STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525108	A. Building B. Wing	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Allis Care Center	9047 W Greenfield Ave West Allis, WI 53214

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 41439 Based on interview and record review, the facility did not ensure their abuse policy was implemented for 1 of 1 employees reviewed for background checks potentially affecting an isolated number of residents within the facility. The facility did not have a complete background check which would include the results from the DOJ (Department of Justice) and the IBIS (Integrated Background Information System) form completed upon hire for CNA-E (Certified Nursing Assistant). Findings include: The facility policy entitled Freedom from Abuse and Neglect dated 10/30/2019 stated SCREENING: Pre-employment screening will be completed on all employees, to include criminal history check, background check, reference check from previous employer, professional licensure, certification or registry check as applicable. On 9/2/21, at 8:14 AM, Surveyor met HR-D (Human Resources) to discuss CNA-E's file which was missing items including a CNA license, orientation or education upon hire, a DOJ and IBIS letter. HR-D stated many forms were electronic including education. On 9/2/21, at 10:12 AM, NHA-A (Nursing Home Administrator) provided a copy of CNA-E's CNA license which was good until 8/31/22 and the signed BID (Background Information Disclosure) dated 7/15/21. NHA-A provided CNA-E's Background Check dated 9/2/21 which was requested and reported today with DOJ and IBIS. NHA-A stated there is no competency or orientation checklist in the file and none can be found. NHA-A stated CNA-E did not complete the on-boarding process so did not show up in the system and CNA-E started working on the units on 7/22/21 until terminated on 8/9/21. Surveyor noted the facility did not have a system in place to check if background checks were completed on new hires other than the computerized process which did not work in the case of CNA-E. On 9/2/21, at 3:00 PM, the Survey team conducted the facility exit and no further information was provided.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41439 Based on interview and record review, the facility did not report an allegation of neglect to the state survey agency for 1 (R4) of 5 Residents reviewed. R4 had a fall from the bed to the floor with subsequent disconnection from the ventilator and inability to be reconnected causing respiratory distress. CNA-E (Certified Nurse Assistant) did not follow the verbal plan of care provided by RN-C (Registered Nurse) to ensure cares were provided by two staff. The facility did not report the allegation of neglect to the state agency. Findings include: The facility policy entitled Freedom from Abuse and Neglect dated 10/30/2019 stated: Neglect is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress. Staff will immediately report any event or injury that may constitute neglect to the Executive Director. The facility will conduct an internal investigation and report the result of the investigation to the enforcement agency in accordance with state law including the state survey and certification agency within 5 working days of the incident or according to state law. R4 was admitted to the facility on [DATE] and transferred to the ER (emergency room) via 911 on 8/7/21 after a fall from the bed to the floor and disconnection from the ventilator. R4's diagnoses include ARF (Acute Respiratory Failure) due to Hypoxia (low oxygenation in the blood), CHF (Congestive Heart Failure), Pneumonia, Pulmonary Hypertension, COPD (Chronic Obstructive Pulmonary Disease), Cardiac Arrest, Diabetes, and Anemia. R4's MDS (Minimum Data Set) which was discharge return anticipated, dated 8/7/21, indicated R4 required extensive assistance for bed mobility and toileting, total staff dependence for transfer. R4 was dependent on the ventilator for breathing and respiratory stability. On 9/2/21, at 6:15 AM, Surveyor interviewed RN-C who works at the facility as the night shift supervisor. RN-C stated R4 was able to make needs known, move slightly in bed but could not roll self over, was alert with a tracheostomy (artificial airway) connected to the ventilator. RN-C stated she reviews the residents and their care with the CNAs in a report at the beginning of the shift. RN-C stated she told CNA-E that R4 was a 2 person assist and transfer but CNA-E chose to care for R4 independently without asking for assistance. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	RN-C stated she was assisting another resident when she heard CNA-E yell for help. RN-C stated when she entered R4's room, R4 was lying on the floor with the top part of R4's body being held up by CNA-E with the bed at medium height. RN-C stated she could not get around to the other side of the bed to assist and CNA-E had to let go of R4. RN-C stated R4's tracheostomy did not come out but R4 had become disconnected from the ventilator as the machine was on the opposite side of the bed from where R4 had fallen. RT came to the room and began to manually provide breaths via an ambu bag as R4 had blue lips, 911 was called, and RT continued to manually provide breaths as R4 remained on the floor until the paramedics took over the care and transported R4 to the hospital. RN-C stated a fall incident report was entered into the computer as per procedure. Surveyor reviewed the fall incident report which indicated R4 was on the floor and incontinent of bowel and bladder. The report indicated that when the RT entered the room, R4 had to be turned on R4's back because RT was unable to reach the tracheostomy and R4's oxygen saturations were dropping to 60-70's and R4 was turning blue. RT was able to begin ambu bagging R4 via the tracheostomy and R4's oxygen saturation began to come up to 88%. On 9/2/21, at 8:08 AM, Surveyor interviewed DON-B (Director of Nursing) who stated she verified with RN-C that CNA-E knew how to care for R4 and the root cause of the fall was failure of the staff to follow the verbal supervisor report as R4 did not have a baseline care plan. (cross-reference F655). On 9/2/21, at 11:08 AM, Surveyor interviewed NHA-A (Nursing Home Administrator) who stated the fall was not reported. On 9/2/21, at 3:00 PM, the Survey team conducted the facility exit and no further information was provided.

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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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41439 Based on interview and record review, the facility did not ensure that 1 (R4) of 5 residents reviewed had a baseline care plan developed and implemented to promote continuity of care and safeguard against adverse events. R4 did not have a baseline care plan initiated upon admission to the facility 8/4/21 prior to transfer to the hospital via 911 on 8/7/21. Findings include: R4 was admitted to the facility on [DATE] and transferred to the ER (emergency room) via 911 on 8/7/21 after a fall from the bed to the floor and disconnection from the ventilator. R4's diagnoses include ARF (Acute Respiratory Failure) due to Hypoxia (low oxygenation in the blood), CHF (Congestive Heart Failure), Pneumonia, Pulmonary Hypertension, COPD (Chronic Obstructive Pulmonary Disease), Cardiac Arrest, Diabetes, and Anemia. R4's MDS (Minimum Data Set) which was discharge return anticipated, dated 8/7/21, indicated R4 required extensive assistance for bed mobility and toileting, total staff dependence for transfer. R4 was dependent on the ventilator for breathing and respiratory stability. R4's ventilator settings were AC (Assist Control) which submits a set number of breaths at a set volume of air which was 500 cc, and a PEEP (Positive End Expiratory Pressure) of 8 cm that is designed to help keep the airway open while the machine delivers R4's required and necessary breaths. R4's progress notes on 8/7/21 at 6:03 AM indicated R4 fell off the bed while CNA-E was changing R4. R4 was disconnected from the ventilator and the RT (Respiratory Therapist) was called into R4's room as R4's oxygen saturation started dropping and R4 was turning blue (due to lack of ventilation and oxygenation). RT began to manually provide breaths via an ambu bag and R4's oxygen saturation began to rise to 88%. 911 was called and R4 was transported to the hospital. On 9/1/21, at 1:44 PM, Surveyor received R4's records from NHA-A (Nursing Home Administrator) who stated the facility was unable to obtain a copy of the physician orders as R4 had been discharged from the system, R4 did not have a CNA Care Card, and she was unaware there was a fall investigation follow up. On 9/2/21, at 6:15 AM, Surveyor interviewed RN-C (Registered Nurse) who works at the facility as the night shift supervisor. RN-C stated R4 was able to make needs known, move slightly in bed but could not roll self over, was alert with a tracheostomy (artificial airway) connected to the ventilator. RN-C stated she reviews the residents and their care with the CNAs in a report at the beginning of the shift. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	RN-C stated she told CNA-E that R4 was a 2 person assist and transfer but CNA-E chose to care for R4 independently without asking for assistance. RN-C stated she was assisting another resident when she heard CNA-E yell for help. RN-C stated when she entered R4's room, R4 was lying on the floor with the top part of R4's body being held up by CNA-E with the bed at medium height. RN-C stated she could not get around to the other side of the bed to assist and CNA-E had to let go of R4. RN-C stated R4's tracheostomy did not come out but R4 had become disconnected from the ventilator as the machine was on the opposite side of the bed from where R4 had fallen. RT came to the room and began to manually provide breaths via an ambu bag as R4 had blue lips, 911 was called, and RT continued to manually provide breaths as R4 remained on the floor until the paramedics took over the care and transported R4 to the hospital. RN-C stated a fall incident report was entered into the computer as per procedure. On 9/2/21, at 8:08 AM, Surveyor interviewed DON-B (Director of Nursing) stated we complete a baseline care plan within 48 hours but R4 was not in the facility long enough. DON-B stated she verified with RN-C that CNA-E knew how to care for R4 and the root cause of the fall was failure of the staff to follow the verbal supervisor report as R4 did not have a baseline care plan and CNA-E was terminated. DON-B stated the facility relies on verbal report until an established baseline care plan. Surveyor noted R4 was admitted on [DATE] and the first progress note is noted on 8/4/21 at 4:32 PM and R4 transferred to the hospital on 8/7/21 around 6:30 AM. A baseline care plan within 48 hours should have been completed on 8/6/21 On 9/2/21, at 3:00 PM, the Survey team conducted the facility exit and no further information was provided.

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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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41439 Based on interview, and record review, the facility did not ensure 1 (R4) of 5 residents reviewed received the necessary care and services for fall prevention. R4 had a fall from the bed to the floor with subsequent disconnection from the ventilator and inability to be reconnected causing respiratory distress and need to be transferred and admitted to the hospital. R4 did not have a fall risk observation completed on 8/4/21 upon admission in accordance with facility policy. R4 did not have a baseline care plan indicating R4's risk status for falls, specifying interventions to prevent falls. Findings include: The facility policy, Fall Management, dated 6/25/17, stated a fall risk observation is used to identify individuals who are at high risk for falls, as well as those individuals who have any risk factors for falls on a regular schedule including admission to the facility. Communicate residents risk status and interventions to care givers. Develop a plan of care which can include general and specific interventions to reduce falls risk. R4 was admitted to the facility on [DATE] and transferred to the ER (emergency room) via 911 on 8/7/21 after a fall from the bed to the floor and disconnection from the ventilator. R4's diagnoses include ARF (Acute Respiratory Failure) due to Hypoxia (low oxygenation in the blood), CHF (Congestive Heart Failure), Pneumonia, Pulmonary Hypertension, COPD (Chronic Obstructive Pulmonary Disease), Cardiac Arrest, Diabetes, and Anemia. R4's MDS (Minimum Data Set) which was discharge return anticipated, dated 8/7/21, indicated R4 required extensive assistance for bed mobility and toileting, total staff dependence for transfer. R4 was dependent on the ventilator for breathing and respiratory stability. R4's ventilator settings were AC (Assist Control) which submits a set number of breaths at a set volume of air which was 500 cc, and a PEEP (Positive End Expiratory Pressure) of 8 cm that is designed to help keep the airway open while the machine delivers R4's required and necessary breaths. R4's progress notes on 8/7/21 at 6:03 AM indicated R4 fell off the bed while CNA-E was changing R4. R4 was disconnected from the ventilator and the RT (Respiratory Therapist) was called into R4's room as R4's oxygen saturation started dropping and R4 was turning blue (due to lack of ventilation and oxygenation). RT began to manually provide breaths via an ambu bag and R4's oxygen saturation began to rise to 88%. 911 was called and R4 was transported to the hospital. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	On 9/1/21, at 1:44 PM, Surveyor received R4's records from NHA-A (Nursing Home Administrator) who stated the facility was unable to obtain a copy of the physician orders as R4 had been discharged from the system, R4 did not have a CNA Care Card, and she was unaware if there was a fall investigation follow up. On 9/2/21, at 6:15 AM, Surveyor interviewed RN-C (Registered Nurse) who works at the facility as the night shift supervisor. RN-C stated R4 was able to make needs known, move slightly in bed but could not roll self over, was alert with a tracheostomy (artificial airway) connected to the ventilator. RN-C stated she reviews the resident's and their care needs with the CNAs in a report at the beginning of the shift. RN-C stated she told CNA-E that R4 was a 2 person assist and transfer but CNA-E chose to care for R4 independently without asking for assistance. RN-C stated she was assisting another resident when she heard CNA-E yell for help. RN-C stated when she entered R4's room, R4 was lying on the floor with the top part of R4's body being held up by CNA-E with the bed at medium height. RN-C stated she could not get around to the other side of the bed to assist and CNA-E had to let go of R4. RN-C stated R4's tracheostomy did not come out but R4 had become disconnected from the ventilator as the machine was on the opposite side of the bed from where R4 had fallen. RT came to the room and began to manually provide breaths via an ambu bag as R4 had blue lips, 911 was called, and RT continued to manually provide breaths as R4 remained on the floor until the paramedics took over the care and transported R4 to the hospital. RN-C stated a fall incident report was entered into the computer as per procedure. Surveyor reviewed the fall incident report which indicated R4 was on the floor and incontinent of bowel and bladder. The report indicated that when the RT entered the room, R4 had to be turned on R4's back because RT was unable to reach the tracheostomy and R4's oxygen saturations were dropping to 60-70's and R4 was turning blue. RT was able to begin ambu bagging R4 via the tracheostomy and R4's oxygen saturation began to come up to 88%. R4 was admitted to the hospital following the respiratory distress. On 9/2/21, at 8:08 AM, Surveyor interviewed DON-B (Director of Nursing) stated we complete a baseline care plan within 48 hours but R4 was not in the facility long enough. DON-B stated she verified with RN-C that CNA-E knew how to care for R4 and the root cause of the fall was failure of the staff to follow the verbal supervisor report as R4 did not have a baseline care plan. DON-B stated the facility relies on verbal report until an established baseline care plan. DON-B stated the fall incident report is entered into the EMR (Electronic Medical Record) by the nurse and DON-B will close it out after completing education. On 9/2/21 at 8:14 am Surveyor noted the nursing admission assessment that would document information such as R4's activity of daily living needs for assistance and functional assessment was marked as in progress in the electronic medical record. Upon further review, Surveyor noted the form was blank at this time. Surveyor noted R4 did not have a fall risk observation completed on 8/4/21 upon admission in accordance with facility policy, and R4 did not have a care plan indicating the risk status and fall interventions for R4. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 9/2/21, at 3:00 PM, the Survey team conducted the facility exit and no further information was provided.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 41439 Based on record review, and interviews, the facility did not ensure 1 (CNA-E) of 1 CNAs (Certified Nurse Assistant) reviewed; possessed the training or competencies necessary to provide care and services to meet the needs of residents including R4. CNA-E did not any new hire education, competencies or orientation checklist in her file. Findings include: On 9/2/21, at 6:15 AM, Surveyor interviewed RN-C (Registered Nurse) who works at the facility as the night shift supervisor. RN-C stated R4 was able to make needs known, move slightly in bed but could not roll self over, was alert with a tracheostomy (artificial airway) connected to the ventilator. RN-C stated she reviews the residents and their care with the CNAs in a report at the beginning of the shift. RN-C stated she told CNA-E that R4 was a 2 person assist and transfer but CNA-E chose to care for R4 independently without asking for assistance. RN-C stated she was assisting another resident when she heard CNA-E yell for help. RN-C stated when she entered R4's room, R4 was lying on the floor with the top part of R4's body being held up by CNA-E with the bed at medium height. RN-C stated she could not get around to the other side of the bed to assist and CNA-E had to let go of R4. RN-C stated R4's tracheostomy did not come out but R4 had become disconnected from the ventilator as the machine was on the opposite side of the bed from where R4 had fallen. RT came to the room and began to manually provide breaths via an ambu bag as R4 had blue lips, 911 was called, and RT continued to manually provide breaths as R4 remained on the floor until the paramedics took over the care and transported R4 to the hospital. RN-C stated a fall incident report was entered into the computer as per procedure. Surveyor reviewed the fall incident report which indicated R4 was on the floor and incontinent of bowel and bladder. The report indicated that when the RT entered the room, R4 had to be turned on R4's back because RT was unable to reach the tracheostomy and R4's oxygen saturations were dropping to 60-70's and R4 was turning blue. RT was able to begin ambu bagging R4 via the tracheostomy and R4's oxygen saturation began to come up to 88%. On 9/2/21, at 8:08 AM, Surveyor interviewed DON-B (Director of Nursing) who stated she verified with RN-C that CNA-E knew how to care for R4 and the root cause of the fall was failure of the staff (CNA-E) to follow the verbal supervisor report as R4 did not have a baseline care plan. On 9/2/21, at 8:14 AM, Surveyor met HR-D (Human Resources) to discuss CNA-E's file which was missing items including a CNA license and orientation or education upon hire. HR-D stated many forms were electronic including education. On 9/2/21, at 10:12 AM, NHA-A (Nursing Home Administrator) stated there is no education, competencies, or orientation checklist in the file for CNA-E and none can be found. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	NHA-A stated CNA-E did not complete the on-boarding process and electronics so did not show up in the system and CNA-E started working on the units on 7/22/21 until 8/9/21. On 9/2/21, at 3:00 PM, the Survey team conducted the facility exit and no further information was provided.