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	10/22/2021

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36161 Based on interview and record review the facility failed to prevent verbal abuse for 1 (R3) of 3 residents reviewed for abuse. Laundry Staff-C was observed to be visibly upset, yelling and pointing her right index finger at R3 after R3 reporting missing clothing to Surveyor. R3 confirmed to Surveyor that Laundry Staff-C had become upset and yelled at her for reporting her missing clothing. Findings include: The facility's policy and procedure dated as revised February 2019 and titled, Abuse and Neglect Prevention documents under the Policy section, All residents have the right to be free from abuse, neglect, misappropriation of resident property, exploitation, corporal punishment, involuntary seclusion, and any physical or chemical restraint not required to treat the resident's medical symptoms. This includes prohibiting nursing facility staff from taking or using photographs or recordings in any manner that would demean or humiliate a resident, and prohibits using any type of equipment (e.g., cameras, smart phones, and other electronic devices) to take, keep, or distribute photographs and/or recordings on social media or through multimedia messages. Residents must not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals. It shall be the policy of this facility to implement written procedures that prohibit abuse, neglect, exploitation and misappropriation of resident property. These procedures shall include the screening and training of employees, protection of Residents and the prevention, identification, investigation, and timely reporting of abuse, neglect, mistreatment, and misappropriation of property, without fear of recrimination or intimidation. 1.) R3 was admitted to the facility on [DATE] with a diagnosis that included Hemiplegia, Hemiparesis, Heart Failure and Cerebral Infraction. R3's Quarterly MDS (Minimum Data Set) dated 8/30/21 documents a BIMS (Brief Interview for Mental Status) score of 14, indicating that R3 is cognitively intact. (continued on next page)

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/22/21 at 11:17 a.m., R3 approached Surveyor and informed Surveyor that she had a concern regarding missing clothing. R3 informed Surveyor that the facility had not responded to her request to find her missing pants. Surveyor informed R3 that he would asked NHA (Nursing Home Administrator)-A about her missing clothing. On 10/22/21 at approximately 11:52 a.m., Surveyor informed NHA-A of the above findings. NHA-A informed Surveyor that she was not aware that R3 had missing clothing but that she would speak with R3 and that she would begin to search for R3's missing pants. On 10/22/21 at 12:47 p.m., Surveyor approached R3's room and stood at the open doorway. Surveyor was able to observe inside of R3's room and observed Laundry Staff-C yelling at R3 in a loud voice. From the open doorway, Surveyor could observe and hear Laundry staff-C, whom had her back to Surveyor, yell at R3, You didn't tell me you were missing pants! You didn't say that! in a loud voice towards R3. Surveyor observed Laundry Staff-C, while yelling at R3, physically use her Right index finger and point it at R3's face at least three times. Surveyor heard R3 attempt to tell Laundry Staff-C, I told them it was jeans but Laundry Staff-C continued yelling at R3 in a loud voice, You didn't tell me you had all these missing clothes. Surveyor observed that as R3 tried to respond, Laundry Staff-C turned to her right and open R3's closed closet door and begin looking for R3's missing pants. Surveyor observed and heard Laundry Staff-C continue yelling at R3 and talk over R3 stating, You never said missing pants in a loud voice. Surveyor observe Laundry Staff-C be visibly upset as she asked R3 why her pants went missing. Surveyor then observed Laundry Staff-C turn around and observe Surveyor observing her. Laundry Staff-C was observed to change her demeanor and began talking to R3 in a softer tone and in a tone that was lower in volume. On 10/22/21 at approximately 12:53 p.m., Surveyor spoke with R3 after Laundry Staff-C had left R3's room. R3 informed Surveyor that Laundry Staff-C was yelling at her and that Laundry Staff-C was visibly upset that she (R3) had reported her missing pants. On 10/22/21 at 1:00 p.m., Surveyor informed NHA (Nursing Home Administrator)-A of the above findings. NHA-A informed Surveyor that she would begin an investigation and remove Laundry Staff-C from the building. No additional information was provided as to why the facility failed to prevent R3 from being verbally abused.

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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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36161 Based on interview and record review the facility did not ensure that 1 (R1) of 3 residents reviewed and at risk for developing pressure injuries received consistent measures to prevent the development of pressure injuries. * R1 developed an unstageable pressure injury at the facility as a result of not having offloading interventions for his left heel upon admission to the facility. Findings include: 1.) R1 was admitted to the facility on [DATE] with a diagnosis that included Diabetes Mellitus Type II, Right Below Knee Amputation and Right Humerus Fracture. R1's Admission MDS (Minimum Data Set) dated 7/20/21 documents a BIMS (Brief Interview for Mental Status) score of 14, indicating that R1 is cognitively intact. Section G (Functional Status) documents that R1 requires extensive two person physical assist for bed mobility needs. Section G also documents that R1 has total dependence on staff and requires a two person physical assist for transfer needs. Section G0400 (Functional Limitation in Range of Motion) documents that R1 has impairment to one side of his upper extremities. Section M (Skin Conditions) documents that upon admission to the facility, R1 did not have any unhealed/open pressure injuries. Section M also documents that R1 was at risk for the development of pressure injuries. R1's Pressure Ulcer/Injury CAA (Care Area Assessment) dated 7/27/21 documents under the Analysis of Findings section, R1 is at risk for pressure ulcers. Under the Care Plan Considerations section it documents, R1 is at risk for pressure ulcers d/t (due to) limited bed mobility, incontinence, and being chairfast. He requires extensive assist of two staff at times for bed mobility and changing his brief. Plan of care to be developed. R1's Pressure Injury care plan dated as initiated on 7/20/21 documents under the Focus section, Resident has potential/actual for impaired skin integrity r/t (related to): Bladder Incontinence, decreased mobility, diabetes, dry skin, left groin open area, scratches to LLE (Left Lower Extremity). R1's Pressure Injury care plan dated as initiated on 7/20/21/21 documents the Interventions section the following offloading interventions in place as of 7/20/21 for R1: Pressure redistribution mattress; Assist to reposition approximately every 2-3 hours and as needed; apply cushion to w/c (wheelchair); apply barrier cream after each incontinence episode; Avoid friction/shearing while repositioning; If Resident is unable to assist use at least two staff members, use lift sheet, bed should be as flat as possible while lifting. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Surveyor was unable to locate any pressure reliving interventions for the offloading of R1's left heel or diabetic checks for R1's left foot upon admission to the facility or prior to 8/6/21. R1's Initial Wound assessment dated [DATE] documents, Date wound was identified: 8/6/21; Where was the wound acquired: acquired after admission to the facility; Type of Wound: Pressure; Site: Left Heel, Type: Pressure, Length 4.3 cm (centimeters), Width 3.9 cm, Depth 0.1 cm, Stage: Unstageable. Surveyor noted that R1's Initial Wound assessment dated [DATE] for his left heel was incomplete as it did not describe the wound bed, percentage of granulation, slough, eschar or epithelization or wound edges. The assessment did not include any documentation that any new interventions were put in place to offload R1's left heel. Surveyor also noted that R1's Initial Wound assessment dated [DATE] for his left heel was completed by LPN (Licensed Practical Nurse) Unit Manager-B and no RN (Registered Nurse) assessment was documented. R1's August 2021 TAR (Treatment Administration Record) documents the following treatment as in place on 8/7/21, Left heel betadine to necrotic area and foam border two times a day. Surveyor was unable to locate any monitoring of R1's left foot prior to 8/6/21, despite R1 being a diabetic and had a prior right below the knee amputation. Surveyor also could not locate an initial assessment by an RN when R1's left heel pressure injury was discovered on 8/6/21. Surveyor was unable to locate any pressure reliving interventions for the offloading of R1's left heel or diabetic checks for R1's left foot upon admission to the facility or prior to 8/6/21. R1's Weekly Wound assessment dated [DATE] documents, Wound Measure Date: 8/10/21; Type of Wound: Pressure; Site: Left Heel, Type: Pressure, Length 4.8 cm (centimeters), Width 4.9 cm, Depth 0.1 cm, Stage: Unstageable; Percentage of Granulation: 10, Percentage of eschar 90; Is wound odorous: No; Onset; Other: Dr (doctor) saw resident this shift. New orders to soak resident foot in iodine soak for 2 minutes, cover with ABD (Army Battle Dressing), wrap with Kerlix, change BID (twice a day)/PRN (as needed), CBC (Complete Blood Count) ordered. R1's Tissue Analytics Wound Evaluation, completed by the wound physician and dated 8/10/21, documents, Location: Left Heel; Length: 4.87 cm (centimeters); Width 4.95 cm; Depth: 0.10 cm; Observations: Depth 0. 10 cm; Etiology: Pressure Ulcer- Unstageable; Margin Detail: Attached edges; Wound bed Assessment: Eschar; Drain Amount: Scant; Periwound: Clean, dry, intact; Plan of Care: Rx (order): Pour betadine in basin, soak wound for 2 minutes in betadine BID (twice a day), secure with ABD and Kerlix. R1's August 2021 TAR documents the following treatment as in place on 8/10/21, Soak Left heel in betadine soak for 2 minutes. Cover wound with ABD pad and wrap with Kerlix BID/PRN two times a day for Wound care Do not use gauze to cover wound. Only ABD against wound. Surveyor noted that despite R1 developing a pressure injury to his left heel on 8/6/21, the facility did not put any pressure relieving interventions until 8/11/21. R1's Pressure Injury care plan dated as initiated on 7/20/21/21 documents the Interventions section the following offloading interventions in place as of 8/11/21 for R1: Diabetic foot checks every shift; Float L (left) heel when in bed; Padded boot to left foot at all times. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Surveyor was unable to locate any documentation in R1's nursing notes, assessments or therapy notes that R1 had any offloading interventions in place for his left heel prior to 8/11/21. Due to R1 no longer residing at the facility at the time of the survey, Surveyor was unable to obtain an interview from R1. On 10/22/21 at 12:01 p.m., Surveyor interviewed Rehabilitation Director-D regarding R1's pressure injury. Surveyor asked Rehabilitation Director-D if R1 had any offloading interventions for his left heel prior to 8/11/21. Rehabilitation Director-D informed Surveyor that to the best of her knowledge, R1 did not have any offloading interventions or boot wearing prior to 8/11/21, as R1 used his left foot/leg for mobility due to him (R1) having a BKA (below knee amputation) to his right foot prior to admission to the facility. Rehabilitation Director-D informed Surveyor that once R1 developed the pressure to his left heel, R1's mobility was diminished and that R1 went from a stand and pivot with assist of two non-weight bearing and a full Hoyer lift. R1's OT (Occupational Therapy) Discharge Summary dated 8/13/21 documents, Summary of Skilled Services: Since therapy was notified of left heel wound from nursing, pt (patient) has been downgraded to LLE (Left Lower Extremity)- trialed standing with two person assist, max assist of 2 and pt unable to stand while adhering to precautions and therefore, pt was downgraded to a Hoyer on the unit to maximize protection of left heel wound. R1's PT (Physical Therapy) Discharge Summary dated 8/13/21 documents, Pt (patient) struggled to make progress during rehabilitation stay d/t (due to) anxiety about transfers, new skin breakdown on left heel and continued NWB (non-weight bearing status) to RUE (Right Upper Extremity). Pt now unable to bear weight through LLE (left lower extremity) d/t (due to) wound therefore Hoyer required for transferred. On 10/22/21 at 2:08 p.m., Surveyor informed LPN Unit Manager-B of the above findings. Surveyor asked LPN Unit Manager-B if she had been the nurse whom initially assessed R1's left heel pressure injury on 8/6/21 and if she had completed the assessment dated [DATE] as it was incomplete in R1's medical record. LPN Unit Manager-B informed Surveyor that she was the nurse whom initially assessed R1's left heel pressure injury on 8/6/21. LPN Unit Manger-B reviewed R1's medical record with Surveyor and informed Surveyor that R1's Initial Wound assessment dated [DATE] for R1's left heel was incomplete and that she could not provide any documentation that an RN (Registered Nurse) assessed R1's left heel along with her (LPN Unit Manager-B). LPN Unit Manager-B informed Surveyor that an RN usually assesses wounds with her but that she was unsure as to why no RN documented an assessment of R1's left heel wound on 8/6/21. Surveyor asked LPN Unit Manager-B why R1 did not have any documented offloading interventions for his left heel prior to 8/11/21. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	LPN Unit Manager-B reviewed R1's medical record with Surveyor and informed Surveyor that R1 should have had offloading interventions for his left heel prior to 8/11/21 but that she could not provide any documentation as to why R1 did not have offloading interventions for his left heel prior to 8/11/21. Surveyor asked LPN Unit Manager-B if R1 had a decline in his mobility upon developing the left heel pressure injury. LPN Unit Manager-B informed Surveyor that R1 did have a decline in his mobility upon developing the left heel pressure injury, as R1 went from transferring with an assist of two to being non-weight bearing. On 10/22/21 at 2:43 p.m., Surveyor informed NHA (Nursing Home Administrator)-A of the above findings. No additional information was provided why R1 did not have pressure relieving interventions in place to prevent the development of his left heel pressure injury.