| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 525547 | A. Building<br>B. Wing | 10/24/2022 |

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| Glendale Care and Rehab Center LLC | 6263 N Green Bay Ave<br>Glendale, WI 53209 |

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| F 0686<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38253<br><br>Based on observation, record review, and interview, the facility did not ensure residents received care consistent with professional standards of practice to prevent pressure injuries, promote healing of pressure injuries, and prevent infection of pressure injuries for 4 (R274, R57, R63, and R55) of 6 residents reviewed for pressure injuries.<br><br>*R274 developed a Moisture Associated Skin Damage (MASD) area to the sacrum on 9/8/2022 and the Care Plan was not revised with interventions to prevent further damage. The MASD progressed into an Unstageable pressure injury on 10/3/2022. The Unstageable pressure injury required hospitalization on [DATE] due to infection and osteomyelitis requiring intravenous antibiotics where it was determined to be a Stage 4 pressure injury.<br><br>The Facility failure to identify the causative factors for the MASD and revise the care plan based on the skin assessment to prevent a Stage 4 pressure injury created a finding of immediate jeopardy that began on 9/8/2022. Surveyor notified Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B of the immediate jeopardy on 10/20/2022 at 11:49 AM. The immediate jeopardy was removed on 10/21/2022 however; the deficient practice continues at a scope/severity of G as evidenced by the following examples.<br><br>*Upon admission to the facility R57 was assessed to be at moderate risk for the development of pressure injuries. R57's Admission Minimum Data Set (MDS) assessment documents R57 did not have any pressure injures upon admission to the facility. R57 developed an unstageable pressure injury to the left trochanter that became infected. R57's care plan did not address the preventative interventions of turning and repositioning. R57 then developed unstageable left heel and left outer ankle pressure injuries. R57's care plan did not address preventative interventions of off loading the heels or wearing off loading heel boots until after the pressure injuries developed.<br><br>*R63 was admitted with a Stage 4 pressure injury. On 10/19/22, Surveyor observed a cushion in R63's Broda chair wrapped with a blanket and sheet. The cushion was identified as a Medline's gel foam cushion. Manufacturer instructions indicated the cushion was for comfort and pressure redistribution. The manufacturer instructions did not include information as to whether this cushion was appropriate for a Stage 4 pressure injury.<br><br>* R55 was identified to be at moderate risk for skin impairment with a history of a stage 3 pressure injury to the coccyx which according to the last assessment healed on 10/3/22.<br><br>(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 0686<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | On 10/18/22 Surveyor noted the facility power outage on 10/18/22 at 7:22 am.<br><br>On 10/18/22 at 7:45 A.M., R55 was observed to be in bed with an alternating pressure mattress that was off during a power outage. Surveyor observed R55's air mattress remained off until 8:01 A.M. when the air mattress was plugged into a red outlet.<br><br>Findings include:<br><br>The facility policy and procedure entitled Clinical Protocol: Pressure Injuries/Skin Breakdown dated 7/22/2022 states: Assessment and Recognition:<br><br>1. The nursing staff and practitioner will assess and document an individual's significant risk factors for developing pressure ulcers; for example, immobility, recent weight loss, and a history of pressure ulcer(s).<br><br>2. In addition, the nurse shall describe and document/report the following: a. Full assessment of pressure sore including location, stage, length, width and depth, presence of exudates or necrotic tissue; b. Pain assessment; c. Resident's mobility status; d. Current treatments, including support surfaces; and e. All active diagnoses.<br><br>3. The staff and practitioner will examine the skin of newly admitted residents for evidence of existing pressure ulcers or other skin conditions.<br><br>4. The physician will assist the staff to identify the type (for example, arterial or stasis ulcer) and characteristics (presence of necrotic tissue, status of wound bed, etc.) of an ulcer.<br><br>5. The physician will help identify and define any complications related to pressure ulcers.<br><br>Cause Identification: 1. The physician will help identify factors contributing or predisposing residents to skin breakdown 2. The physician will clarify the status of relevant medical issues; for example, whether there is a soft tissue infection or just wound colonization, whether the wound has necrotic tissue, and the impact of comorbid conditions on healing an existing wound.<br><br>Treatment/Management:<br><br>1. The physician will order pertinent wound treatments, including pressure reduction surfaces, wound cleansing and debridement approaches, dressings (occlusive, absorptive, etc.), and application of topical agents.<br><br>2. The physician will help identify medical interventions related to wound management; for example, treating a soft tissue infection surrounding an ulcer, removing necrotic tissue, addressing comorbid medical conditions, managing pain related to the wound or to wound treatment, etc.<br><br>a. Although poor nutritional status is associated with increased risk of pressure ulcer development, no specific nutritional interventions clearly prevent or heal pressure ulcer.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | b. Beyond trying to maintain a stable weight and providing approximately 1.2-1.5 gm/kg protein daily there are no routine pressure ulcer-specific nutritional measures for those with or at risk for developing a pressure ulcer.<br><br>c. Any nutritional supplementation should be based on realistic appraisal of an individual's current nutritional status and minimizing any medications and conditions that may be affecting appetite and weight.<br><br>3. The physician will help staff characterize the likelihood of wound healing, based on a review of pertinent factors<br><br>4. As needed, the physician will help identify medical and ethical issues influencing wound healing; for example, the impact of end-stage heart disease or because the resident or family declines artificial nutrition and hydration. a. Advance directives may limit the scope, intensity, duration, and selection of various wound-related or adjunctive treatments such as a choice to forego artificial nutrition and hydration.<br><br>Monitoring:<br><br>1. During resident visits, the physician will evaluate and document the progress of wound healing - especially for those with complicated, extensive, or poorly-healing wounds.<br><br>2. The physician will guide the care plan as appropriate, especially when wounds are not healing as anticipated or new wounds develop despite existing interventions.<br><br>a. Healing may be delayed or may not occur, or additional ulcers may occur because of other factors which cannot be modified.<br><br>b. Current approaches should be reviewed for whether they remain pertinent to the resident/patient's medical conditions, are affected by factors influencing wound development or healing, and the impact of specific treatment choices made by the resident/patient or a substitute decision-maker.<br><br>1. R274 was admitted to the facility on [DATE] with diagnoses of encephalopathy, end-stage renal disease requiring dialysis, ulcerative pancolitis with rectal bleeding, gastrointestinal hemorrhage, anemia, gastroesophageal reflux disease, and depression. R274's admission Minimum Data Set (MDS) assessment dated [DATE] indicated R274 had severe cognitive impairment with a Brief Interview for Mental Status score of 7 and needed extensive assistance with bed mobility, transfers, toilet use, and hygiene. R274 was coded as being frequently incontinent of bladder and always incontinent of bowel. R274 was admitted with a deep tissue injury to the right heel. The Care Area Assessment (CAA) for Pressure Ulcer stated R274 was at risk for pressure ulcers due to currently impaired skin, incontinence, and decreased mobility; a Care Plan was implemented to have pressure reducing devices in place. On admission, R274 weighed 119 pounds. R274 did not have an activated Power of Attorney and was a full code. R274 went to dialysis every Monday, Wednesday, and Friday at the dialysis center located in the facility.<br><br>R274's Potential Impairment to Skin Integrity Care Plan was initiated on 3/3/2022 with the following interventions:<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | -Encourage good nutrition and hydration.<br><br>-Assess skin on a weekly basis on scheduled bath day and document findings on a weekly skin assessment.<br><br>-Report any skin redness/impaired integrity areas to the nurse.<br><br>-Use barrier cream to prevent skin impairment issues as needed.<br><br>On 3/17/2022, R274's Functional Bladder Incontinence Care Plan was initiated with the following interventions:<br><br>-Check frequently and as required for incontinence; wash, rinse, and dry perineum; change clothing as needed after incontinence episodes.<br><br>-Monitor/document for signs/symptoms of urinary tract infection.<br><br>On 3/17/2022, R274's Potential Impairment to Skin Integrity Care Plan included the Deep Tissue Injury to the right heal and was revised with the following interventions:<br><br>-R274 needs a pressure reducing cushion to protect the skin while up in chair.<br><br>-R274 needs a pressure reducing mattress to protect the skin while in bed.<br><br>On 4/1/2022, R274 developed Moisture Associated Skin Damage (MASD) to the buttocks that measured 7.0 cm x 8.0 cm x 0.1 cm with 50% intact skin and 50% pink or red non-granulating tissue. Wound Registered Nurse (RN)-J documented scattered areas denuded across bilateral buttocks; R274 has had obvious weight loss due to loose, extra skin folds throughout body and has poor intake. Supplements and off-loading mattress and cushion in place. R274 had a medical history of end stage renal disease on dialysis.<br><br>On 4/1/2022, a treatment to the buttocks was obtained: wash with normal saline, apply silver alginate followed by a bordered gauze dressing every Monday, Wednesday, and Friday. Surveyor noted silver alginate is contraindicated for individuals with severe renal disease.<br><br>R274's MASD to the buttocks was comprehensively assessed weekly from 4/1/2022 until 5/16/2022 when the wound healed.<br><br>On 4/18/2022, 17 days after the discovery of the MASD to the buttocks, R274's Altered Skin Integrity Care Plan for non-pressure rash was initiated with the following interventions:<br><br>-Conduct weekly skin inspection.<br><br>-Monitor for signs/symptoms of infection such as swelling, redness, warmth, discharge, odor; notify physician of significant findings.<br><br>-Provide pressure-reducing wheelchair cushion.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | -Provide thorough skin care after incontinent episodes and apply barrier cream.<br><br>-Treatments as ordered.<br><br>-Weekly Wound assessment.<br><br>On 5/4/2022, R274's Potential Impairment to Skin Integrity Care Plan was resolved.<br><br>On 5/4/2022, R274's Bowel Incontinence Care Plan was initiated with the following interventions:<br><br>-Apply barrier cream every shift as needed or after every incontinent episode.<br><br>-Check R274 every two hours and assist with toileting as needed.<br><br>-Provide loose fitting, easy to remove clothing.<br><br>-Provide pericare after each incontinent episode.<br><br>On 5/16/2022, the treatment to the MASD to the buttocks was discontinued.<br><br>On 5/16/2022, R274's Altered Skin Integrity Care Plan for non-pressure rash was resolved.<br><br>On 5/17/2022, Ensure Plus 240 cc daily with breakfast was ordered for additional calories and protein.<br><br>On 6/1/2022, R274's Potential Impairment to Skin Integrity Care Plan was reinstated with the following interventions:<br><br>-Assist and encourage to keep nails short/trimmed.<br><br>-Avoid scratching and keep hands and body parts from excessive moisture.<br><br>-Monitor/document location, size, and treatment of skin injury; report abnormalities, failure to heal, signs/symptoms of infection, maceration etc. to physician.<br><br>-Use draw sheet or lifting device to move R274.<br><br>-Use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surface.<br><br>On 6/3/2022, R274 was positive for COVID-19 and recovered.<br><br>On 8/24/2022, Magic Cup 120 cc daily was ordered.<br><br>On 9/5/2022, R274's Braden scale score was 16 indicating at risk for pressure injuries.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | On R274's quarterly MDS assessment dated [DATE], R274 was coded as having moderate cognitive impairment with a BIMS score of 12 and needed extensive assistance with bed mobility, transfers, toilet use, and hygiene. R274 was frequently incontinent of bladder and always incontinent of bowel. No skin impairments were identified. R274 weighed 118 pounds on 8/25/2022 which was the weight used on the MDS assessment.<br><br>On 9/8/2022 at 3:24 PM in the progress notes, Licensed Practical Nurse (LPN)-I charted an open area to the coccyx and an open area to the left buttock were discovered during cares for R274. A dressing was applied, Wound RN-J was notified, DON-B was notified, and Medical Director (MD)-K was updated.<br><br>On 9/8/2022 on the Head to Toe Skin Check form, LPN-I documented a new skin integrity issue with open areas to the coccyx and left buttock. LPN-I documented the coccyx was a pressure injury and the left buttock was a skin tear. LPN-I charted in the area for further description of skin issues: R274 has very dry and flaky skin. No measurements or characteristics of the wounds were documented.<br><br>On 9/8/2022, R274's Braden Scale score was 14 indicating moderate risk for pressure injuries, a change from 9/5/2022 where R274 was at risk for pressure injuries. No revisions were made to the Care Plan to address the increase in risk for pressure injury based on the Braden Scale score.<br><br>On 9/9/2022 on the Wound Assessment Details form, Wound RN-J documented R274 had MASD caused by incontinence that was facility acquired on 9/9/2022 to the coccyx that measured 1.5 cm x 1.5 cm x 0.1 cm with 100% pink or red non-granulating tissue. Wound RN-J documented: Area with skin has been removed to the maceration area has virtually no drainage but resident does report some paying (sic) their resident has no Adipost tissue in the region? Surveyor noted the MASD started on 9/8/2022, not on 9/9/2022 as documented by Wound RN-J. The Wound Assessment Details form included a colored picture of the area and Surveyor noted the right half of the wound to have shiny pink tissue and the left half of the wound to have what appeared to be yellow slough-like tissue; the wound did not appear to be MASD but pressure due to the presentation of the tissue types.<br><br>Surveyor noted RN-J's wound assessment does not accurately describe the picture of the coccyx wound, as there is no referencing that the wound having slough-like tissue.<br><br>On 9/9/2022 on the Weekly Skin Review form, Wound RN-J documented R274 had a new area of MASD to the coccyx and buttocks.<br><br>Surveyor noted the documentation on 9/8/2022 and the Weekly Skin Review form on 9/9/2022 indicated two skin impairment areas: the coccyx and the (left) buttock. Only the coccyx was documented on, and no clarification was documented regarding the total number of areas present.<br><br>On 9/9/2022, an order to cleanse the coccyx wound with normal saline, apply skin prep to the surrounding area, apply xeroform to the wound bed and cover with a bordered gauze dressing every evening shift was entered onto the Treatment Administration Record (TAR). Surveyor noted the packaging for Xeroform dressing indicated it is an occlusive dressing that keeps air out, which can help to protect the area while also promoting a moist environment for healing. Surveyor noted a Xeroform dressing to an area of skin breakdown caused by moisture would keep the skin moist and potentially increase the damage to the skin.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | On 9/9/2022, an order to monitor the skin alteration to the coccyx for any signs or symptoms of infection (warmth to wound site or surrounding area, increased pain, odor, bleeding, edema, or change in the amount or the color of the wound drainage) and notify the physician if any signs or symptoms of infection were noted every shift was entered onto the TAR.<br><br>No interventions to the Care Plan were added to address increased incontinence care, turning, or prevention of further damage to the skin.<br><br>On 9/10/2022 at 3:10 PM in the progress notes, LPN-I charted the dressing change was done that morning and remained clean and intact to the coccyx/buttocks.<br><br>On 9/11/2022 at 6:38 AM in the progress notes, nursing charted R274 slept through the night with no complaints of any pain. Nursing will continue to monitor the open area to the coccyx.<br><br>On 9/11/2022 at 9:56 PM in the progress notes, nursing charted the dressing was intact to the coccyx; R274 was encouraged to reposition self from side to side while in bed.<br><br>On 9/12/2022 at 3:56 AM in the progress notes, nursing charted R274 had no complaints of pain from the open area to the coccyx.<br><br>On 9/12/2022 on the Wound Assessment Details form, Wound RN-J documented R274 had MASD caused by incontinence that was facility acquired on 9/9/2022 to the coccyx that measured 2.0 cm x 1.0 cm x 0.1 cm with 100% pink or red non-granulating tissue. Wound RN-J documented: area with skin has been removed to the maceration area has virtually no drainage but resident does report some paying (sic) their resident has no Adipose tissue in the region overall skin condition very dry and flaking. Surveyor noted the MASD started on 9/8/2022, not on 9/9/2022 as documented by Wound RN-J. The Wound Assessment Details form included a colored picture of the area and Surveyor noted two areas present. Surveyor noted RN-J's wound assessment does not describe the picture of the coccyx wound which shows 2 areas.<br><br>On 9/12/2022 at 10:14 PM in the progress notes, Medical Director (MD)-K documented a physician visit was done due to staff and family concerns. The progress note states no complaints from R274, and nursing concerns are R274 was sleepier than before, difficult to be aroused on occasion, and more confused than at baseline. The Assessment and Plan section of the note stated R274 was a demented patient with increasing sleepiness and some failure to thrive; fluctuating consciousness may suggest delirium and acute process. Labs for CBC (Complete Blood Count), CMP (Comprehensive Metabolic Panel), and ammonia level will be checked; R274 was non-focal on exam and in interview. Surveyor noted MD-K did not address or document any skin concerns that had been brought to MD-K's attention on 9/8/2022.<br><br>On 9/13/2022, R274 weighed 107.8 pounds, a weight loss of 10.6 pounds in 19 days or 9%.<br><br>On 9/14/2022 at 10:43 AM in the progress notes, DON-B charted R274 had a weight loss. DON-B charted R274 was alert and responsive and denied any stomach discomfort stating R274 did not have an appetite. MD-K was updated, and labs were ordered.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | On 9/14/2022 at 2:24 PM in the progress notes, nursing charted R274 complained of headache and left eye pain. R274 was alert and oriented, no swelling was noted to the left eye, R274 had decreased food and fluid intake and complained of diminished vision to the left eye. MD-K was updated, and an order was received to send R274 to the hospital for evaluation and treatment.<br><br>On 9/14/2022 at 5:32 PM in the progress notes, nursing charted a call was received from the hospital and all labs, vital signs, and the CT of the head were negative and R274 would be coming back to the facility.<br><br>On 9/14/2022 at 10:15 PM in the progress notes, MD-K documented a physician visit due to patient request for services. MD-K documented R274 complained of a headache which R274 could provide no details of except that it was the worst headache of R274's life; R274 was unable to recall a trigger, duration, recurrent, aggravating or mitigating factors surrounding the headache but says there is something wrong with the eye and then was unable to finish the thought. MD-K documented nursing had concerns R274 was sleepier than before, difficult to arouse on occasion, and more confused than at baseline. MD-K documented nursing stated R274 had complained to two different nurses about the left hand and then the right eye. The Assessment and Plan section of the progress note indicated R274 would be sent for imaging to rule out any active bleeding and if negative, add Topamax to the medication regimen to address the headache. Surveyor noted MD-K did not address or document any skin concerns that had been brought to MD-K's attention on 9/8/2022.<br><br>On 9/16/2022 on the Weekly Skin Review form, LPN-I documented R274 had an open area to the coccyx and the right buttock. No further description of the areas was documented.<br><br>On 9/16/2022 at 3:58 PM in the progress notes, the Registered Dietician (RD) documented R274's significant weight loss of 12.2 pounds (11%) in the last month, a loss of 9 pound (8.3%) in the last three months, and an under significant loss of 6.2 pounds (5.8%) in the last six months. Oral intake over the last four weeks averaged 36-52% of the meals. Some weight fluctuations were anticipated due to dialysis, but R274 appeared to have wrinkled skin from notable weight decrease. Labs were reviewed and with decreased intake and weight loss, Ensure was increased to three times daily.<br><br>On 9/16/2022, Ensure Plus 240 cc three times daily was ordered, increasing the Ensure Plus from once daily to three times daily and Magic Cup was discontinued.<br><br>On 9/18/2022 at 10:15 AM in the progress notes, MD-K documented a physician visit due to staff concerns. MD-K documented nursing had concerns with R274 losing weight and having a poor appetite occasionally refusing meals stating R274 did not like the food. The Assessment and Plan section of the progress note indicated R274 had progressive weight loss without significant fluid overload to begin with and could not account for the weight loss. R274 had severe protein malnutrition and was running out of option and not responding to current therapies. MD-K offered R274 a PEG (percutaneous endoscopic gastrostomy) feeding tube which R274 could not understand and would have to discuss with R274's family which had been declining the PEG tube lately.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | On 9/19/2022 on the Wound Assessment Details form, Wound RN-J documented R274 had MASD caused by incontinence that was facility acquired on 9/9/2022 to the coccyx that measured 5.0 cm x 6.0 cm x 0.1 cm with 50% intact skin and 50% pink or red non-granulating tissue. Wound RN-J documented: area with skin has been removed Now in a minute with other small areas that the maceration has removed the top layer of dermis doesn't (sic) resident does report area being tender resident appetite is poor returned from dialysis and just wanted to sleep? Surveyor noted the MASD started on 9/8/2022, not on 9/9/2022 as documented by Wound RN-J. The Wound Assessment Details form included a colored picture of the area and Surveyor noted multiple areas present. Surveyor noted RN-J's wound assessment details does not include a description of the multiple areas as shown on the coccyx wound picture.<br><br>Surveyor noted the area increased in size with more open areas; no change in treatment or revision of R274's Potential Impairment to Skin Integrity Care Plan was implemented to prevent further damage. No documentation was found that the physician was notified of the change in the wound.<br><br>On 9/20/2022 at 10:16 AM in the progress notes, MD-K documented a physician visit due to patient request for services. MD-K documented R274 complained of low back pain but was unable to state how long the pain had been present, if there were any triggers, associated symptoms, or modifying factors to the pain; R274 only stated that it hurts. MD-K documented nursing had no concerns. The Assessment and Plan section of the progress note indicated R274 was a demented cachectic dialysis patient with low back pain in advanced age with possible osteoporotic fracture and an x-ray would be ordered to rule out a fracture; R274 did not have any neurological deficits to suggest spinal cord compromise or fever to suggest an epidural abscess. No documentation was found that MD-K was informed of R274's increase in MASD to the coccyx or participation in developing interventions to address the MASD.<br><br>On 9/21/2022 at 4:06 PM in the progress notes, DON-B charted DON-B spoke to R274 regarding the weight loss and R274 stated R274 does not have an appetite. DON-B charted MD-K was updated and recommended a gastrostomy tube (G tube). DON-B charted DON-B discussed the G tube with R274 and R274 stated, I don't want a tube, I will try to eat what I can. DON-B also discussed the recommendation of a colonoscopy by the gastrointestinal clinic and after much encouragement and reassurance, R274 agreed to have a colonoscopy scheduled.<br><br>On 9/22/2022 at 10:18 AM in the progress notes, MD-K documented a physician visit due to a preoperative cardiopulmonary risk assessment requested in preparation for a colonoscopy for a patient on anticoagulant and multiple cardiovascular risk factors. MD-K documented R274 had no complaints. MD-K documented nursing had no concerns. The Assessment and Plan section of the progress note indicated R274 denied chest pain and there were no signs or symptoms of heart failure; routine labs and EKG before the procedure were acceptable. The anticoagulant medication would be discontinued.<br><br>On 9/23/2022 at 6:57 PM in the progress notes, the RD documented R274 continued to trend down in weight with current weight of 102.6 pounds on 9/23/2022. The RD documented R274 eats 25-50% of meals which was similar to the last RD review; tube feeding had been discussed with R274 and R274 had declined tube feeding. Oral intake was encouraged and R274 accepts approximately 1.5 cans of Ensure per day of the three cans that are offered.<br><br>On 9/23/2022 on the Weekly Skin Review form, nursing documented R274 had open areas on both buttocks with a treatment in place. No further description of the areas was documented.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 525547 | A. Building<br>B. Wing | 10/24/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Glendale Care and Rehab Center LLC | 6263 N Green Bay Ave<br>Glendale, WI 53209 |

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

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|---|---|
| F 0686<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | On 9/26/2022 on the Wound Assessment Details form, Wound RN-J documented R274 had MASD caused by incontinence that was facility acquired on 9/9/2022 to the coccyx that measured 6.0 cm x 2.0 cm x 0.1 cm with 50% intact skin and 50% pink or red non-granulating tissue. Wound RN-J documented: area has contracted and filled with scar tissue now displays as 4 areas separated by scar tissue resident does report area being tender resident appetite is poor returned from dialysis and just wanted to sleep. Surveyor noted the MASD started on 9/8/2022, not on 9/9/2022 as documented by Wound RN-J. Surveyor noted scar tissue is not a typical tissue type for MASD; no change in treatment or revision of R274's Potential Impairment to Skin Integrity Care Plan was implemented to prevent further damage. No documentation was found that the physician was notified of the change in the wound.<br><br>On 9/26/2022 at 8:46 AM in the progress notes, MD-K documented a physician visit due to weight loss. MD-K documented R274 had no complaints. MD-K documented nursing had a concern with continued weight loss, decreased oral intake, and several weeks of R274 losing as much as 2 pounds per week. The Assessment and Plan section of the progress note indicated R274 was failure to thrive with multiple medical issues and unresolved gastrointestinal problems requiring an EGD (esophagogastroduodenoscopy), colonoscopy, and likely a PEG tube as interventions against weight loss. MD-K documented R274 had failed appetite stimulants and had lost 20 pounds over the last fifteen months to get to the current weight of 102 pounds. MD-K documented R274 was unable to carry out conversation regarding management of the weight loss due to dementia and cannot discuss directives, issues, and cannot give informed consent; R274's family was not returning phone calls. No documentation was found that MD-K was informed of R274's change in MASD to the coccyx or participation in developing interventions to address the MASD.<br><br>On 9/27/2022 at 8:29 AM in the progress notes, DON-B charted R274 continued to have poor food and fluid intake and DON-B spoke to R274 regarding the consequences of malnutrition like continued skin breakdown, fatigue, and decline in overall health and discussed R274's declination of artificial feeding. DON-B charted R274 stated R274 never said R274 did not want artificial feeding and R274 did not seem to recall conversations about artificial feeding. MD-K was updated.<br><br>On 9/28/2022 at 12:16 PM in the progress notes, MD-K documented a physician visit due to staff concerns. MD-K documented R274 had no complaints. MD-K documented nursing had a concern R274 was unable to participate in making decisions regarding decisions with healthcare. The Assessment and Plan section of the progress note indicated R274 was assessed for mental capacity and met the statutory definition of incapacity, and the Power of Attorney (POA) for Health Care would be activated.<br><br>On 9/30/2022 on the Weekly Skin Review, LPN-I documented R274 had open areas to the coccyx and right buttock. No further description of the areas was documented.<br><br>On 9/30/2022 at 10:30 AM in the progress notes, the RD documented the RD visited R274 due to continued weight loss. The RD documented R274 was hallucinating and pointed to snacks that did not exist when asked what food sounded good to R274. The RD documented R274 visualized a lady in the room and perseverated on that vision and could not focus on the RD when encouraging R274 to drink Ensure. The RD documented R274's behavior was discussed with the nursing staff and nursing staff reported R274 did better with drinking the Ensure at breakfast; nursing staff was monitoring intake and encouraging R274 to eat and drink. The RD documented nursing and the interdisciplinary team was working on a GI consult, interventions for weight loss, and POA activation. The RD recommended staff offer R274 food and fluids between meals.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | On 9/30/2022, give snacks at 10:00 AM, 2:00 PM, and 10:00 PM was ordered to help gain weight, and to notify physician if R274 was not eating.<br><br>On 9/30/2022 at 12:02 PM in the progress notes, MD-K documented a physician visit due to confusion and polypharmacy. MD-K documented R274 had no complaints. MD-K documented nursing had a concern R274 was progressively more confused than before. The Assessment and Plan section of the progress note indicated R274's medications were reviewed with some being discontinued, and labs would be drawn to rule out reversible causes of confusion.<br><br>From 9/30/2022 through 10/2/2022, nursing monitored and charted on R274's appetite and intake.<br><br>On 10/2/2022 at 10:37 AM in the progress notes, MD-K documented a physician visit due to self-care deficits. MD-K documented R274 had no complaints. MD-K documented nursing had no concerns. The Assessment and Plan section of the progress note did not have any information documented.<br><br>On 10/3/2022 on the Wound Assessment Details form, Wound RN-J documented R274 had MASD caused by incontinence that was facility acquired on 9/9/2022 to the coccyx that measured 6.0 cm x 2.0 cm x unknown depth with 100% necrotic tissue. Wound RN-J documented the wound had degraded and was now an Unstageable pressure injury; tissue was necrotic with no drainage. Wound RN-J documented supplements were added, and an off-loading mattress was ordered. Surveyor noted the MASD started on 9/8/2022, not on 9/9/2022 as documented by Wound RN-J. The Wound Assessment Details form included a colored picture of the area and Surveyor noted the wound appeared drastically different from any of the previous pictures and assessments. Surveyor reviewed the TAR from 9/9/2022-10/3/2022; the order to notify the physician if there were any signs or symptoms of infection to the coccyx wound was marked n or 0 indicating no signs or symptoms of infection were noted by the nursing staff for each shift. No documentation was found that MD-K, administrative staff, or Wound RN-J had been notified by nursing staff of the deterioration of the wound from 9/26/2022 through 10/3/2022.<br><br>On 10/3/2022 on the Head to Toe Skin Check form, Wound RN-J documented R274 had a new Unstageable pressure injury to the sacrum measuring 3.5 cm x 9.0 cm x unable to determine depth. Further description of the skin section of the form stated the area had declined rapidly.<br><br>Surveyor noted the measurements of the Unstageable pressure i [TRUNCATED] |