nutrition Assessment with an assessment date of 11/4/20 completed by Former RD-E. Documented under Nutritional Assessment/Recommendations was [R1] is a 75 [year old male] admitted with [Altered Mental Status] and hx of frequent falls and [alcohol (ETOH)] abuse . Current wt. 163. 0#, [Body Mass Index (BMI)]: 22.1 (normal). Weight maintenance is desired. Skin intact. No new labs. Will monitor weight, intakes, and labs. Surveyor reviewed R1's Comprehensive Care Plan with an initiation date of 11/4/20 and. Documented was: Focus: Resident has potential for altered nutritional status [related to (r/t)] [history (hx)] of ETOH abuse. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Goal: The resident will maintain adequate nutritional status as evidenced by gradual [weight (wt)] gain of 1-3#/month, no [signs or symptoms (s/sx)] of malnutrition, and consuming at least 75% of meals/supplement daily through review date. Interventions: Monitor/record/report to MD [as needed (PRN)] s/sx of malnutrition. Emaciation (Cachexia), muscle wasting, significant weight loss: 3 lbs. in 1 week, >5% in 1 month, >7.5% in 3 months, >10% in 6 months. Provide, serve diet as ordered. Monitor intake and record [every (q)] meal. [Registered Dietician (RD)] to evaluate and make diet change recommendations PRN. Surveyor reviewed the MDS with an assessment reference date of 2/1/21 for R1. Documented under Section K, Swallowing/Nutritional Status was Height: 72 inches. Weight: 163 pounds. Surveyor reviewed R1's MD orders. Documented on 2/22/21 was Weight for MDS - one time a day for weight for 1 day. One time a day for weight until 2/23/21. There is no documented weight on 2/22/21 or 2/23/21. Surveyor reviewed the MDS with an assessment reference date of 2/23/21 for R1. Documented under Section K, Swallowing/Nutritional Status was Height: 72 inches but the Weight section was blank. Surveyor reviewed R1's Nutrition Assessment with an assessment date of 2/24/21 completed by Former RD-E. Documented under Nutritional Assessment/Recommendations was .No current wt. Last wt. (11/3/20): 163.0#, BMI: 22.1 (normal). Meeting nutritional needs with current diet/intake. Skin intact. Will monitor weight, intakes, and labs. There was no current weight taken so assessment was not accurate. The Comprehensive Care Plan was revised on 3/19/21 and documented Focus: 03/18/21 - refused for staff to obtain weight. There is no documentation of staff attempting to reweigh R1. Surveyor reviewed R1's weights. R1's weight was documented as 140 pounds on 3/31/21. There are no documented weights since the admission weight of 163 on 11/3/20 until this weight. The resident lost 14.1% of his body weight in 5 months. Surveyor noted there was no Nutritional Assessment completed at this time, no attempt to reweigh R1 and no documentation completed by a Registered Dietician addressing the significant weight loss. Surveyor reviewed the MDS with an assessment reference date of 5/26/21 for R1. Documented under Section K, Swallowing/Nutritional Status was Height: 72 inches. Weight: 140 pounds. The Comprehensive Care Plan was revised on 6/24/21 and documented Intervention: Provide supplement as ordered: magic cup [twice daily (BID)]. There was no Nutritional Assessment completed when this order was placed. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor reviewed the MDS with an assessment reference date of 8/2/21 for R1. Documented under Section K, Swallowing/Nutritional Status was Height: 72 inches. Weight: 138 pounds. Surveyor also reviewed R1's Care Area Assessments (CAA) from this MDS with an assessment date of 8/2/19. Documented under Nature of the problem/need was Intake not meeting needs, addition of supplements. A Nutritional Assessment was completed by RD-D and the Comprehensive Care Plan was revised to include Intervention: Provide supplement as ordered: fortified cereal at breakfast. On 8/12/21 at 2:15 PM Surveyor interviewed RD-D. Surveyor asked how often a resident is assessed for nutrition. RD-D stated on admissions, quarterly and as needed. Surveyor asked if a significant weight change would trigger an assessment. RD-D stated yes. Surveyor asked how often a resident should be weighed. RD-D stated monthly unless the MD requests more frequent. Surveyor asked if R1 should have been weighed more often than 11/3/21 and 3/30/21. RD-D stated yes, at least monthly. Surveyor noted the 23 pound weight loss from November to March. Surveyor asked if this was a significant weight loss and if so, what the RD would do. RD-D stated yes it is a significant amount and she would reweigh to make sure it is accurate, complete an assessment and update interventions and intake as needed. RD-D stated she did not work at the facility at that time and was unsure why Former RD-E would not have reassessed the resident. On 8/12/21 at 2:45 PM Surveyor interviewed Director of Nursing (DON)-B. Surveyor asked what happens if a resident has a significant weight loss. DON-B stated the RD would email her, she would update the clinical sheet, update the family and the MD and get recommendations and/or orders to help increase the resident's weight and prevent further weight loss. Surveyor asked what the minimum amount a resident should be weighed was. DON-B stated at least monthly. Surveyor asked if RD's should have a current and accurate weight to perform assessments. DON-B stated yes. Surveyor noted Former RD-E's assessment from February with no current weight. DON-B stated Former RD-D should have obtained a current weight and then completed the assessment for the resident.