STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525604	A. Building B. Wing	04/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southpointe Care and Rehab Center LLC	4500 W Loomis Rd Greenfield, WI 53220

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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 0580 Level of Harm - Actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44063 Based on interview and record review, the Facility did not immediately consult with a Resident's physician for 1 (R93) of 29 sample residents reviewed for physician notification. R93 had a physician's order for STAT labs to be drawn on 3/22/22. On 3/23/22 at 3:39 PM, the Final Report of the lab test results indicate the order was reported and resulted. The results of the lab test were noted to be abnormal, specifically with the white blood count as being high. The physician was not notified of the lab results until 3/25/22. Once the physician was notified of the abnormal lab results, the physician ordered to send R93 to the hospital for evaluation and treatment. R93 was admitted to the hospital with diagnosis of acute cystitis, sepsis and ulcer. Findings include: R93 was admitted to the facility on [DATE] with diagnoses that includes encephalopathy, hemiplegia and hemiparesis following cerebral infarction, frontal lobe and executive function deficit following cerebral infarction, Type 2 Diabetes, Pressure Ulcer of Sacral Region, and history of local infection of the skin and subcutaneous tissue. R93's Quarterly MDS (Minimum Data Set) dated 12/14/21 documents that R93 has a BIMS (Brief Interview for Mental Status) assessment score of 00 indicating R93 demonstrates severe cognitive impairment for daily decision making. R93 has a Healthcare Power of Attorney. On 3/22/22, there is a Physician's order stating CBC (Complete Blood Count), CMP (Comprehensive Metabolic Panel) STAT (Immediate) related to Local Infection of the Skin and Subcutaneous Tissue and Sacral Wound C&S (Culture and sensitivity) one time only related to Local Infection of the Skin and Subcutaneous Tissue. On 3/22/22, the Wound Care Assessment in R93's electronic health record documents (in part): Wound to sacrum.Afebrile at 98.4.Stage 4 pressure injury to sacrum.There is a large amount of malodorous serosanguineous drainage. Periwound with scar tissue. Status: declined. Wound infection with odorous declining wound. Plan: CBC, CMP, Flagyl and vanco. culture taken - modify antibiotics based on culture results. (continued on next page)

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

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F 0580 Level of Harm - Actual harm Residents Affected - Few	On 3/22/22 at 6:02 PM, the Wound RN (Registered Nurse)-GG writes a skin/wound note stating Culture obtained of Sacral wound. Floor nurse to send to lab for C&S. Also floor nurse to call and have PICC line place and labs drawn. On 3/22/22 at 8:35 PM, the Final Report from the laboratory indicates the blood specimen was collected from R93. On 3/22/22 at 9:00 PM, a nursing note documents the following New order for Vancomycin (antibiotic) 1 gram twice daily via IV, Stat CBC/CMP and Sacral wound C&S. Lab made aware of lab orders via telephone and fax, awaiting lab draw and specimen pick up. On 3/23/22 at 3:39 PM, the Final Report of the lab test results indicate the order was reported and resulted. Surveyor noted there were no comments in the progress notes on 3/23/22 regarding the lab results and physician notification. On 3/24/22 at 4:40 PM, the Wound RN-GG wrote a nursing note that states Lab results obtained and faxed to pharmacy at pharmacy request for vanco dosing. Also pharmacy to call to have PICC line inserted. Surveyor noted there were no comments in the progress notes on 3/24/22 regarding physician notification of the lab results that were sent to the pharmacy. On 3/24/22 at 10:38 PM, a nursing note documents PICC line placed this evening. Left upper arm. 1st dose of Vanco given as ordered. Surveyor noted this is two days after ordered by the physician. On 3/25/22 at 1:50 PM, the Wound RN-GG wrote a skin/wound note indicating Writer notified Wound NP (Nurse Practitioner) of lab results with WBC (White blood cell count) of 22.8. Instructed to call MD. MD called back and order to send to Hospital received. Floor nurses to send resident to hospital. Wound NP said would notify POA. According to the American Medical Directors Association (AMDA), Acute Change of Condition in the Long-Term Care Setting, Clinical Practice Guideline, page 17, Table 14 Framework for Reporting Changes in Vital Signs or Laboratory Values to a Practitioner, Complete blood count WBC>12,000 Report Immediately. On 3/25/22 at 2:03 PM, a nursing note states Doctor informed of abnormal labs of 3/24/22. New orders received to send resident to ER (emergency room) for Eval and Treatment. Daughter informed of pending transfer. On 3/25/22 at 2:10 PM, a nursing note documents Hospital called regarding transport for eval and treatment regarding abnormal labs. Ambulance called for transport to hospital. On 3/25/22 at 2:33 PM, a nursing note states Ambulance here to transport resident to hospital. (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Few	On 3/25/22 at 10:45 PM, an infection progress note documents Was contacted by hospital emergency room . R93 has been admitted to the hospital this evening. Admitting Dx (diagnosis): Acute Cystitis, Sepsis, Ulcer. On 03/29/22 at 11:20 AM, Surveyor interviewed NP (Nurse Practitioner)-MM. NP-MM stated she wanted immediate labs drawn on 3/22/22 as there was concern about R93's wound evaluation that day. NP-MM stated she wasn't notified until Friday 3/25/22 of the abnormal WBC which is when she recommended to call the doctor right away. NP-MM stated she would have sent R93 out when notified of the high WBC numbers and knew the doctor would too. NP-MM indicated R93 should have gone to the hospital earlier when the results were available, but we didn't hear from the facility about the labs until Friday (3/25/22). NP-MM said it was a concern that it took so long to get the lab results to the doctor as R93 could have gotten a work up at the hospital quicker. NP-MM stated from now on, Wound RN-GG will be following up on all of NP-MM's labs so they will be checked regularly and will talk to Facility administration to make sure this doesn't happen again. On 3/29/22 at 12:30 PM, Surveyor interviewed Wound RN-GG. Wound RN-GG stated he did send in the lab results to pharmacy on Thursday, 3/24/22, but did not look at the results and assumed they were already sent to the doctor. Wound RN-GG believed the other floor nurses would check the labs daily so assumed that part was done, but on Friday 3/25/22, Wound RN-GG printed out the labs and noticed the doctor was not notified so then contacted NP-MM to see what to do. Wound RN-GG stated the lab used to fax the results, but now the staff have to go in to the computer system to print them out. Wound RN-GG was not sure of the procedure for who can do this or when it should be done, but will now make sure to print out all of the Wound labs and keep the doctor up to date timely. On 03/30/22 at 10:45 AM, LPN-LL was interviewed by Surveyor. LPN-LL said labs should be checked every shift, printed out, call the doctor, write a progress note, file and put new orders in if necessary. LPN-LL stated nurses need access to the lab results with a password and was not sure if everyone had access. LPN-LL was not sure why there was a delay in notifying the physician of R93's abnormal lab results, but believes it is tough with the agency nursing staff to make sure they know procedure or have access. On 3/30/22 at 12:08 PM, Surveyor interviewed DON-B. DON-B stated labs should be checked daily online and then contact the doctor with the results. DON-B stated R93's lab results were not looked at timely and someone missed it. DON-B indicated there was no policy or procedure for the nursing staff on laboratory results and notification to the physician. On 3/30/22 at 12:18 PM, Surveyor notified NHA-A of the concern that R93's lab results were not shared with the physician timely which then delayed the evaluation and treatment of R93 at the hospital. No further information was provided.

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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. 20483 Based on interview & policy review, the Facility did not ensure 1 (R135) 2 allegations of mistreatment were immediately reported to the Administrator and to the State Survey Agency within 2 hours. Findings include: The Abuse & Neglect Prohibition Policy & Procedure with a revision date of July 2018 under policy documents Each resident has the right to be free from abuse, neglect, mistreatment, injuries of unknown origin, misappropriation of resident property, exploitation, corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. The facility does not allow involuntary seclusion. Any observations or allegations of abuse, neglect or mistreatment must be immediately reported to the Administrator. Under Procedures for Reporting and Response documents 1. STATE REPORTING OBLIGATIONS: The facility will report all allegations and substantiated occurrences of abuse, neglect, exploitation, mistreatment including injuries of unknown origin, and misappropriation of property to the administrator, State Survey Agency, and law enforcement officials and adult protective services (where state law provides for jurisdiction in long-term care facilities) in accordance with Federal and State law through established procedures. R135's quarterly MDS (Minimum Data Set) with an assessment reference date of 3/9/22 documents a BIMS (Brief Interview Mental Status) score of 13 which indicates cognitively intact. On 3/22/22 at 12:08 p.m. during the screening process Surveyor asked R135 how staff treat her. R135 informed Surveyor she doesn't know where they get some of these girls, they are rough, and don't give you a second to turn. Surveyor asked R135 if she has told anyone about staff being rough. R135 replied oh yes and explained she told a couple if they don't like their job then quit. R135 informed Surveyor RN (Registered Nurse)-U is good. Surveyor asked R135 if she told RN-U staff has treated her roughly. R135 replied oh yes she knows it too. On 3/22/22 at 2:22 p.m. Surveyor asked RN-U if any Residents have reported to her staff treats them roughly or yells at them. RN-U replied [R135] and explained they are rough with her roommate. Surveyor asked RN-U if R135 is the only Resident who said staff was rough with her and her roommate. RN-U replied yes. Surveyor asked RN-U if she has informed anyone of this. RN-U replied no not yet and explained R135 told her when she was giving medications at noon. On 3/23/22 at 3:41 p.m. Surveyor asked R135 what she told RN-U about staff. R135 replied I said some of the girls are so mean and she (referring to RN-U) said someone else said that too. R135 informed Surveyor no one wants to say anything as they don't want to lose their jobs. Surveyor asked R135 if she told RN-U staff are rough. R135 replied oh yes. Surveyor asked R135 if she gave RN-U any names of staff who are rough. R135 replied oh no, she knows. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/24/22 at 7:43 a.m. Surveyor asked RN-U what R135 told her again about staff treatment. RN-U informed Surveyor [R135] told her staff was being rough with [R54]. Surveyor asked RN-U if she reported this to anyone. RN-U informed Surveyor she told the social worker about R135 saying staff was rough with R54. Surveyor asked RN-U when did she speak with the social worker. RN-U replied after I text the DON (Director of Nursing). Surveyor asked who the social worker is. RN-U replied [first name] of Social Worker-FF. On 3/24/22 at 8:57 a.m. Surveyor asked SW-FF if RN-U reported anything to her. SW-FF informed Surveyor she wrote up a concern & let the Administrator & Director of Nursing know. Surveyor asked what this was in regards to. SW-FF informed Surveyor it was regards to a specific resident not getting blood sugars done & giving insulin. Surveyor asked if RN-U reported anything else. SW-FF replied no. Surveyor asked SW-FF if RN-U reported anything about R135 or R54. SW-FF informed Surveyor all she remembers is [R23] and the insulin. Surveyor asked if RN-U reported to her R135 informed her staff was rough with her and R54. SW-FF informed Surveyor RN-U did not report this to her and now that she knows about it she will take action. SW-FF informed Surveyor RN-U told her about R23 when they were standing at the nurses station and may be got busy. SW-FF informed Surveyor she will probably walk out with Surveyor and talk to her administrator now. On 3/24/22 at 1:34 p.m. Surveyor spoke with Administrator-A regarding a concern that R135 reported to RN-U staff was rough. According to RN-U she reported this to SW-FF but when Surveyor spoke to SW-FF, SW-FF informed Surveyor RN-U had not reported this to her. Administrator-A informed Surveyor she was informed today by SW-FF and self reported the allegation today. Surveyor informed Administrator-A this allegation should have been reported to her & the State Agency immediately on 3/22/22.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20025 Based on interview and record review the facility did not ensure 2 (R188 and R135) and of 3 resident with allegations of abuse was reported to NHA (Nursing Home Administrator) A immediately and facility conducted a thorough and complete investigation. On [DATE] R188 suffered a change in condition became unresponsive and died at the facility. The facility's investigation was not complete and thorough to identify if staff neglect was the cause of R188 death. On [DATE] R135 reported to RN (registered nurse)-U staff was rough. RN-U indicated she reported this to the social worker on [DATE] but when interviewed the social worker stated RN-U did not report anything regarding R135 to her. Administrator-A was unaware of the allegation until [DATE], self reported the allegation on this date and started an investigation. Findings include: The facility's Abuse and Neglect Prohibition policy with revision date of [DATE] indicate: Each resident has the right to be free from abuse, neglect, mistreatment, injuries of unknown origin, misappropriation of resident property, exploitation, corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. The facility does not allow involuntary seclusion. Any observations or allegations of abuse, neglect, or mistreatment must be immediately reported to the Administrator. . Investigation 1. The facility will timely conduct an investigation of any alleged abuse/neglect, exploitation, mistreatment, injuries of unknown origin, or misappropriation of resident property in accordance with state law. 2. Any employee alleged to be involved in an instance(s) of abuse and/or neglect will be interviewed and suspended immediately, and will not be permitted to return to work unless and until such allegations of abuse/neglect are unsubstantiated. Reporting and Response (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. State reporting obligations: The facility will report all allegations and substantiated occurences of abuse, neglect, exploitation, mistreatment including injuries of unknown origin, and misappropriation of property to administrator, State Survey Agency, and law enforcement officials and adult protective services (where state law provides for jurisdiction in long term care facilities) in accordance with Federal and State law through established procedures. Timeline for reporting is as follows: a. If events that caused the allegation involved abuse or result in serious bodily injury, a report is made not later than 2 hours after the facility is notified of the allegation; or b. If events that cause the allegation do not involve abuse and do not result in serious bodily injury, a report is made not later than 24 hours after the facility is notified of the allegation; . 4. The facility will report any occurrences of abuse by licensed or certified staff and any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for employment to the applicable State Board in accordance with State law. 5. The facility will submit a summary of its investigation to the appropriate State agency within 5 days of its initial report or within whatever time frame required by the State agency. . 1. R188 was admitted to the facility on [DATE] with diagnoses of surgical repair of left femur fracture, Type 2 diabetes, morbid obesity, sleep apnea, atrial fibrillation and hypertension. The admission MDS (Minimum Data Set) dated [DATE] indicates R188 is alert and cognitively intact, needs extensive assistance of two staff for bed mobility and hygiene. It also indicates R188 had a urinary catheter due to urinary retention. The nurses note dated [DATE] at 5:46 a.m. indicate RN called to room per CNA (certified nursing assistant) during rounding. observed resident unresponsive. 911 called immediately. CPR (cardiopulmonary resuscitation) initiated. (Physician) paged. ADON (assistant director of nursing) updated. Surveyor reviewed the facility self report dated [DATE] which includes a statement from RN H as documented, found patient had a change in status. She called the doctor (paged X 2). Called 911 immediately, as the patient was a full code. (RN) reviewed the chart and found 0 family contacts. While awaiting 911 to come, all necessary documents were printed. DON/NHA were notified. ADON (who was in the building) was notified . (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The RN H completed an SBAR (situation, background, assessment and recommendation) dated [DATE]. The SBAR indicates RN H was called to R188 room per CNA L. RN H observed resident to be unresponsive. 911 called immediately. The SBAR had vital signs dated [DATE]. The SBAR had the following conditions to assess during a change in condition: Mental status changes, Functional status changes, respiratory, GI/abdomen and GU/urinary changes. RN had marked NA for all changes. The SBAR assessment section asks the nurse completing the SBAR for an assessment of what may be the problem with the patient and RN did not complete an assessment and only wrote called 911 immediately. The facility self report does not have any other staff statement. On [DATE] at 9:00 a.m. Surveyor interviewed Paramedic I. Paramedic I stated the rescue squad arrived at the facility on [DATE] at 5:11 a.m. and arrived at the resident's bedside at 5:13 a.m. Paramedic I stated when they arrived at the resident's bedside, the facility staff were performing CPR. Paramedic I stated they let the facility staff continue with CPR until rescue squad got their equipment ready to take over CPR. Paramedic I stated R188 remained asystole (state of total cessation of electrical activity from the heart) through the whole call. Paramedic I stated they pronounced R188 dead at the facility with the permission of their medical director. Paramedic I stated R188 had all signs of death. On [DATE] at 7:45 a.m. NHA A explained to Surveyor, the Former DON (Director of Nursing) J participated in investigating R188's death and would have information. NHA A explained RN H no longer works at the facility and did not return to the facility after R188 death. NHA A stated they have tried to reach out to RN H but she doesn't return any of the phone calls. On [DATE] at 8:00 a.m. Surveyor interviewed Former DON J. Former DON J stated she did not participate in investigating R188 death. Former DON J stated she was in Atlanta when this incident occurred and has no information. Former DON J stated ADON K was at the facility when R188 expired and performed CPR along with RN H. On [DATE] at 8:09 AM Surveyor interviewed CNA (certified nursing assistant) L. CNA L stated she worked the night shift on [DATE] into [DATE]. CNA L stated sometime earlier in her shift (not sure the time) R188 was vomiting and he had his cpap off at the time. CNA L stated R188 asked her to let the nurse know he was vomiting. CNA L stated she told RN H R188 had vomited. CNA L stated RN H just said ok. CNA stated she was doing her rounds and about 2 am R188 had his call light on and CNA L answered R188 call light. R188 had vomited again and CNA L cleaned the basin. CNA L stated R188 asked again if she told the nurse. CNA L stated she told R188 she did tell the nurse. CNA L stated she told RN H again that R188 had vomited again. CNA L stated she's not sure about the time but about 3 or 4 am CNA L went into R188 room to empty out his catheter saw R188 turned a different color and CNA L immediately told RN H. CNA L stated RN went to look for ADON K for help. CNA L stated she did not participate in the CPR only doing rounds on the rest of the residents on the unit. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 9:02 AM Surveyor interviewed ADON K. ADON K stated she was on the rehab unit and R188 was on LTC (Long Term Care) 1 unit. RN H came from LTC 1 to rehab unit to tell ADON K that R188 was unresponsive. ADON K stated she went to R188 room and saw R188 wasn't breathing. ADON K state R188 lips were purple in color and there was foam around his mouth. ADON K stated his CPAP was not on. ADON K stated they started CPR and another nurse called 911. Surveyor asked ADON K if there was a paging system when there is a code situation. ADON K stated there isn't a paging system which is why RN H had to walk to get help. Surveyor asked ADON K if she knew that R188 was having episodes of vomiting during the night. ADON K stated she was not aware of this. On [DATE] at 10:30 a.m. Surveyor spoke with NHA A. Surveyor explained to NHA A the concern the facility self report isn't thorough. The facility self report does not interview all staff that were present on [DATE] on the night shift. NHA A told Surveyor that Former DON J participated in the investigation but Former DON J states she did not and was in Atlanta at the time. Surveyor explained to NHA A the facility self report indicates R188 expired due to accidental reasons related to his respiratory issues. There were no findings of neglect, abuse of any kind at play but because more interviewes were not conducted with staff the facility incorrectly assumed there wasn't findings of neglect. Surveyor explained to NHA A the interviews Surveyor conducted indicates RN H did not assess R188 when R188 experienced a change in condition and did not assess R188 when he was found unresponsive. RN H also did not immediately perform life saving support. NHA A stated she understood the concern and stated we didn't do a thorough job on this investigation. On [DATE] at 3:00 p.m. during the daily exit meeting with NHA A and DON B, RNC M asked Surveyor if Surveyor interviewed RN H. Surveyor stated NHA A told Surveyor that RN H no longer works at the facility and the facility was unable to reach RN H. RNC M stated RN H was scheduled to interview at a sister facility tomorrow and if RNC M could get RN H to speak with Surveyor would Surveyor interview RN H. Surveyor stated would like to interview RN H if RN H is willing to speak with Surveyor. On [DATE] at 10:20 a.m. Surveyor spoke with NHA A. NHA A stated RN H did not show up for the interview at the sister facility today. NHA A stated they have RN H phone number if Surveyor wanted to talk with RN H. Surveyor received RN H phone number. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 10:32 a.m. Surveyor interviewed RN H. RN H stated she remembers that day because it was the worse night of my nursing career. RN H stated when she arrived on her shift [DATE] at 11:00 p.m. RN H stated she was made aware that she would be working on LTC 1 and Rehab unit. RN H stated both units would total 70 residents for RN H to care for and she said she couldn't do it. RN H stated she called Former DON J and ADON K that she couldn't do both units and she needed help. RN H stated ADON K came in at 12:00 a.m. to work the rehab unit. Surveyor asked RN H how many residents did she have on LTC 1. RN H stated about ,d+[DATE] residents on LTC 1. Surveyor asked RN H when was she made aware R188 was unresponsive. RN H stated about 5:00 a.m. CNA L told her R188 was unresponsive. Surveyor asked RN H what specifically did CNA L tell her about R188 condition. RN H said CNA L told her R188 was unresponsive. RN H stated she immediately went to R188 room and saw he was unresponsive. Surveyor asked RN H what did R188 look like. RN H stated he just looked unresponsive. Surveyor asked if RN H did an assessment, RN H state no she did not because he looked like he needed 911. RN H stated she then ran down the hall to the Rehab unit to get ADON K. RN H stated ADON K and an agency nurse from another unit went to R188 to perform CPR and RN H called 911. Surveyor asked RN H if at any point during the shift, prior to 5:00 a.m., did CNA L tell her R188 was vomiting. RN H stated I don't remember. Surveyor asked RN H at 5:00 a.m. when she found R188 unresponsive, did R188 have his CPAP on. RN H stated she doesn't remember. RN H stated at 2:00 a.m. she went into R188 room to attend to R188 roommate. RN H stated R188 roommate bed was high and his TV was on, so she lowered the bed because R188 roommate was a fall risk and turned off the TV. Surveyor asked if she looked at R188 while she was in the room. RN H stated she saw R188 sleeping. Surveyor asked did R188 have his CPAP on. RN H stated she doesn't remember. Surveyor asked RN H if she was aware R188 was bleeding from his penis on the previous shift. RN H stated she was aware a UA was collected but was not aware of R188 bleeding from his penis. Throughout the interview RN H kept repeating how horrible it was that the facility wanted for RN H to work 2 units. RN H kept repeating how she will never work in a nursing home again. At no point during the interview did RN H explain why an assessment was not completed on [DATE]. On [DATE] at 12:50 p.m. Surveyor interviewed Agency LPN (licensed practical nurse) AA. Agency LPN AA stated on [DATE] she doesn't remember who told her but she was made aware of R188 needing CPR. Agency LPN AA stated when she arrived to R188 room with a medication tech (doesn't remember the name of the med tech), Agency LPN AA saw R188 laying on his back, his right arm hanging off the side of the bed and his eyes closed. Agency LPN AA listened for R188 breath sounds and didn't hear anything so immediately started CPR with the assistance of the medication tech. Agency LPN AA stated ADON K came into the room shortly and took over for the medication tech. Agency LPN AA stated RN H did not participate in the code situation. Agency LPN AA stated RN H called 911. Agency LPN AA stated R188 did not have his CPAP on and heard that he sometimes was noncompliant with putting it on. Agency LPN AA stated she and RN H continued with CPR until the paramedics arrived. As of [DATE] at 3:30 p.m. the facility had no additional information to provide to Surveyor. 20483 The Abuse & Neglect Prohibition Policy & Procedure with a revision date of [DATE] under procedure for Prevention documents 3. Facility supervisors will immediately investigate and correct reported or identified situations in which abuse, neglect, injuries of unknown origin, or misappropriation of resident property is at risk for occurring. (continued on next page)

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	525604	A. Building B. Wing	04/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southpointe Care and Rehab Center LLC	4500 W Loomis Rd Greenfield, WI 53220

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Under Investigation documents 1. The facility will timely conduct an investigation of any alleged abuse/neglect, exploitation, mistreatment, injuries of known origin, or misappropriation of resident property in accordance with state law. 2. R135's quarterly MDS (Minimum Data Set) with an assessment reference date of [DATE] documents a BIMS (brief interview mental status) score of 13 which indicates cognitively intact. On [DATE] at 12:08 p.m. during the screening process Surveyor asked R135 how staff treat her. R135 informed Surveyor she doesn't know where they get some of these girls, they are rough, and don't give you a second to turn. Surveyor asked R135 if she has told anyone about staff being rough. R135 replied oh yes and explained she told a couple if they don't like their job then quit. R135 informed Surveyor RN (Registered Nurse)-U is good. Surveyor asked R135 if she told RN-U staff has treated her roughly. R135 replied oh yes she knows it too. On [DATE] at 2:22 p.m. Surveyor asked RN-U if any Residents have reported to her staff treats them roughly or yells at them. RN-U replied [R135] and explained they are rough with her roommate. Surveyor asked RN-U if R135 is the only Resident who said staff was rough with her and her roommate. RN-U replied yes. Surveyor asked RN-U if she has informed anyone of this. RN-U replied no not yet and explained R135 told her when she was giving medications at noon. On [DATE] at 3:41 p.m. Surveyor asked R135 what she told RN-U about staff. R135 replied I said some of the girls are so mean and she (referring to RN-U) said someone else said that too. R135 informed Surveyor no one wants to say anything as they don't want to lose their jobs. Surveyor asked R135 if she told RN-U staff are rough. R135 replied oh yes. Surveyor asked R135 if she gave RN-U any names of staff who are rough. R135 replied oh no, she knows. On [DATE] at 7:43 a.m. Surveyor asked RN-U what R135 told her again about staff treatment. RN-U informed Surveyor [R135] told her staff was being rough with [R54]. Surveyor asked RN-U if she reported this to anyone. RN-U informed Surveyor she told the social worker about R135 saying staff was rough with R54. Surveyor asked RN-U when did she speak with the social worker. RN-U replied after I text the DON (Director of Nursing). Surveyor asked who the social worker is. RN-U replied [first name] of Social Worker-FF. On [DATE] at 8:57 a.m. Surveyor asked SW-FF if RN-U reported anything to her. SW-FF informed Surveyor she wrote up a concern & let the Administrator & Director of Nursing know. Surveyor asked what this was in regards to. SW-FF informed Surveyor it was regards to a specific resident not getting blood sugars done & giving insulin. Surveyor asked if RN-U reported anything else. SW-FF replied no. Surveyor asked SW-FF if RN-U reported anything about R135 or R54. SW-FF informed Surveyor all she remembers is [R23] and the insulin. Surveyor asked if RN-U reported to her R135 informed her staff was rough with her and R54. SW-FF informed Surveyor RN-U did not report this to her and now that she knows about it she will take action. SW-FF informed Surveyor RN-U told her about R23 when they were standing at the nurses station and may be got busy. SW-FF informed Surveyor she will probably walk out with Surveyor and talk to her administrator now. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 1:34 p.m. Surveyor spoke with Administrator-A regarding a concern that R135 reported to RN-U staff was rough. According to RN-U she reported this to SW-FF but when Surveyor spoke to SW-FF, SW-FF informed Surveyor RN-U had not reported this to her. Administrator-A informed Surveyor she was informed today by SW-FF and self reported the allegation today. Surveyor informed Administrator-A this allegation should have been reported to her on [DATE] and investigated.

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38146 Based on interview and record review the facility did not ensure a resident's discharge was completely assessed, evaluated and documented for 1 of 1 (R339) residents who were involuntarily discharged from the facility. R339 admitted to the facility on [DATE]. The facility was advised the next day, on 3/17/22, R339 was on the sexual offender registry. The facility discharged R339 back to the hospital on 3/18/22 after the facility became aware R339 was on the sexual offender registry. R339's medical record did not include the required regulatory documentation from R339's physician that included the following information: The specific needs that the facility could not meet for R339, the facility's attempt to meet R339's needs, and the services available at the receiving facility to meet the needs of R339. R339's medical record did not include documentation from R339's attending physician that R339's welfare and/or needs could not be met in the facility or that the safety and health of other residents were endangered. Findings include: R339 admitted to the facility on [DATE]. The facility was advised R339 was on the sexual offender registry on 3/17/22. The facility discharged R339 back to the hospital on 3/18/22. The facility policy titled: Admission to the Center dated revised September 2021 documents (in part) . .The center will only admit residents referred by written physician's order, if their needs can be met clinically. The admissions process is conducted in accordance with State and Federal requirements. Residents are admitted to the center without regard to race, color, national origin, age (unless specified in State regulations), religion, sex, gender identity, sexual orientation, disability, ancestry, marital or veteran status or payment source. Purpose: Provide uniform guidelines for the admission of residents to the center. Admit residents whose needs can be met by the center. Provide sufficient information to residents and/or resident's representatives about center services, the concern/grievance process, and resident and resident representative roles and responsibilities while in the center. The facility policy titled: Discharge Plan and Summary dated revised June 2018 documents (in part) . (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	.Policy: The facility will implement a discharge planning process that focuses on the resident's discharge goals and effectively prepares the resident for transition to post-discharge care. Purpose: To provide appropriate discharge plans that are specific and person centered. 5. If discharge to the community is determined not to be feasible, the discharge plan is updated to reflect the determination, the person making the determination and the reason(s) given. The option of remaining in the facility as a long term care resident will be reviewed. 6. The discharge plan is documented in the comprehensive care plan and must indicate: a. Where the resident plans to reside b. Any arrangements that have been made for follow up care c. Any required post-discharge medical and non-medical services Surveyor noted the policy did not include information related to involuntary discharge. Progress notes documented: 3/17/2022 3:19 PM Facility was informed this afternoon that resident is on the Sexual Offenders Registry. Review of location of nearby schools reveal that there are 2 elementary schools in close proximity to facility: 1 is 0.4 miles and the other is 1.4 miles away from facility and a high school 1.4 miles away from facility. Writer and SW (Social Worker) informed resident that we are not able to accommodate [resident] staying in facility d/t (due to) sexual offender status and close proximity of schools to facility. Resident also informed that [resident] will be transferred back to (hospital) which is where [resident] was prior to transfer to facility. Resident upset stating [resident] is no longer that person and that this will always follow [resident] around. RN (Registered Nurse) supervisor will call for ambulance transport. (Physician) updated by Admission and informed of need to transfer [resident] back to the hospital. He (physician) is in agreement. Hospital updated by Admissions of return of resident. 3/18/2022 9:30 AM Resident sent to [name of Hospital] via Bell Ambulance. On 3/23/22 at 11:00 AM Surveyor spoke with Admissions Coordinator-W who stated: Prior to admission, we look a the referral to see if we can clinically handle the resident medically and behaviorally. Surveyor asked if the facility does a background check or looks at the sex offender registry. Admissions Coordinator-W stated: We employ Central intake - they are people who work from home. They look at the national sex offender registry. If person is on the registry - we will send denial for admission. Surveyor confirmed with Admissions Coordinator-W the facility denies anyone on the registry and asked what is the basis of denial. Admissions Coordinator-W stated: What do you mean? Surveyor asked: if you deny anyone on the registry - what is the reasoning? Admissions Coordinator-W stated: I don't want to speak out of turn, I'll have to check the policy. We don't really come across this very often. Recently someone admitted without notification. They were on the registry, but we weren't notified. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/23/22 at 12:30 PM Surveyor spoke with Admissions Coordinator-W regarding discharge of R339. Admissions Coordinator-W stated: It was a resident [R339] .who is returning today. Surveyor asked Admissions Coordinator-W to explain the discharge of R339. Admissions Coordinator-W stated: [R339] was admitted to the facility. We were notified later that [R339] was on the sex offender registry. We were told by Corporate that [R339] could not stay here because we were too close to a school, and that was the offense - it involved a child. Surveyor asked what the facility did. Admissions Coordinator-W stated: [R339] was sent back to the hospital. [R339] was agreeable to go back. I called the hospital and they said they understood we could not keep [R339] here. Surveyor asked if the facility did any discharge planning, 30 day notice, behold information or Ombudsman notification? Admissions Coordinator-W stated: No. [R339] was here for a day and was sent back to the hospital. In the meantime [R339] ended up with a GI bleed in the hospital. I was looking at [R339] record and [R339] was admitted through the ER (emergency room) for leg pain, so we probably wouldn't have kept [R339] anyway, but I've been in contact with the social worker at the hospital and [R339] is due to come back today. On 3/24/22 at 9:05 AM Surveyor spoke with Social Worker (SW) Manager-V. SW-V stated: I got direction from administrator/corporate DON (Director of Nursing) together to meet with [R339] to advise [R339] we are close proximity to school and [R339] would not be able to stay. SW-V reported [R339] was Bummed but understood. SW-V stated: I just know there was a discussion with the higher ups. We were just updated this is what we're doing. There was a round table discussion regarding the specifics of the registry, and we tried to get information from the correctional officer. I do know [R339] was not mobile and was max 2 person assist for bed mobility, that's why [R339] couldn't go to [R339's] other placement until April - [R339] was basically bed bound. R339's admission assessment dated [DATE] documented: Confined to bed or chair. Non-weight bearing. Non-ambulatory. On 3/24/22 at 10:41 AM, DON-B reported the Division of Quality Assurance Regional Field Operations Director called last week, Basically asking what we were going to do regarding taking [R339] back. We spoke to [R339's] Probation officer. [R339] is being monitored, and probably will be forever. We determined [R339] is not at risk and [R339] was readmitted . On 3/29/22 at 11:05 AM Surveyor spoke with R339 in R339's room. R339 stated: With the first admission, they just came to me a couple days later and told me I couldn't stay here anymore. I didn't understand - it had all been approved through the DOC (Department of Corrections) and my PO (Parole Officer). They (facility) said they were sending me back to the hospital. I didn't have a choice, where else was I to go? I lost my apartment and I'm immobile now, so I was just like, OK - because they said I couldn't stay here. Surveyor asked what the hospital said when [R339] was sent back. R339 stated: I don't think they were happy. I was discharged . Now I was back like a day later for no reason. Surveyor confirmed [R339] was admitted back to the hospital. R339 stated: I don't think they had a choice, the nursing home wouldn't let me stay. Surveyor confirmed with R339 that R339 was not sent back to the hospital for medical reasons. R339 stated: No. Everything was going OK. Surveyor asked R339 is R339 had complications in the hospital of increased pain or Gastrointestinal bleed. R339 stated: No. What is that? I guess I had some blood in my stool, but it turned out it was just an ulcer, and I always have knee pain, ever since I went to the hospital. Surveyor asked if the facility asked R339 about conditions or specifics related to R339's supervision. R339 stated: No. I can't have any contact with minors. That shouldn't be a problem here, and besides that - I'm pretty much immobile. I don't understand what the problem is. I think they're just being prejudice. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/29/22 at 3:30 PM Nursing Home Administrator-A and Director of Nursing-B were advised of concern the facility did not ensure R339's involuntary discharge was completely assessed, evaluated and documented. No additional information was provided.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38146 Based on record review and interviews the facility did not ensure that 5 of 5 residents (R339, R92, R115, R11, and R62) reviewed for facility initiated transfers, received the written transfer notice with the date of transfer, reason for discharge, location of transfer and appeal rights. In addition, the facility did not notify the State Long Term Care Ombudsman of the residents' transfer/discharge. Findings include: The facility policy titled: Discharge Plan and Summary dated revised [DATE] documents (in part) . .Policy: The facility will implement a discharge planning process that focuses on the resident's discharge goals and effectively prepares the resident for transition to post-discharge care. Purpose: To provide appropriate discharge plans that are specific and person centered. 3. The resident is asked about his or her interest in receiving information regarding returning to the community and the resident's response is documented. If the resident indicates interest in returning to the community, any referrals to outside agencies are documented and the comprehensive care plan and the discharge plan are updated accordingly. 5. If discharge to the community is determined not to be feasible, the discharge plan is updated to reflect the determination, the person making the determination and the reason(s) given. The option of remaining in the facility as a long term care resident will be reviewed. 6. The discharge plan is documented in the comprehensive care plan and must indicate: a. Where the resident plans to reside b. Any arrangements that have been made for follow up care c. Any required post-discharge medical and non-medical services d. If long term placement is an appropriate alternative, the IDT (Interdisciplinary Team) will review placement with the resident and resident representative to assist with a smooth and safe transition. The resident's plan of care will be updated accordingly. 8. A final meeting with the resident and/or the resident's representative is scheduled to discuss post-discharge plans and arrangements. 9. Social service department arranges for post-discharge services. 1. R339 admitted to the facility on [DATE]. The facility was advised R339 was on the sexual offender registry on [DATE]. The facility discharged R339 back to the hospital on [DATE]. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 12:30 PM Surveyor spoke with Admissions Coordinator-W regarding discharge of R339. Admissions Coordinator-W stated: [R339] was admitted to the facility. We were notified later that [R339] was on the sex offender registry. We were told by Corporate that [R339] could not stay here because we were too close to a school, and that was the offense - it involved a child. Admissions Coordinator-W reported R339 was sent back to the hospital. [R339] was agreeable to go back. I called the hospital and they said they understood we could not keep [R339] here. Surveyor asked if the facility did any discharge planning, 30 day notice, behold information or Ombudsman notification. Admissions Coordinator-W stated: No. [R339] was here for a day and was sent back to the hospital. On [DATE] at 9:05 AM Social Worker (SW) Manager-V reported the facility did no discharge planning including written transfer notice with the date of transfer, reason for discharge, location of transfer, appeal rights and Long Term Care Ombudsman notification because the resident discharged so quickly. SW Manager-V stated: I got direction from administrator/corporate DON (Director of Nursing) together to meet with [R339] to advise [R339] we are close proximity to school and [R339] would not be able to stay. On [DATE] at 3:30 PM Nursing Home Administrator-A and DON-B were advised of concern the facility did not provide R339 with an involuntary discharge notice, to include written transfer notice with the date of transfer, reason for discharge, location of transfer and appeal rights In addition, the facility did not notify the State Long Term Care Ombudsman of the residents' transfer/discharge. No additional information was provided. 44063 2. R92 was admitted to the facility on [DATE] with diagnoses of chronic ulcer of lower leg, chronic venous hypertension with ulcer of bilateral lower extremity, lymphedema, anxiety disorder, peripheral vascular disease, and infection to the skin and subcutaneous tissue. R92's Quarterly MDS (Minimum Data Set) with an assessment reference date of [DATE], documents that R92 has a BIMS (Brief Interview for Mental Status) assessment score of 14 indicating R92 is cognitively intact for daily decision making. R92 is R92's own person. The nurse's SBAR (Situation, background, assessment and recommendation) Summary, dated [DATE], at 5:00 AM documents .Resident . seems to be gasping for air. 911 was called. Resident head lowered to floor and CPR started. Paramedics arrived and took over cares resident transported to Hospital. R92 was readmitted to the facility from the hospital on [DATE]. Surveyor reviewed R92's electronic medical record and was unable to locate any documentation that a transfer notice had been provided to R92. On [DATE] at 11:26 AM, Surveyor interviewed R92. R92 stated they did not remember receiving any transfer notification or communication from the facility after the hospital transfer. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. R115 was admitted to the facility on [DATE] with diagnoses of encephalopathy, absence of right leg below knee, Type 2 Diabetes, immunodeficiency, chronic kidney disease, paroxysmal atrial fibrillation and respiratory disorders. R115's Quarterly MDS (Minimum Data Set) with an assessment reference date of [DATE], documents that R115 has a BIMS (Brief Interview for Mental Status) assessment score of 13 indicating R115 is cognitively intact for daily decision making. R115 has a Healthcare Power of Attorney. The nurse's SBAR (Situation, background, assessment and recommendation) Summary, dated [DATE], at 4:32 PM documents MD updated writer that resident has positive blood cultures and to send resident back to Hospital. R115 was readmitted to the facility from the hospital on [DATE]. Surveyor reviewed R115's electronic medical record and was unable to locate any documentation that a transfer notice had been provided to R115 and/or R115's Healthcare Power of Attorney. On [DATE] at 11:40 AM, Surveyor interviewed R115. R115 was unsure if there were any transfer notices given to him or his POA. R115 stated he does not remember any communication from the facility after he left to go to the hospital, but he was allowed to return to the facility. 4. R11 was admitted to the facility on [DATE] with diagnoses of cerebral infarction, aphasia, Stage 2 Chronic Kidney disease, cellulitis, body mass index of 60XXX,d+[DATE].9 and paroxysmal atrial fibrillation. R11's Admission MDS (Minimum Data Set) with an assessment reference date of [DATE], documents that R11 has a BIMS (Brief Interview for Mental Status) assessment score of 15 indicating R11 is cognitively intact for daily decision making. R11 is R11's own person. R11 was sent out to the hospital on [DATE]. R11 was readmitted to the facility from the hospital on [DATE]. Surveyor reviewed R11's electronic medical record and was unable to locate any documentation that a transfer notice had been provided to R11. On [DATE] at 12:11 PM, Surveyor interviewed R11. R11 stated she believes she had a stroke in mid-January which is why she was sent to the hospital. R11 said it was all so confusing and doesn't remember anything. R11 remembers nothing about a transfer notice or any paperwork in fact at that time. 20483 5. R62's diagnoses includes cerebrovascular disease, history of urinary calculi and dementia. The nurses note dated [DATE] documents [name] from Dr. [name] office with day surgery called and asked writer about pt (patient) mental status. Was informed pt is alert and orientated times ,d+[DATE]. Responds to all questions without difficulty. She stated He is not answering questions and not looking at staff when talking to him. Writer informed her not his usual behavior. She stated we will observe him a little longer and see if changes. (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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The nurses note dated [DATE] documents [Name] RN (Registered Nurse) from day surgery called writer back and inform writer Pt noted with temp and still not responding appropriately sending to ER (emergency room) for eval (evaluation). The nurses note dated [DATE] documents Spoke with [name] RN at [name of hospital] and was updated on pts (patients) status Pt admitted with fever. R62 was readmitted to the facility on [DATE]. On [DATE] at 3:23 p.m. during the end of the day meeting with Administrator-A and DON (Director of Nursing)-B Surveyor asked who notifies the Ombudsman when a Resident is discharged or transferred to the hospital. Administrator-A indicated SWM (Social Worker Manager)-V. On [DATE] at 12:38 p.m. Administrator-A informed Surveyor there has been no Ombudsman notification. In reference to the above examples: On [DATE] at 3:37 PM, Surveyor asked Nursing Home Administrator(NHA)-A who handles transfer notices for residents discharged to the hospital and notifies the Ombudsman of the discharges to the hospital. NHA-A was not sure, but would get back to Surveyor. On [DATE] at 8:55 AM, NHA-A notified the Surveyor there were no transfer notices found and believes the Ombudsman may be notified by the Social Services Manager. On [DATE] at 11:04 AM, Surveyor interviewed Care Transition Advisor(CTA)-OO. CTA-OO stated she was not aware of any transfer notices being done for the residents who were sent to the hospital. CTA-OO was not notifying the Ombudsman and was unsure who would do the notifications. On [DATE] at 11:08 AM, Surveyor interviewed Admissions Coordinator-W. Admissions Coordinator-W stated she was not aware of any transfer notices being done for the residents who were sent to the hospital. Admissions Coordinator-W was not notifying the Ombudsman and was unsure who would do the notifications. On [DATE] at 9:20 AM, Surveyor interviewed Social Worker Manager-V. Social Worker Manager-V stated she was not notifying the ombudsman when a resident was discharged to the hospital. Social Worker Manager-V indicated that this notification was not being done since she started in June of 2019. Social Worker Manager-V discussed this with the NHA-A and will start doing the ombudsman notifications. On [DATE] at 12:15 PM, Surveyor notified the NHA-A that the above residents or their representative had not been provided a transfer notice when the residents were discharged to the hospital. Surveyor also shared that the ombudsman had not been notified of the transfers to the hospital. No further information was provided at this time.

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	525604	A. Building B. Wing	04/07/2022

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44063 Based on interview and record review, the facility did not ensure 7 (R93, R92. R115, R64, R11, R62, R339) of 7 residents reviewed were provided written notice of the facility's bed hold policy at the time of transfer or a written bed hold notice. Findings include: *R93 was transferred to the hospital on [DATE]. R93 and/or their representative was not provided written notification which specifies the bed hold policy at the time of transfer and not provided with a written bed hold notice. *R11 was transferred to the hospital on [DATE]. R11 and/or their representative was not provided written notification which specifies the bed hold policy at the time of transfer and not provided with a written bed hold notice. *R115 was transferred to the hospital on [DATE]. R115 and/or their representative was not provided written notification which specifies the bed hold policy at the time of transfer and not provided with a written bed hold notice. *R92 was transferred to the hospital on [DATE]. R92 and/or their representative was not provided written notification which specifies the bed hold policy at the time of transfer and not provided with a written bed hold notice. *R64 was transferred to the hospital on [DATE]. R64 and/or their representative was not provided written notification which specifies the bed hold policy at the time of transfer and not provided with a written bed hold notice. *R62 was transferred to the hospital on [DATE]. R62 and/or their representative was not provided written notification which specifies the bed hold policy at the time of transfer and not provided with a written bed hold notice. *R339 was transferred to the hospital on [DATE]. R339 and/or their representative was not provided written notification which specifies the bed hold policy at the time of transfer and not provided with a written bed hold notice. The facility's policy dated as revised [DATE] is titled Bed Hold/Leave of Absence and documents (in part) the following: Policy. The facility provides written notification of the bed hold/leave of absence policy to all residents and/or responsible parties upon admission, and at the time of leave of absence or transfer, in accordance with Federal and State regulations. Procedure. Bed Hold Notification. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. Upon admission or Leave of Absence, a facility designee will provide the resident and/or responsible party written information concerning the option to exercise the Bed Hold/Leave of Absence policy. b. Upon Leave of Absence, a Bed Hold Authorization form is distributed to the resident and/or responsible party. 2. The Bed Hold Authorization form will include the Bed Hold Rate and the Bed Hold Days (if applicable). 3. A copy of the Bed Hold Authorization form must be sent with the resident at the time of transfer. In case of emergency transfer, written notice to the resident and/or responsible party is provided within 24 hours of the transfer. 4. A Bed Hold Authorization form will be issued to the resident and/or responsible party if the State Medicaid Plan or the facility's policy changes. 5. Payment inquires concerning the Bed Hold are referred to the Business Office. 6. Census information regarding Bed Hold is updated in the AR system. 1. R93 was admitted to the facility on [DATE] with diagnoses of encephalopathy, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, frontal lobe and executive function deficit following cerebral infarction, immunodeficiency, gastrostomy status, pressure ulcer of sacral region, heart failure and Type 2 diabetes. R93's Quarterly MDS (Minimum Data Set) with an assessment reference date of [DATE] documents that R93 has a BIMS (Brief Interview for Mental Status) score of 00 indicating R93 demonstrates severe cognitive impairment for daily decision making. R93 has a Healthcare Power of Attorney. The nurse's note, dated [DATE], at 3:48 PM documents Patient was sent out to [Hospital] ER (emergency room) per family's request. Patient left at 3:40 PM with ambulance personnel. R93 was readmitted to the facility from the hospital on [DATE]. Surveyor reviewed R93's electronic medical record and was unable to locate any documentation that a bed hold notice had been provided to R93 and R93's representative. R93 was not interviewable due to severe cognitive impairment. On [DATE] at 3:37 PM, Surveyor asked Nursing Home Administrator(NHA)-A who handles the bed hold notices for residents discharged to the hospital. NHA-A was not sure, but would get back to Surveyor. On [DATE] at 8:55 AM, NHA-A notified the Surveyor there were no bed hold notices found. On [DATE] at 11:04 AM, Surveyor interviewed Care Transition Advisor(CTA)-OO. CTA-OO stated she was not aware of any bed hold notices being done for the residents who were sent to the hospital. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 11:08 AM, Surveyor interviewed Admissions Coordinator-W. Admissions Coordinator-W stated she was not aware of any bed hold notices being done for the residents who were sent to the hospital. Admissions Coordinator-W was unsure who would do the bed hold notifications. On [DATE] at 12:15 PM, Surveyor notified the NHA-A that R93 and/or R93's representative had not been provided a bed hold notice when discharged to the hospital on [DATE]. No further information was provided at this time. 2. R92 was admitted to the facility on [DATE] with diagnoses of chronic ulcer of lower leg, chronic venous hypertension with ulcer of bilateral lower extremity, lymphedema, anxiety disorder, peripheral vascular disease, and infection to the skin and subcutaneous tissue. R92's Quarterly MDS (Minimum Data Set) with an assessment reference date of [DATE], documents that R92 has a BIMS (Brief Interview for Mental Status) assessment score of 14 indicating R92 is cognitively intact for daily decision making. R92 is R92's own person. The nurse's SBAR (Situation, background, assessment and recommendation) Summary, dated [DATE], at 5:00 AM documents .Resident .seem to be gasping for air. 911 was called. Resident head lowered to floor and CPR started. Paramedics arrived and took over cares resident transported to Hospital. R92 was readmitted to the facility from the hospital on [DATE]. Surveyor reviewed R92's electronic medical record and was unable to locate any documentation that a bed hold notice had been provided to R92. On [DATE] at 11:26 AM, Surveyor interviewed R92. R92 stated they did not remember receiving any bed hold notification or communication from the facility after the hospital transfer. On [DATE] at 3:37 PM, Surveyor asked Nursing Home Administrator(NHA)-A who handles bed hold notices for residents discharged to the hospital. NHA-A was not sure, but would get back to Surveyor. On [DATE] at 8:55 AM, NHA-A notified the Surveyor there were no bed hold notices found. On [DATE] at 11:04 AM, Surveyor interviewed Care Transition Advisor(CTA)-OO. CTA-OO stated she was not aware of any bed hold notices being done for the residents who were sent to the hospital. CTA-OO was unsure who would do the notifications. On [DATE] at 11:08 AM, Surveyor interviewed Admissions Coordinator-W. Admissions Coordinator-W stated she was not aware of any bed hold notices being done for the residents who were sent to the hospital. Admissions Coordinator-W was unsure who would do the notifications. On [DATE] at 12:15 PM, Surveyor notified the NHA-A that R92 and R92's representative had not been provided a bed hold notice when discharged to the hospital on [DATE]. No further information was provided at this time. 3. R115 was admitted to the facility on [DATE] with diagnoses of encephalopathy, absence of right leg below knee, Type 2 Diabetes, immunodeficiency, chronic kidney disease, paroxysmal atrial fibrillation and respiratory disorders. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R115's Quarterly MDS (Minimum Data Set) with an assessment reference date of [DATE], documents that R115 has a BIMS (Brief Interview for Mental Status) assessment score of 13 indicating R115 is cognitively intact for daily decision making. R115 has a Healthcare Power of Attorney. The nurse's SBAR (Situation, background, assessment and recommendation) Summary, dated [DATE], at 4:32 PM documents MD updated writer that resident has positive blood cultures and to send resident back to Hospital. R115 was readmitted to the facility from the hospital on [DATE]. Surveyor reviewed R115's electronic medical record and was unable to locate any documentation that a bed hold notice had been provided to R115 and R115's Healthcare Power of Attorney. On [DATE] at 11:40 AM, Surveyor interviewed R115. R115 was unsure if there were any bed hold notices given to him or his POA. R115 stated he does not remember any communication from the facility after he left to go to the hospital, but he was allowed to return to the facility. On [DATE] at 3:37 PM, Surveyor asked Nursing Home Administrator(NHA)-A who deals with bed hold notices for residents discharged to the hospital. NHA-A was not sure, but would get back to Surveyor. On [DATE] at 8:55 AM, NHA-A notified the Surveyor there were no bed hold notices found. On [DATE] at 11:04 AM, Surveyor interviewed Care Transition Advisor(CTA)-OO. CTA-OO stated she was not aware of any bed hold notices being done for the residents who were sent to the hospital. CTA-OO was unsure who would do the notifications. On [DATE] at 11:08 AM, Surveyor interviewed Admissions Coordinator-W. Admissions Coordinator-W stated she was not aware of any bed hold notices being done for the residents who were sent to the hospital. Admissions Coordinator-W was unsure who would do the notifications. On [DATE] at 12:15 PM, Surveyor notified the NHA-A that R115 and/or R115's representative had not been provided a bed hold notice when discharged to the hospital on [DATE]. No further information was provided at this time. 4. R 64 was admitted to the facility on [DATE] with diagnoses of Paroxysmal atria fibrillation, encephalopathy, hepatic failure, cirrhosis of liver, Type 2 Diabetes, Chronic Kidney Disease Stage 5 with dependence on renal dialysis, moderate protein-calorie malnutrition and respiratory disorders. R64's Admission MDS (Minimum Data Set) with an assessment reference date of [DATE], documents that R64 has a BIMS (Brief Interview for Mental Status) assessment score of 15 indicating R64 is cognitively intact for daily decision making. R64 is R64's own person. The nursing note, dated [DATE], at 4:21 PM documents At 4:15 PM Patient left with ambulance personnel via stretcher. Face sheet and MAR (Medication Administration Record) printed and given to Paramedic. Reason for wife to call for ambulance is unknown. Today was the first dialysis treatment has been to in one week. Will notify Doctor's office. R64 was readmitted to the facility from the hospital on [DATE]. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Surveyor reviewed R64's electronic medical record and was unable to locate any documentation that a bed hold notice had been provided to R64. On [DATE] at 10:05 AM, Surveyor interviewed R64. R64 stated they did not remember receiving any thing from the facility after the hospital transfer. R64 stated his spouse deals with all the paperwork. On [DATE] at 3:37 PM, Surveyor asked Nursing Home Administrator(NHA)-A who handles bed hold notices for residents discharged to the hospital. NHA-A was not sure, but would get back to Surveyor. On [DATE] at 8:55 AM, NHA-A notified the Surveyor there were no bed hold notices. On [DATE] at 11:04 AM, Surveyor interviewed Care Transition Advisor(CTA)-OO. CTA-OO stated she was not aware of any bed hold notices being done for the residents who were sent to the hospital. CTA-OO was unsure who would do the notifications. On [DATE] at 11:08 AM, Surveyor interviewed Admissions Coordinator-W. Admissions Coordinator-W stated she was not aware of any bed hold notices being done for the residents who were sent to the hospital. Admissions Coordinator-W was unsure who would do the notifications. On [DATE] at 12:15 PM, Surveyor notified the NHA-A that R64 had not been provided a bed hold notice when discharged to the hospital on [DATE]. No further information was provided at this time. 5. R11 was admitted to the facility on [DATE] with diagnoses of cerebral infarction, aphasia, Stage 2 Chronic Kidney disease, cellulitis, body mass index of 60XXX,d+[DATE].9 and paroxysmal atrial fibrillation. R11's Admission MDS (Minimum Data Set) with an assessment reference date of [DATE], documents that R11 has a BIMS (Brief Interview for Mental Status) assessment score of 15 indicating R11 is cognitively intact for daily decision making. R11 is R11's own person. R11 was sent out to the hospital on [DATE]. R11 was readmitted to the facility from the hospital on [DATE]. Surveyor reviewed R11's electronic medical record and was unable to locate any documentation that a bed hold notice had been provided to R11. On [DATE] at 12:11 PM, Surveyor interviewed R11. R11 stated she believes she had a stroke in mid-January which is why she was sent to the hospital. R11 said it was all so confusing and doesn't remember anything. R11 remembers nothing about a bed hold notice or any paperwork in fact at that time. R11 was upset that the facility did not discuss the bed hold policy with her as R11 stated she would like to know her rights. On [DATE] at 3:37 PM, Surveyor asked Nursing Home Administrator(NHA)-A who handles bed hold notices for residents discharged to the hospital. NHA-A was not sure, but would get back to Surveyor. On [DATE] at 8:55 AM, NHA-A notified the Surveyor there were no bed hold notices found. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 11:04 AM, Surveyor interviewed Care Transition Advisor(CTA)-OO. CTA-OO stated she was not aware of any bed hold notices being done for the residents who were sent to the hospital. CTA-OO was unsure who would do the notifications. On [DATE] at 11:08 AM, Surveyor interviewed Admissions Coordinator-W. Admissions Coordinator-W stated she was not aware of any bed hold notices being done for the residents who were sent to the hospital. Admissions Coordinator-W was unsure who would do the notifications. On [DATE] at 12:15 PM, Surveyor notified the NHA-A that R11 and/or R11's representative had not been provided a bed hold notice when discharged to the hospital on [DATE]. No further information was provided at this time. 20483 6. R62's diagnoses includes cerebrovascular disease, history of urinary calculi and dementia. R62 has an activated power of attorney for healthcare. The nurses note dated [DATE] documents [name] from Dr. [name] office with day surgery called and asked writer about pt (patient) mental status. Was informed pt is alert and orientated times ,d+[DATE]. Responds to all questions without difficulty. She stated He is not answering questions and not looking at staff when talking to him. Writer informed her not his usual behavior. she stated we will observe him a little longer and see if changes. The nurses note dated [DATE] documents [Name] RN (Registered Nurse) from day surgery called writer back and inform writer Pt noted with temp and still not responding appropriately sending to ER (emergency room) for eval (evaluation). The nurses note dated [DATE] documents Spoke with [name] RN at [name of hospital] and was updated on pts (patients) status Pt admitted with fever. R62 was readmitted to the facility on [DATE]. Surveyor was unable to locate R62 and R62's power of attorney received written notification of the bed hold policy in R62's electronic or paper medical record. On [DATE] at 3:27 during the end of the day meeting with the Facility a Surveyor asked where bed hold notices could be located. Administrator-A indicated she needs to look into this and will get back to surveyors. On [DATE] at 12:38 p.m. Surveyor asked Administrator-A if she had any information regarding bedhold for R62 who went to the hospital in December. Administrator-A informed Surveyor there isn't a bed hold notice for this date and indicated they are going back and doing them if a Resident was discharged in the last 30 days. 38146 7. R339 admitted to the facility on [DATE]. The facility was advised R339 was on the sexual offender registry on [DATE]. The facility discharged R339 back to the hospital on [DATE]. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 12:30 PM Surveyor spoke with Admissions Coordinator-W regarding R339's discharge. Admissions Coordinator-W stated: R339 was admitted to the facility. We were notified later that [R339] was on the sex offender registry. We were told by Corporate that [R339] could not stay here because we were too close to a school, and that was the offense - it involved a child. Admissions Coordinator-W reported [R339] was sent back to the hospital. Surveyor asked if the facility did any discharge planning, 30 day notice, bed hold information or Ombudsman notification. Admissions Coordinator-W stated: No. [R339] was here for a day and was sent back to the hospital. On [DATE] at 9:05 AM Social Worker (SW) Manager-V reported the facility did no discharge planning, including bed hold information, because the resident discharged so quickly. SW-V stated: I got direction from administrator/corporate DON (Director of Nursing) together to meet with [R339] to advise [R339] we are close proximity to school and [R339] would not be able to stay. On [DATE] at 3:30 PM Nursing Home Administrator-A and DON-B were advised of concern the facility did not provide R339 the necessary regulatory information regarding bedhold in regards to her involuntary discharge.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 20483 Based on observation, interview and record review the Facility did not ensure 1 (R62) of 4 dependent residents reviewed received the necessary services to carry out their activities of daily living. R62 was observed with long finger nails and had not been shaved for multiple days. Findings include: R62's diagnoses includes cerebrovascular disease and dementia. The quarterly MDS (minimum data set) with an assessment reference date of 1/26/22 documents a BIMS (brief interview mental status) score of 8 which indicates moderately impaired. R62 is not coded as having any behavior including refusal of care. R62 requires extensive assistance with one person physical assist for personal hygiene. On 3/22/22 at 2:07 p.m. Surveyor observed R62 in bed on his back with the head of the bed elevated wearing a gown. Surveyor observed R62's finger nails are very long and asked R62 if he likes his finger nails long or would like them shorter. R62 replied shorter. Surveyor also observed R62 with facial hair stubbles and asked R62 if he likes facial hair or would like to be shaved. R62 informed Surveyor he would like to be shaved. On 3/23/22 at 8:02 a.m. Surveyor observed R62 in bed on his back asleep with the head of the bed elevated and Fibersource tube feeding running at 65 cc (cubic centimeters). Surveyor observed R62's finger nails are still long and he has not been shaved. On 3/23/22 at 3:23 p.m. during the end of the day meeting with the Facility Surveyor informed Administrator-A and DON (Director of Nursing)-B Surveyor noted R62 listed on the grievance log on 12/10/21 and would like to see this grievance. On 3/24/22 at 9:10 a.m. Surveyor observed R62 in bed on his back with the head of the bed elevated and Fibersource tube feeding running at 65 cc. Surveyor observed R62's finger nails are still long with dirt under the nails and long stubble on his face and under his chin. On 3/24/22 Surveyor reviewed R62's concern decision form for date concern received of 12/10/21. Under concern summary documents Finger nails need to be cut. and under summary of findings documents Nursing completed nail care. On 3/28/22 at 12:32 p.m. Surveyor observed R62 in bed on his back with the head of the bed elevated. R62's tube feeding of Fibersource is running at 65 cc. Surveyor observed R62's finger nails are still long and he has not been shaved. Surveyor asked R62 if he would like his nails cut. R62 shook his head yes. Surveyor then asked if he would like to be shaved. R62 shook his head yes. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/28/22 at 12:33 p.m. Surveyor asked RN (Registered Nurse)-U who cuts Resident's finger nails. RN-U replied RCS (Resident Care Specialist) Surveyor asked if RCS were CNA's (Certified Nursing Assistant). RN-U replied yes and explained unless the Resident was diabetic. Surveyor asked if the CNA's would also shave Residents. RN-U replied yes. At 12:34 p.m. Surveyor asked RN-U if RN-U could accompany Surveyor to R62's room. RN-U informed Surveyor she did notice this morning he needs to be shaved. Surveyor asked RN-U if she noticed R62's finger nails. RN-U indicated she didn't. At 12:37 p.m. RN-U accompanied Surveyor to R62's room. Surveyor showed RN-U R62's finger nails. RN-U informed Surveyor they are very long and will see if she can get a RCS (CNA) to cut them. On 3/28/22 at 3:42 p.m. Surveyor informed Administrator-A and DON (Director of Nursing)-B of R62's finger nails long and has not been shaved for multiple days. On 3/28/22 at 4:13 p.m. Surveyor went to R62's room to check to see if staff had cut R62's finger nails and shaved him. Surveyor observed R62's finger nails are still long and he has not been shaved. On 3/28/22 at 4:21 p.m. Surveyor telephoned POA (Power of Attorney)-X and left a message requesting a call back. On 3/28/22 at 7:09 p.m. Surveyor spoke with POA-X on the telephone. Surveyor asked POA-X if R62 prefers to be clean shaven. POA-X informed Surveyor her grandfather always had just a moustache and the rest was clean shaven. POA-X stated just a moustache. POA-X informed Surveyor his finger nails have been horrible and she has had a problem with staff not cutting his finger nails. POA-X informed Surveyors she doesn't want her grandfather's finger nails too long as she is afraid he will scratch himself and he is on blood thinners. On 3/29/22 at 9:29 a.m. Surveyor observed R62 in bed on his back. R62's finger nails have been cut and he has been shaved.

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20025 Based on interview and record review, the facility did not have a system to ensure that there was someone working each shift who was certified in CPR (cardiopulmonary resuscitation, which had the potential to affect 93 of 144 residents who are full code. The facility did not immediate basic life support, including Cardio Pulmonary Resuscitation (CPR) to 1(R188) of 2 residents who was unresponsive. On [DATE] during the night shift, R188 was found unresponsive by Certified Nursing Assistant (CNA) L. CNA L told Registered Nurse (RN) H about R188 being unresponsive and RN H did not immediately perform life saving measures. RN H did not assess R188's breathing or pulse. RN H did not use the paging system for assistance, but instead went to a different unit to get Assistant Director of Nursing (ADON) K to assist. Agency Licensed Practical Nurse (LPN) AA was told R188 needed CPR. Agency LPN AA checked R188's breathing and found him to not be breathing and began CPR. The facility's failure to immediately perform basic life support when R188 was found unresponsive and the failure to have a system that ensured each shift had CPR-certified staff created a finding of immediate jeopardy that began on [DATE]. Surveyor notified Nursing Home Administrator (NHA) A of the immediate jeopardy on [DATE] at 12:00 p.m. The immediate jeopardy was removed on [DATE] however, the deficient practice continues at a scope/severity of E (potential for harm/pattern) as the facility continues to implement its action plan. Findings include: The facility's policy Medical Emergency Management with revised date of February 2017 indicates: The facility ensures residents receive timely and appropriate interventions in the event of a medical emergency. The staff takes actions to ensure that the resident's airway, breathing, and circulation are maintained until emergency personnel arrive. Staff is aware of each resident's physician's orders and advance directives prior to the administration of cardio-pulmonary resuscitation. Guidelines: 1. Licensed nursing staff in the facility must obtain their CPR certification during their probationary period and keep their certification current during their employment. It is recommended that unlicensed staff that provide direct resident care also maintain a current CPR certification. 4. The facility will maintain an Automated External Defibrillator (AED) if required by state regulation. (continued on next page)

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	525604	A. Building B. Wing	04/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southpointe Care and Rehab Center LLC	4500 W Loomis Rd Greenfield, WI 53220

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	5. Once a medical emergency is identified, qualified staff assesses the resident, initiate the appropriate emergency procedure (s) in accordance with physician's orders and/or the resident's advance directive, and calls 911. The staff continues to provide care and monitor the resident until the emergency personnel arrive. 1.) R188 was admitted to the facility on [DATE] with diagnoses of surgical repair of left femur fracture, type 2 diabetes, morbid obesity, sleep apnea, atrial fibrillation and hypertension. The admission MDS (minimum data set) dated [DATE] indicates R188 is alert and cognitively intact, needs extensive assistance of two staff for bed mobility and hygiene. It also indicates R188 had a urinary catheter due to urinary retention. R188 was full-code. The nurses note dated [DATE] at 5:46 a.m. indicates: RN called to room per CNA (certified nursing assistant) during rounding. observed resident unresponsive. 911 called immediately. CPR (cardiopulmonary resuscitation) initiated. (Physician) paged. ADON (assistant director of nursing) updated. Surveyor reviewed the facility self report dated [DATE] which includes RN H's statement indicating: found patient had a change in status. She called the doctor (paged X 2). Called 911 immediately, as the patient was a full code. (RN) reviewed the chart and found 0 family contacts. While awaiting 911 to come, all necessary documents were printed. DON (Director of Nursing)/NHA were notified. ADON (who was in the building) was notified . RN H completed an SBAR (situation, background, assessment and recommendation) dated [DATE]. The SBAR indicates RN H was called to R188's room per CNA L. RN H observed resident to be unresponsive. 911 called immediately. The SBAR had vital signs dated [DATE]. The SBAR had the following conditions to assess during a change in condition: Mental status changes, Functional status changes, respiratory, GI/abdomen and GU/urinary changes. RN had marked NA for all changes. The SBAR assessment section asks the nurse completing the SBAR for an assessment of what may be the problem with the patient and RN did not complete an assessment and only wrote called 911 immediately. The facility self report does not have any other staff statements. The facility self report does not indicate who began CPR and when R188 was assessed to need CPR. On [DATE] at 9:00 a.m. Surveyor interviewed Paramedic I. Paramedic I stated the rescue squad arrived at the facility on [DATE] at 5:11 a.m. and arrived at the resident's bedside at 5:13 a.m. Paramedic I stated when they arrived at the resident's bedside, the facility staff were performing CPR. Paramedic I stated they let the facility staff continue with CPR until rescue squad got their equipment ready to take over CPR. Paramedic I stated R188 remained asystole (state of total cessation of electrical activity from the heart) through the whole call. Paramedic I stated they pronounced R188 dead at the facility with the permission of their medical director. Paramedic I stated R188 had all signs of death. On [DATE] at 8:09 AM Surveyor interviewed CNA L. CNA L stated she worked the night shift on [DATE] into [DATE]. CNA L stated she's not sure about the time but about 3 or 4 am CNA L went into R188's room to empty out his catheter and saw R188 had turned a different color. CNA L immediately told RN H. CNA L stated RN H went to look for ADON K for help. CNA L stated she did not participate in CPR only doing rounds on the rest of the residents on the unit. (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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On [DATE] at 10:32 a.m. Surveyor interviewed RN H. RN H stated she remembers that day because it was the worse night of my nursing career. Surveyor asked RN H when was she made aware R188 was unresponsive. RN H stated about 5:00 a.m. CNA L told her R188 was unresponsive. Surveyor asked RN H what specifically did CNA L tell her about R188's condition. RN H said CNA L told her R188 was unresponsive. RN H stated she immediately went to R188's room and saw he was unresponsive. Surveyor asked RN H what did R188 look like. RN H stated he just looked unresponsive. Surveyor asked if RN H did an assessment, RN H stated no she did not because he looked like he needed 911. RN H stated she then ran down the hall to the Rehab unit to get ADON K. RN H stated ADON K and an agency nurse from another unit went to R188 to perform CPR and RN H called 911. Surveyor asked RN H at 5:00 a.m. when she found R188 unresponsive, did R188 have his CPAP on. RN H stated she doesn't remember. At no point during the interview did RN H explain why basic life support wasn't started immediately when R188 was found unresponsive. Surveyor asked RN H if she had a current CPR certification card. RN H stated her CPR certification expires in [DATE]. On [DATE] at 9:02 AM Surveyor interviewed ADON K. ADON K stated she was on the rehab unit and R188 was on LTC 1 unit. RN H came from LTC 1 to rehab unit to tell ADON K that R188 was unresponsive. Surveyor asked ADON K approximately how long does it take to go from LTC 1 unit to the Rehab unit where ADON K was located. ADON K indicated it would be at least a minute each way. ADON K stated she went to R188's room and saw R188 wasn't breathing. ADON K stated R188's lips were purple in color and there was foam around his mouth. ADON K stated his CPAP was not on. ADON K stated they started CPR and another nurse called 911. Surveyor asked ADON K if there was a paging system when there is a code situation. ADON K stated (incorrectly) there isn't a paging system which is why RN H had to walk to get help. On [DATE] at 12:50 p.m. Surveyor interviewed Agency LPN AA. Agency LPN AA stated on [DATE] she doesn't remember who told her but she was made aware of R188 needing CPR. Agency LPN AA stated when she arrived to R188's room with a medication tech (doesn't remember the name of the med tech), Agency LPN AA saw R188 laying on his back, his right arm hanging off the side of the bed and his eyes closed. Agency LPN AA listened for R188's breath sounds and didn't hear anything so immediately started CPR with the assistance of the medication tech. Agency LPN AA stated ADON K came into the room shortly and took over for the medication tech. Agency LPN AA stated RN H did not participate in the code situation. Agency LPN AA stated RN H called 911. Agency LPN AA stated R188 did not have his CPAP on and heard that he sometimes was noncompliant with putting it on. Agency LPN AA stated she and RN H continued with CPR until the paramedics arrived. The facility staff did not begin CPR immediately upon finding R188 unresponsive. RN H did not use the paging system but, instead, went to another unit to find a nurse to assist. According to a 2019 Division of Appeals Board (DAB) hearing decision, The driving force behind the American Heart Association guidelines . and regulatory requirements is that CPR must be initiated immediately when a full code resident is found to be nonresponsive. Time is of the essence in initiating CPR. Any delay endangers a nonresponsive individual's safety and his or her life. With CPR, seconds may mean the difference between resuscitation and death. https://www.hhs.gov/about/agencies/dab/decisions/alj-decisions/2019/alj-cr5339/index.html 2.) The total facility census was 144 and total of 93 residents had a full code status at the time of the survey. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On [DATE] at 9:52 AM Surveyor asked NHA A for a list of all nursing staff and their CPR certification status. NHA A stated HR (human resources) has not been keeping track of staff's CPR certification status. On [DATE] at 12:16 PM, Surveyor interviewed Director of Nursing (DON)-B. DON-B stated every nurse should be CPR certified, but DON-B was not sure if they were or not since the facility has not been tracking that data. DON-B stated it is unknown which staff are or are not certified when they are scheduled to work at this time. DON-B hopes to have CPR training here within the next few days. Subsequently, NHA A gave Surveyor a copy of Agency LPN AA and ADON K CPR certification card. Agency LPN AA's CPR Certification expires [DATE]. ADON K's CPR certification expires [DATE]. The facility was unable to verify the certification status of Registered Nurse (RN) D who successfully provided CPR to R92 on [DATE] when R92 was found unresponsive. Surveyor reviewed RN H personnel file and there wasn't any evidence of a CPR card being obtained at the time of hire. Surveyor reviewed the Facility Assessment which indicates licensed nurses are to annually update their CPR certification. The facility assessment indicates this was reviewed in QAPI (quality assurance performance improvement) on [DATE]. On [DATE] at 10:30 a.m. Surveyor spoke with NHA A. Surveyor explained to NHA A the concern R188 was found unresponsive and an immediate assessment of R188's breathing or pulse was not done. RN H went to a different unit to get another nurse to help. Immediate action was not done when R188 was found unresponsive. Surveyor also explained the concern the facility has no record of their nursing staff CPR certification and no system on keeping track of CPR certification. These failures created a reasonable likelihood that serious harm could occur, thus creating a finding of immediate jeopardy. The facility removed the jeopardy on [DATE], when it had completed the following: ~ The Medical Director was contacted by the NHA A and advised of deficiency on [DATE]. ~ The Human Resource Director audited licensed nursing staff employee files to determine CPR status. Copy of CPR cards were verified with each licensed nurse and if CPR status is not current employee to be provided with CPR certification class information. ~ An in facility CPR certification class to be held Wednesday, [DATE]. ~ The Human Resource Director will be educated on requirements for mandatory CPR education for licensed nursing staff. Human Resource Director will be responsible for verifying nursing CPR status prior to beginning employment and maintaining current licensed nursing staff CPR status. Copy of CPR cards will be placed in employee files and list expiration dates monitored by Human Resource Director. ~ All licensed nursing staff was educated by the Nurse Manager related to the requirement to maintain an up to date CPR certification at all times while employed at the facility. ~ All licensed nursing staff was educated on the procedure of handling a change of condition and what to do in an emergent situation to avoid delay in treatment. See steps below: (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	If licensed staff/ RCS (CNA) notices change in condition: If RCS (Resident Care Staff/CNA), they would verbally advise licensed staff member of change. If licensed staff member notices the change with the resident, they would follow the following steps: - Call for help verbally and pull call light - CODE BLUE announced through paging system - Chart/PCC would be checked for code status - 911 called - Physician and RP notified regarding change of condition - Based on resident's CPR status, CPR is initiated immediately and continued until 911 arrives. ~ Education was completed. ~ The Scheduler will be provided with a list of current CPR certified licensed nursing staff to ensure at least one CPR certified nurse is working each shift. ~ HRM (Human Resources Manager) or designee audited new licensed nurse employee files weekly to ensure CPR status is verified. ~ DON or designee audited list of CPR certified staff weekly to ensure CPR status is being maintained and review any upcoming expiration dates. ~ DON or designee audited licensed nursing schedules daily (M-F) x 2 weeks to ensure at least one CPR certified licensed nurse is working. 44063

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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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20025 Based on interview and record review the facility did not ensure 1 (R188) of 1 resident experiencing a change in condition and eventually becoming unresponsive received the necessary RN assessment to prevent further decline. On [DATE] into [DATE] during the night shift, R188 experienced a change in condition. R188 was having vomiting episodes and Certified Nursing Assistant (CNA) L twice notified Registered Nurse (RN) H. RN H did not assess R188. Around 5:00 a.m. R188 was found unresponsive; an assessment still was not completed and R188 died at the facility. The facility's failure to assess R188 immediately after the change in condition and after being found unresponsive created a finding of immediate jeopardy that began on [DATE]. Surveyor notified Nursing Home Administrator (NHA) A of the immediate jeopardy on [DATE] at 12:00 p.m. The facility removed the jeopardy on [DATE]. However, the deficient practice continues at a scope/severity of an E (potential for harm/pattern) as the facility continues to implement its action plan. Findings include: Facility policy regarding Changes in Resident Condition with revision date [DATE] indicate: The nursing staff, the resident, the attending physician and the resident's legal representative are notified when changes in the resident's condition occur. Communication with the Interdisciplinary Team and caregivers is also important to ensure that consistency and continuity are maintained for the resident's benefit. Guidelines: 1. For life-threatening events, call 911 if initial assessment indicates that such action is necessary 4. The SBAR communication form and the progress note are used to a. assess and document changes in condition in an efficient and effective manner; b. Provide assessment information to the physician, and c. Provide clear comprehensive documentation Professional standards of practice for a registered nurse in Wisconsin are delineated in N6, Wisconsin Nurse Practice Act. According to N6, Wisconsin Nurse Practice Act: (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An R.N. shall utilize the nursing process in the execution of general nursing procedures in the maintenance of health, prevention of illness or care of the ill. The nursing process consists of the steps of assessment, planning, intervention and evaluation. This standard is met through performance of each of the following steps of the nursing process: (a) Assessment. Assessment is the systematic and continual collection and analysis of data about the health status of a patient culminating in the formulation of a nursing diagnosis. (b) Planning. Planning is developing a nursing plan of care for a patient which includes goals and priorities derived from the nursing diagnosis. (c) Intervention. Intervention is the nursing action to implement the plan of care by directly administering care or by directing and supervising nursing acts delegated to L.P.N.'s (Licensed Practical Nurse) or less skilled assistants. (d) Evaluation. Evaluation is the determination of a patient's progress or lack of progress toward goal achievement which may lead to modification of the nursing diagnosis. R188 was admitted to the facility on [DATE] with diagnoses of surgical repair of left femur fracture, Type 2 diabetes, morbid obesity, sleep apnea, atrial fibrillation and hypertension. The admission MDS (minimum data set) dated [DATE] indicates R188 was alert and cognitively intact, needed extensive assistance of two staff for bed mobility and hygiene. It also indicates R188 had a urinary catheter due to urinary retention. The nurses note dated [DATE] 11:41 p.m. indicates UA (urinary analysis) obtained. C and S (culture and sensitivity) pending. Slight bleeding from penis. Has new foley. Is obese. Keeps pulling on tube. Cranberry juice encouraged. Ate 100 percent. No sob (shortness of breath). No n/v (nausea/vomiting). vss (vital signs stable). The nurses note dated [DATE] at 4:15 a.m. indicate observed resting comfortably in bed. UA was sent per lab pick up. no c/o (complaints of) pain or discomfort. foley intact. monitored for bleeding. call light in reach at all times. This nurses note was written by RN H. On [DATE] at 8:09 AM Surveyor interviewed CNA L. CNA L stated she worked the night shift on [DATE] into [DATE]. CNA L stated sometime earlier in her shift (not sure the time) R188 was vomiting and he had his CPAP (continuous positive airway pressure device) off at the time. CNA L stated R188 asked her to let the nurse know he was vomiting. CNA L stated she told RN H R188 had vomited. CNA L stated RN H just said ok. CNA stated she was doing her rounds and about 2 am R188 had his call light on. CNA L answered R188's call light. R188 had vomited again, and CNA L cleaned the basin. CNA L stated R188 asked again if she told the nurse. CNA L stated she told R188 she did tell the nurse. CNA L stated she told RN H again that R188 had vomited again. CNA L stated she's not sure about the time but about 3 or 4 am CNA L went into R188's room to empty out his catheter. She saw R188 had turned a different color, and CNA L immediately told RN H. CNA L stated RN went to look for ADON K for help. CNA L stated she did not participate in the CPR (cardiopulmonary resuscitation) because she continued doing rounds on the rest of the residents on the unit. (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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	RN H completed an SBAR (situation, background, assessment and recommendation) dated [DATE]. The SBAR indicate RN H was called to R188's room per CNA L. RN H observed resident to be unresponsive. 911 called immediately. The SBAR had vital signs dated [DATE]. (There were no vital signs from the current shift.) The SBAR had the following conditions to assess during a change in condition: Mental status changes, Functional status changes, respiratory, GI/abdomen and GU/urinary changes. RN had marked NA for all changes. The SBAR assessment section asks the nurse completing the SBAR for an assessment of what may be the problem with the patient and RN did not complete an assessment and only wrote called 911 immediately. The nurses note dated [DATE] at 5:46 a.m. indicates RN called to room per CNA (certified nursing assistant) during rounding. observed resident unresponsive. 911 called immediately. CPR (cardiopulmonary resuscitation) initiated. (Physician) paged. ADON (assistant director of nursing) updated. (Cross reference F678. Nursing did not immediately call 911 or begin CPR.) On [DATE] at 9:00 a.m. Surveyor interviewed Paramedic I. Paramedic I stated the rescue squad arrived at the facility on [DATE] at 5:11 a.m. and arrived at the resident's bedside at 5:13 a.m. Paramedic I stated R188 remained asystole (state of total cessation of electrical activity from the heart) through the whole call. Paramedic I stated they pronounced R188 dead at the facility with the permission of their medical director. Paramedic I stated R188 had all signs of death. On [DATE] at 10:32 a.m. Surveyor interviewed RN H. RN H stated she remembers that day because it was the worse night of my nursing career. RN H stated when she arrived on her shift [DATE] at 11:00 p.m. she was made aware that she would be working on LTC 1 and Rehab unit. RN H stated both units would total 70 residents for RN H to care for, and she said she couldn't do it. RN H stated she called Former Director of Nursing (DON) J and ADON K that she couldn't do both units and she needed help. RN H stated ADON K came in at 12:00 a.m. to work the rehab unit. Surveyor asked RN H how many residents did she have on LTC 1. RN H stated about ,d+[DATE] residents on LTC 1. Surveyor asked RN H when was she made aware R188 was unresponsive. RN H stated about 5:00 a.m. CNA L told her R188 was unresponsive. Surveyor asked RN H what specifically did CNA L tell her about R188 condition. RN H said CNA L told her R188 was unresponsive. RN H stated she immediately went to R188 room and saw he was unresponsive. Surveyor asked RN H what did R188 look like. RN H stated he just looked unresponsive. Surveyor asked if RN H did an assessment, RN H state no she did not because he looked like he needed 911. RN H stated she then ran down the hall to the Rehab unit to get Assistant Director of Nursing (ADON) K. RN H stated ADON K and an agency nurse from another unit went to R188 to perform CPR and RN H called 911. Surveyor asked RN H if at any point during the shift, prior to 5:00 a.m., did CNA L tell her R188 was vomiting. RN H stated I don't remember. Surveyor asked RN H at 5:00 a.m. when she found R188 unresponsive if R188 had on his CPAP. RN H stated she doesn't remember. RN H stated at 2:00 a.m. she went into R188's room to attend to R188's roommate. RN H stated R188's roommate bed was high and his TV was on, so she lowered the bed because R188's roommate was a fall risk and turned off the TV. Surveyor asked if she looked at R188 while she was in the room. RN H stated she saw R188 sleeping. Surveyor asked if R188 had his CPAP on. RN H stated she doesn't remember. Surveyor asked RN H if she was aware R188 was bleeding from his penis on the previous shift. RN H stated she was aware a UA was collected but was not aware of R188 bleeding from his penis. Throughout the interview RN H kept repeating how horrible it was that the facility wanted RN H to work 2 units. At no point during the interview did RN H explain why an assessment was not completed on [DATE]. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	RN H failed to follow the Nurse Practice Act by failing to assess, plan, and intervene. This prevented nursing from assessing the significance of R188's change in condition. Although vomiting is often symptomatic of an innocuous condition, according to Healthline, Vomiting accompanied by the following symptoms should be treated as a medical emergency: severe chest pain sudden and severe headache shortness of breath blurred vision sudden stomach pain stiff neck and high fever blood in the vomit https://www.healthline.com/health/vomiting-causes-treatment#see-a-doctor On [DATE] at 10:30 a.m. Surveyor spoke with NHA A. Surveyor explained to NHA the concern R188 was experiencing a change in condition, with episodes of vomiting and RN H did not assess R188. Surveyor explained through interviews RN H did not assess R188 when he was found unresponsive. Surveyor explained RN H completed the SBAR dated [DATE] with vital signs from [DATE] and the areas for assessment were not completed. NHA A stated she was not aware R188 was vomiting that night and was not aware RN H did not assess R188 at the time of the change in condition and at the time he was found unresponsive. The failure to follow the Nurse Practice Act by failing to assess R188 after R188 experienced a potentially significant change in condition and after being found unresponsive created a reasonable likelihood for serious harm, thus creating a finding of Immediate Jeopardy. The facility removed the jeopardy on [DATE] when it had implemented the following: ~ The Medical Director contacted by the NHA and advised of deficiency. ~ All licensed nursing staff were educated by the Nurse Manager related to identifying resident change of condition, ensuring completion of a comprehensive assessment, physician/RP notification and ensuring clear comprehensive documentation. ~ Education was provided regarding prompt notification being required when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention: a significant change in the residents attending physical, mental or psychosocial status, including a deterioration in health, mental or psychosocial status in either life threatening conditions or clinical complications: or need to alter treatment significantly. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	~ Current residents with noted change of condition as of [DATE] were reviewed for SBAR documentation including comprehensive assessment, physician/RP notification and clear comprehensive documentation. If licensed staff/ RCS (CNA) notices change in condition: If RCS notices a change of condition, they will immediately notify licensed staff as well as fill out the STOP & WATCH form. If licensed staff member notices the change, they would do an assessment/evaluation of the resident, notify physician for further instructions, notify RP and complete SBAR. If resident is unresponsive, they would follow the following steps: - Call for help verbally and pull call light - Chart/PCC (PointClick Care) would be checked for code status - CODE BLUE announced through paging system - 911 called - Physician and RP notified regarding change of condition Based on resident's CPR status, CPR is initiated immediately and continued until 911 arrives. ~ Changes of condition will be communicated shift to shift through change of report as well as the 24-Hour Report. For life threatening events call 911 if initial assessment indicates that such action is necessary. ~ Changes in resident that affect the problem(s)/goal(s) or approach(es) on his/her care plan are documented as revisions and communicated by the IDT (interdisciplinary team) to direct care staff. ~ Director of Nursing (DON) or Nurse Manager will audit 2 resident medical records that have been identified to experience a change of condition, per day x 2 weeks (M-F) to ensure elements of the change of condition procedure have been met. ~ DON or Nurse Manager will review PCC dashboard, 24-hour board, for any noted resident change of condition daily (M-F) for 2 weeks, then 3 times a week for 2 weeks, then weekly thereafter until QA committee deems appropriate. ~ MDS (Minimum Data Set Nurse)/Designee will audit 3 residents care plans from noted resident change of condition for appropriate interventions being care planned 2 times a week for 2 weeks, then weekly thereafter until QA committee deems appropriate. ~ All weekly AT RISK meeting notes will be reviewed and submitted to QAPI monthly to identify trends x 3 months or until QA committee deems appropriate.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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** 38146 Based on observation, interview and record review the facility did not ensure residents received adequate supervision and assistance to prevent accidents for 2 of 8 (R69 and R340) residents reviewed for accidents. R340 sustained a fall from a mechanical lift, which resulted in a head injury requiring staples, due to the care plan not being followed. R69 sustained a fall from bed due to the care plan not being followed. Findings include: The Facility policy titled: Fall Management revised [DATE] documents (in part) . .Policy The center assists each resident in attaining/maintaining his or her highest practicable level of function by providing the resident adequate supervision, assistive devices and/or functional programs, as appropriate to minimize the risk for falls. The Interdisciplinary Team (IDT) evaluates each resident's fall risks. A Care Plan is developed and implemented, based on this evaluation, with ongoing review. Fall Event 1. When a fall occurs, the resident is assessed for injury by the nurse. 4. The nurse will discuss recommended interventions to reduce the potential for additional falls with the resident and/or resident's representative and document in the Care Plan and Progress Notes. 7. The IDT reviews all resident falls within ,d+[DATE] hours at the IDT meeting to evaluate circumstances and probable cause for the fall. 6. The IDT (Interdisciplinary Team) designee will discuss recommended significant changes to the Care Plan to minimize repeat falls with the resident and/or resident's representative. The Care Plan will be reviewed and/or revised as indicated. Care Kardexes are updated as appropriate. 1.) R340 admitted to the facility on [DATE] with diagnoses that included Vascular Dementia, Diabetes Mellitus Type 2, Paroxysmal Atrial Fibrillation, Malnutrition, Anemia, Hypertensive Heart Disease, history of Transient Ischemic Attack and Cerebral Infarction without residual deficits. R340's Care Plan Focus area initiated and revised on [DATE] documented: (R340) has an ADL (Activity of Daily Living) self-care performance deficit r/t (related to) Confusion, Dementia, Fatigue, Impaired balance. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Interventions: RESOLVED: TRANSFER: The resident requires SIT -STAND Mechanical Lift with (2) staff assistance for transfers. Date Initiated [DATE], Revision on [DATE], Resolved Date [DATE]. TRANSFER: The resident requires FULL BODY Mechanical Lift with (2) staff assistance for transfers. Date Initiated [DATE] Facility Progress notes documented: [DATE] 9:24 AM Nursing Note (entered by Licensed Practical Nurse (LPN)-XX): Resident fell from the sit to stand, blood loss noted to the back of the head, pupils are uneven, writer unaware if that is CVA (Cerebrovascular Accident) residual or new. MD (Medical Doctor) and family aware resident being sent out. [DATE] 9:30 AM SBAR (Situation, Background, Assessment, Recommendation) documented: Situation: Resident fell from sit to stand. Writer was called to room, walked into room, noted resident laying supine and blood noted on floor. Pupils uneven and reactive to light and hand grasps weak. Resident denied pain, HA (Headache), dizziness Hx (history) shows CVA (Cerebrovascular Accident) unaware as to if that is why her pupils are uneven. Sent to (hospital) per family request. MD aware. Temperature 97.7 Pulse 101 Respirations 20 Blood pressure ,d+[DATE]. [DATE] Orders - Administration Note: Sent out [DATE] at 9:45 AM. [DATE] 2:50 PM Nursing Note: Resident back from ER (emergency room) 7 staples to the back of her head. CT (Computerized Tomography) scan negative. [DATE] ED (Emergency Department) note documented: Pt (patient) comes in via EMS (Emergency Medical Services) who state patient at (facility) where staff were using a sit to stand and the patient fell . Pt has laceration to the posterior scalp. Is A&O (Alert and Oriented) x 1, no LOC (Loss of Consciousness). Left sided facial droop and unequal pupils. Staff and family were not aware of any residual CVA effects such as are present. [DATE] AVS (After Visit Summary) documented: Diagnoses - fall from standing, laceration of scalp. Imaging CT cervical spine, CT chest abdomen pelvis, ECG (Electrocardiogram), head CT. No cervical spine fracture, no evidence trauma to chest, abdomen or pelvis. No acute intracranial abnormality. [DATE] NP (Nurse Practitioner) Provider Note: Patient seen sitting in wheelchair in common room. She was sent to theER on [DATE] after sustaining a fall with abnormal pupil dilation following. Patient returned from ER with staples to laceration on posterior scalp. She denies any pain at the site. Patient denies any nausea, vomiting, constipation, lightheadedness, dizziness. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	[DATE] NP Provider Note: Patient is lying in bed this morning. She fell earlier in the week and had staples placed in the back of her head. She did not appear to be in any pain during exam. No fevers or chills noted. She remains afebrile at 97.7. Surveyor reviewed the facility self report dated [DATE] which documented: Resident fall from sit to stand [DATE] approximately 9:20 AM. Certified Nursing Assistant (CNA)-YY statement: I was getting resident up, I got her into the sit to stand and up in the air. The sit to stand stopped working, it would not let the resident down by remote, so I then turned to call the other aide to the door to help, and the resident slid through the sling. We went to the supervisor who was at the nurses station and she came in. The sling was still attached to sit to stand as I placed it. Resident was lying head back on the floor. Surveyor noted CNA-YY did not follow R340's care plan. CNA-YY transferred R340 with a mechanical lift alone, not with 2 person assist as indicated on the care plan. CNA-ZZ statement: I was waiting by the nurse station when my coworker yelled my name from hallway for help. When I went in the room, the resident was laying on her back with blood coming from her head. I asked resident was she OK, she responded yes. After that I quickly went and got the nurse supervisor (LPN-XX). LPN-XX statement: I was called to the room by a CNA and other CNA came out of the room both telling me and talking at the same time. I had to stop them and redirect, asking one to get BP (Blood Pressure) machine and allowing the other to tell me what happened. She stated she was transferring the resident and she slipped out of the straps, the other CNA came in and stated the lift was broken, it would go up, but not down. LPN-N statement: I was called to resident's room. Upon entrance CNA x 2 and supervisor (LPN-XX) were assisting resident back onto bed. Registered Nurse (RN)-O statement: I did not know anything about (R340)'s fall. Nobody notified me. Prior Interim Director of Nursing (DON)-J statement: I came into the facility at 1300 (1:00 PM). I spoke with (CNA-YY) and asked where was the sit to stand. It was taken to the shower room (tagged out of service pending maintenance inspection-contacted). (CNA-YY) demonstrated how the sling was placed on resident, inappropriate noted, the strap was very loose the way she showed me on herself. I noted she did not use all the devices on the sling to put the straps through. She verified therapy went over proper use of the sit to stand with her. She was asked why would she use the device without another person, stated other facilities used only 1 person. Education provided immediately that we use 2 person assist with all mechanical lifts. Findings: Improper use of sit to stand, requires 2 person assist and CNA did not request assistance. Improper use of sling when applying it to the resident person and to the sit to stand. Surveyor reviewed Supplemental Education forms dated [DATE]: (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	CNA-YY: Sit to stand requires two person assist when operating. Education by PT (Physical Therapy) on use/proper use of sling. LPN-YY: Fall on [DATE] not assessed by RN. RN to assess the resident/situation on all incidents in the building. Facility-wide education CNA's/nurses on proper uses/transfer with sit to stand 2 person assist. On [DATE] at 12:26 PM Surveyor advised Corporate Administrator-BBB of concern related to R340's fall. CNA-YY transferred R340 with a mechanical lift alone and not with 2 person assist as indicated on R340's care plan. Failure to follow the care plan resulted in R340's fall which required staples to a head laceration. Surveyor advised of concern there was no RN assessment following the fall. LPN and CNA's assisted R340 back to bed, and R340 was sent to the hospital. 2.) R69 admitted to the facility on [DATE] with diagnoses that include Heart Failure, Alcoholic Polyneuropathy, Cirrhosis of liver, Personality Disorder, Anxiety disorder, Dementia, major Depressive Disorder, Cerebral Atherosclerosis, Atrial Fibrillation and Arthritis, multiple sites. R69's Brief Interview for Mental Status dated [DATE], documents a score of 14, indicating R69 is cognitively intact. R69's Quarterly MDS (Minimum Data Set) dated [DATE], documents bed mobility (how resident moves to and from lying position, turns side to side, and positions body while in bed or alternate sleep furniture) as Extensive assistance, Two+ persons physical assist. R69's Care Plan focus area initiated [DATE] and revised [DATE] documents: (R69) has an ADL (Activities of Daily Living) self-care performance deficit r/t (related to) mobility. Interventions include: Bathing/Showering: The resident requires assistance by (2) staff with bathing/showering. Date Initiated [DATE], Revision on [DATE]. Bed Mobility: The resident requires assistance by (2) staff to turn and reposition in bed. Date Initiated [DATE], Revision on [DATE]. R69's Care plan focus area initiated [DATE] and revised [DATE] documents: (R69) is at risk for falls r/t Confusion, Deconditioning, Incontinence, Unaware of safety needs. (R69) has had an actual fall. Interventions include: - Anticipate and meet the resident's needs - initiated [DATE] - Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance - initiated [DATE] (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	- Educate the staff to keep resident's bed against the wall per resident's choice - initiated [DATE] - The resident needs a safe environment with even floors free from spills and/or clutter; adequate, glare-free light; a working and reachable call light, handrails on walls, personal items within reach - revised [DATE]. Surveyor reviewed the facility Point of Care documentation from [DATE] through [DATE]. Bed Mobility Self Performance - How resident moves to and from lying position, turns side to side, and positions body while in bed or alternate sleep furniture documented R69 required extensive assist 9 times and and total dependence 20 times. On [DATE] at 1:31 PM Surveyor observed R69 lying in bed with the head of bed elevated, eating lunch. Surveyor noted the bed was near the window approximately 3 feet from the wall. Surveyor stood between the bed and the wall to speak with R69. R69 informed Surveyor he fell out of bed 2 weeks ago on a Tuesday. R69 stated: That's the only problem I have here. Everything else is OK. R69 stated: I can't turn or roll by myself. The aide (CNA-Y) was rolling me. They should have 2 people, but didn't. I told her I can't roll any further, but she still tried to roll me and I fell right out of bed. R69 reported he hurt his arm, hip and leg. R69 reported he had no fractures or lacerations. R69 stated: But just because I wasn't injured doesn't mean anything. I could have died . It scared the hell out of me. I want a settlement for this and it better be good. R69 reported no one from the facility spoke to him or interviewed him after the fall. R69 stated: I don't have any other problems with this place, except for falling out of bed - they should've had 2 people, 1 on each side so it wouldn't have happened. Surveyor asked R69 if he had any arm, hip or leg pain as a result of the fall, to which he replied: No. I just have real bad arthritis (showed surveyor hands/noted some finger deformity) that's about it. Surveyor review of R69's medical record revealed an SBAR (Situation, Background, Assessment and Recommendation) dated (Tuesday) [DATE] which documented: During care resident rolled down from bed. No apparent injuries noted. ROM (Range of Motion) WNL (Within Normal Limits). Denied hit head. no c/o (complaints of) pain at this this time. Neuro (neurological) check negative. R69 had no falls the previous 6 months. Surveyor asked Director of Nursing (DON)-B for R69's fall investigation and was provided paperwork titled: Fall/Attended. Surveyor asked if this was the entire fall investigation. DON-B stated: Yes. Surveyor review of the Fall report dated [DATE] at 11:23 AM documented: Nursing Description: During care resident rolled down from bed. No apparent injuries notes. ROM WNL. Denied hit head. time, neuro check negative. Resident description: Resident unable to give description. Immediate action taken: Check vitals, skin check, transferred to bed with hoyer lift. offered pain med, H20 (water) and snacks. Stay with him ,d+[DATE] min. Taken to hospital - No. No injuries observed at time of incident. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Mental status: Oriented to person, place, time and situation. Predisposing environmental, physiological, situation factors: NONE Witnesses: No witnesses found. IDT Post Fall Review: Date and time of fall: [DATE] 10:15. Witnessed. No injury. During care resident rolled down from bed. No apparent injuries noted. ROM WNL. Denied hit head. No c/o pain at this time, neuro check negative. Where was the resident prior to the fall? Bed What was the resident doing at the time of the fall? checked other Does the resident have any of the following predisposing diseases? checked CVA (Cerebrovascular accident). Does the resident have any of the following conditions that may contribute to the fall? checked other - during peri care, rolled down from bed. Intervention recommendations: Staff education. Indicate all intervention recommendations: Care plan revision. Surveyor noted the fall investigation did not include an interview with the Certified Nursing Assistant (CNA) assigned to R69 at the time of the fall. On [DATE] at 11:03 AM Surveyor spoke with CNA-Y who was assigned to R69 at the time of the fall. CNA-Y reported she was washing R69 up/getting him ready in bed. CNA-Y reported she is familiar with R69 he likes to talk a lot while you're doing cares. CNA-Y reported R69 used to be in another room and his bed was against the wall. CNA-Y stated: I have him roll over and cross his leg over the other and tell him not to move while I wash his back side. CNA-Y stated: He moved to another room, and his bed wasn't against the wall anymore. So that day, I was washing him up and had him roll over, that's when he rolled out of bed. I've never had that happen before, I got the nurse right away. Surveyor asked CNA-Y if R69 needed assist of 1 or 2 people for bed mobility, to which CNA-Y stated: He was 1 assist. On [DATE] at 11:23 AM Surveyor observed R69's bed not positioned against the wall according to the care plan. On [DATE] at 12:11 PM Surveyor spoke with CNA-Z. CNA-Z reported R69 should have 2 person assist to turn and roll over in bed, he can't roll by himself. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On [DATE] at 12:19 PM Surveyor asked Director of Nursing (DON)-B about R69's fall from bed. DON-B stated: That fall was literally like my first day working here. I thought he needed 2 assist with cares because he was grabby and sexually inappropriate. Surveyor advised DON-B that R69's MDS documented the need for extensive assistance, two+ persons physical assist, and the Care Plan documents R69 requires assistance by (2) staff to turn and reposition in bed. Surveyor asked DON-B if, during the fall investigation, the facility identified concern related to CNA-Y not following R69's care plan for 2 assist with bed mobility, which resulted in R69's fall from the bed. DON-B stated: I seem to remember something about there was confusion between the care card and the care plan. Surveyor advised DON-B that R69's Care Plan and MDS indicated 2 person assist with bed mobility and asked if this was noted during the fall investigation. DON-B stated: I see that. I don't think so. DON-B reported education and training was not completed with facility staff following R69's fall. DON-B stated: Looking back on it now, we should have done education with all the CNAs. I'm thankful he wasn't injured. Surveyor advised DON-B of observations of R69's bed not positioned against the wall as indicated on the care plan. On [DATE] at 3:30 PM Nursing Home Administrator (NHA)-A and DON-B were advised of concerns regarding R69's fall: A thorough investigation was not completed, which identified the care plan was not followed, resulting in R69's fall. In addition, observations during survey revealed R69's bed not positioned against the wall as indicated on the care plan. On [DATE] at 8:01 AM NHA-A provided Surveyor a Supplemental Education form dated [DATE] for CNA-Y. No additional information was provided.

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38146 Based on interview and record review the facility did not provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well being of each resident for 1 of 1 (R339) residents reviewed. Findings include: R339 admitted to the facility on [DATE]. The facility was advised R339 was on the sexual offender registry on 3/17/22. The facility discharged R339 back to the hospital on 3/18/22, and he/she was readmitted to the facility on [DATE]. Surveyor review of R339's current Care Plan noted the care plan did not include information regarding R339's supervision related to listing on the sexual offender registry. In addition, R339's care plan did not address concerns or interventions related to his/her psychosocial health. On 3/23/22 at 12:30 PM Surveyor spoke with Admissions Coordinator-W who stated: He/She (R339) was admitted to the facility. We were notified later that he/she was on the sex offender registry. We were told by Corporate that he/she could not stay here because we were too close to a school, and that was the offense - it involved a child. R339 was then discharged back to the hospital. On 3/24/22 at 9:05 AM Surveyor spoke with Social Worker (SW) Manager-V. SW-V stated: I got direction from administrator/corporate DON (Director of Nursing) together to meet with (R339) to advise him/her we are close proximity to school and he/she would not be able to stay. SW-V reported R339 was Bummed but understood. SW-V stated: I just know there was a discussion with the higher ups. We were just updated this is what we're doing. There was a round table discussion regarding the specifics of the registry, and we tried to get information from the correctional officer. I do know he/she was not mobile and was max 2 person assist for bed mobility, that's why he/she couldn't go to his/her other placement until April - he/she was basically bed bound. On 3/28/22 at 12:29 PM Surveyor spoke with Director of Nursing (DON)-B. DON-B reported R339 is in a private room and does not come out of his/her room except for therapy. Surveyor advised DON-B of concern there is no Care Plan development addressing R339's listing on the sexual offender registry and supervision status, and no Care Plan addressing R339's psychosocial health. DON-B stated: He/she should have a care plan. Initially, we did not think he/she was coming back, so I think that's how it got missed. On 3/29/22 at 10:39 AM Surveyor advised SW-V of the above concerns regarding R339's care plan. SW-V reported the facility is not aware of specifics related to R339's supervision. We've reached out to the hospital and spoke to the PO, but they will not divulge specifics of supervision unless the resident signs off on it, and apparently he/she will not. So it was difficult and I really wasn't sure what to write for the care plan. Surveyor asked SW-V if she asked R339 about the conditions regarding supervision. SW-V stated: No, I didn't. We were just directed from Corporate the resident could not remain in the facility, so he/she was discharged back to the hospital. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/29/22 at 11:05 AM Surveyor spoke with R339 in his/her room. R339 stated: With the first admission, they just came to me a couple days later and told me I couldn't stay here anymore. I didn't understand - it had all been approved through the DOC (Department of Corrections) and my PO (Parole Officer). They (facility) said they were sending me back to the hospital. I didn't have a choice, where else was I to go? I lost my apartment and I'm immobile now, so I was just like, OK - because they said I couldn't stay here. Surveyor asked what the hospital said when he/she was sent back. R339 stated: I don't think they were happy. I was discharged . Now I was back like a day later for no reason. Surveyor confirmed he/she was admitted back to the hospital. R339 stated: I don't think they had a choice, the nursing home wouldn't let me stay. Surveyor confirmed with R339 he/she was not sent back to the hospital for medical reasons. R339 stated: No. Everything was going OK. Surveyor asked if the facility asked him/her about conditions or specifics related to his/her supervision. R339 stated: No. I can't have any contact with minors. That shouldn't be a problem here, and besides that - I'm pretty much immobile. I don't understand what the problem is. I think they're just being prejudice. On 3/29/22 at 3:30 PM Nursing Home Administrator (NHA)-A and DON-B were advised of concern the facility did not implement an appropriate care plan addressing R339's listing on the sexual offender registry and current status of supervision, or R339's psychosocial health. Surveyor was advised a Care plan was initiated on 3/28/22. No additional information was provided.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20483 Based on observation, interview, and record review the Facility did not ensure pharmaceutical services including accurate acquiring and administering of medications to meet the needs for 5 (R115, R43, R244, R243, & R238) of 5 Residents reviewed. * On 3/24/22 R115 Humalog insulin 4 units and Gabapentin 100 mg were administered late. R115 did not receive Amlodipine Besylate 10 mg, Bumetanide 4 mg, Clonidine 0.3 mg/24 hr (hour) patch, and Sodium Bicarbonate 650 mg. * On 3/24/22 R43 did not receive Lispro insulin at 6:30 a.m. R43 did not receive scheduled 8:00 a.m. medications of Aspirin 325 mg, Fluticasone Propionate Suspension 50 mcg (micrograms)/act nasal spray, Lisinopril 10 mg, Loratadine 10 mg, Omeprazole 40 mg, Glargine insulin per sliding scale, Miralax 17 grams, and Bumetanide 4 mg. R43 did not receive Gabapentin 400 mg at 9:00 a.m. * On 3/28/22 R244 received his 8:00 a.m. medications of Nitroglycerin Patch 0.2 mg/hr, Chewable aspirin 81 mg, Vitamin D3 2000 IU, Clopidogrel 75 mg, Ditiazem ER (extended release) 24 hour 120 mg, Fluoxetine 10 mg, Lisinopril 10 mg, and Metoprolol Tartrate 12.5 mg after 11:00 a.m. * On 3/28/22 R243 received his 8:00 a.m. medication of Chewable Aspirin 81 mg, Folic Acid 1 mg, Multivitamin with Minerals, Pantoprazole Sodium 40 mg, Zinc Sulfate 220 mg, Morphine Sulfate 15 mg, and Acetaminophen 1000 mg late at 12:14 p.m. R243's Aspart insulin scheduled at 8:00 a.m. was administered at 11:41 a.m. R243 did not receive Thiamine 200 mg and Detemir insulin 15 units. * On 1/17/22 R238 did not receive her 8:00 a.m. medication of Cholecalciferol 150 mcg (micrograms) (6000 UT), Cyanocobalmin 500 mcg, Duloxetine HCL delayed release sprinkle 60 mg, Folic Acid 1 mg, Furosemide 40 mg, Vitamin E 800 unit, Gabapentin 300 mg, Metformin HCL ER extended release 500 mg, Metoprolol Tartrate 25 mg, Pulmicort Flexhaler Aerosol Powder Breath Activated 180 mcg/act inhaler, Zyrtec D, and Mupirocin calcium cream 2%. On 1/17/22 R238 did not receive the following medication: at 7:00 a.m. Montelukast Sodium 10 mg, at 12:00 p.m. Furosemide 40 mg, at 2:00 p.m. Mupirocin Calcium cream, at 4:00 p.m. Pulmicort Flexhaler Aerosol Powder Breath Activated 180 mcg/act inhaler, at 8:00 p.m. Zyrtec-D, and at 10:00 p.m. Mupirocin Calcium cream 2%. On 1/25/22 at 8:00 a.m. R238 did not receive Humulin R U-500 130 units and sliding scale. R238 did not receive Mupirocin Calcium Cream 2% at 6:00 a.m. on 1/25/22, 1/27/22, 1/28/22, 1/29/22, & 1/30/22. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525604	A. Building B. Wing	04/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southpointe Care and Rehab Center LLC	4500 W Loomis Rd Greenfield, WI 53220

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Findings include: 1.) On 3/24/22 at 9:13 a.m. Surveyor informed RN (Registered Nurse)-G Surveyor would like to observe insulin being administered. RN-G informed Surveyor she just got to the Facility about 20 minutes ago and usually works in a hospital but the agency she works for told her the Facility needs help. RN-G informed Surveyor she wasn't sure who receives insulin as she didn't get report from anyone and they just threw her here. On 3/24/22 at 9:24 a.m. RN (Registered Nurse)-G informed Surveyor she was going to give R115 just his insulin as she doesn't have a blood pressure cuff. At 9:33 a.m. RN-G checked R115's blood sugar and informed R115 his blood sugar is 242. RN-G removed her gloves, cleansed her hands, and placed gloves on. At 9:35 a.m. RN-G informed R115 she was not going to give him his blood pressure medications as she doesn't have anything to check his blood pressure. RN-G then proceeded to prepare R115's oral medication which consisted of Atorvastatin 80 mg (milligrams) 1 tablet, Metolazone 5 mg 1 tablet, Clopidogrel 75 mg 1 tablet, Gabapentin 100 mg 1 capsule, and Acetaminophen 500 mg 2 tablets. At 9:46 a.m. RN-G removed her gloves, cleansed her hands and placed gloves on. RN-G cleansed the tip of the Humalog insulin pen with an alcohol pad, connected the needle, primed the insulin pen and dialed to 4 units. At 9:48 a.m. RN-G cleansed the back of R115's right upper arm and administers 4 units of Humalog insulin. At 9:49 a.m. RN-G administered R115's oral medication. Surveyor reviewed R115's March MAR (medication administration record). Surveyor noted the following medications were administered late as RN-G did not administer R115's insulin until 9:46 a.m. and oral medication until 9:49 a.m. Humalog insulin 4 units and Gabapentin 100 mg were scheduled to be administered at 8:00 a.m. The following medications are not initialed on 3/24/22 at 0800 (8:00 a.m.) as being administered to R115: Amlodipine Besylate 10 mg, Bumetanide 4 mg, Clonidine 0.3 mg/24 hr (hour) patch, and Sodium Bicarbonate 650 mg. 2.) On 3/24/22 at 10:06 a.m. RN-G informed Surveyor she has another blood sugar and insulin for R43. At 10:07 RN-G entered R43's room, checked R43's blood sugar and stated the blood sugar is 366. While in the room, R43 stated she had already had her blood done. RN-G asked R43 if she already received her medication as there is medication in a cup which RN-G threw away. At 10:19 a.m. RN-G informed Surveyor she needs to speak with the scheduler to see if someone was here this morning. (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 10:34 a.m. RN-G informed Surveyor there wasn't a nurse and she wasn't going to give R43 her insulin as she was suppose to have insulin at 6:30 a.m. and 8:00 a.m. Surveyor asked if R43 had received any of her insulin. RN-G replied no. As RN-G was speaking with Surveyor, ADON (Assistant Director of Nursing)-C approached the medication cart with RN-G and informed RN-G she is going to have to leave the medication as they are red on the screen and she can't give medication that is due at 8:00 a.m. ADON-C informed RN-G she needs to call the doctor for all the residents that didn't get their medication and see what the doctor says. Surveyor asked ADON-C when 8:00 a.m. medications can be administered. ADON-C informed Surveyor they can be administered an hour before or after. Surveyor reviewed R43's physician orders and March MAR (medication administration record) and noted Lispro Solution Insulin Inject per sliding scale was not initialed on 3/24/22 as being administered at 0630 (6:30 a.m.). The following medication were not initialed on 3/24/22 at 0800 (8:00 a.m.) as being administered to R43: Aspirin 325 mg, Fluticasone Propionate Suspension 50 mcg (micrograms)/act nasal spray, Lisinopril 10 mg, Loratadine 10 mg, Omeprazole 40 mg, Glargine insulin per sliding scale, Miralax 17 grams, and Bumetanide 4 mg. Gabapentin 400 mg is not initialed as being given on 3/24/22 at 0900 (9:00 a.m.). 3.) On 3/28/22 at 10:53 a.m. Surveyor observed RN (Registered Nurse)-F prepare R244's medication which consisted of Nitroglycerin Patch 0.2 mg/hr, Chewable aspirin 81 mg 1 tablet, Vitamin D3 1000 IU 2 capsules, Clopidogrel 75 mg 1 tablet, Ditiazem ER (extended release) 24 hour 120 mg 1 capsule, Fluoxetine 10 mg 1 capsule, Lisinopril 10 mg 1 tablet, and Metoprolol Tartrate 25 mg 1/2 tablet. R244's oral medications were not administered until 11:06 a.m. and the Nitroglycerin 0.2 mg patch was not applied until 11:09 a.m. These medications were scheduled at 8:00 a.m. 4.) On 3/28/22 at 11:20 a.m. RN (Registered Nurse)-F washed her hands, placed gloves on and checked R243's blood sugar. RN-F informed R243 his blood sugar is 600. At 11:28 a.m. RN-F removed her gloves and informed Surveyor she was going to call R243's doctor. At 11:33 a.m. RN-F returned stating she was going to give R243 Aspart 25 units and recheck in 2 hours. Surveyor inquired if R243 was scheduled for insulin this morning. RN-F replied yes, I missed he was a blood sugar. At 11:36 a.m. RN-F washed her hands, placed gloves on, cleansed the tip of the Aspart insulin pen with an alcohol pad, attached a needle, primed the insulin pen and then dialed to 25 units. At 11:41 a.m. RN-F cleansed the back of R243's right upper arm and administered Aspart 25 units of insulin. RN-F removed her gloves and washed her hands. At 11:47 a.m. RN-F informed Surveyor she will have to call the pharmacy as she's unable to find R243's Detemir insulin. At 11:48 a.m. RN-F started to prepare R243's oral medication which consisted of Acetaminophen 500 mg 2 tablets, Chewable Aspirin 81 mg 1 tablet, Folic Acid 1 mg 1 tablet, & Multivitamin with Minerals 1 tablet. (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 12:01 p.m. RN-F tipped the medication cup over. RN-F disposed of the medication on the med cart and re-poured the above medication along with Morphine Sulfate 15 mg 1 tablet, Pantoprazole Sodium 40 mg 1 tablet, and Zinc Sulfate 220 mg 1 tablet. At 12:08 p.m. RN-F informed Surveyor R243 gets 2 tablets of Thiamine 100 mg but will have to call the pharmacy as it's not available. At 12:14 p.m. R243 received his medications. On 3/28/22 at 12:20 p.m. Surveyor asked RN-F why she is still passing medication. RN-F explained she usually works nights on long term care one unit and they didn't figure out a plan until 8:30 or 9:00 a.m. as there was a nurse who did not show up for the day shift and the other nurse on this unit didn't want to take the keys until there was a safe plan in place. RN-F informed Surveyor if she was prepared she would be looking through Resident's MARs but made a mistake and just started passing pills. Surveyor asked what time were the Residents suppose to receive their medication. RN-F informed Surveyor 8:00 & 9:00 a.m. Surveyor reviewed R243's March MAR (medication administration record) and noted R243 received the following 8:00 a.m. medications late as R243 did not receive these medications until 12:14 p.m.: Chewable Aspirin 81 mg, Folic Acid 1 mg, Multivitamin with Minerals, Pantoprazole Sodium 40 mg, Zinc Sulfate 220 mg, Morphine Sulfate 15 mg, and Acetaminophen 1000 mg. R243's Aspart insulin scheduled at 8:00 a.m. was administered at 11:41 a.m. R243 did not receive Thiamine 200 mg and Detemir insulin 15 units. 5.) R238 was admitted to the facility on [DATE] and discharged on [DATE]. Diagnoses includes necrotizing fasciitis, sepsis, diabetes mellitus, morbid obesity, asthma, congestive heart failure, and depressive disorder. On 3/27/22 at 1:53 p.m. Surveyor spoke with R238 on the telephone. R238 informed Surveyor she had problems receiving her medication and after she was admitted did not receive her medication on January 17th. R238 informed Surveyor there were other days also when she didn't receive her medication. Review of R238's January 2022 MAR (medication administration record) reveals R238 did not receive the following medications scheduled at 8:00 a.m. on 1/17/22.: Cholecalciferol 150 mcg (micrograms) (6000 UT), Cyanocobalmin 500 mcg, Duloxetine HCL delayed release sprinkle 60 mg, Folic Acid 1 mg, Furosemide 40 mg, Vitamin E 800 unit, Gabapentin 300 mg, Metformin HCL ER extended release 500 mg, Metoprolol Tartrate 25 mg, Pulmicort Flexhaler Aerosol Powder Breath Activated 180 mcg/act inhaler, Zyrtec D, and Mupirocin calcium cream. On 1/17/22 R238 did not receive the following medication: at 7:00 a.m. Montelukast Sodium 10 mg, at 12:00 p.m. Furosemide 40 mg, at 2:00 p.m. Mupirocin Calcium cream, at 4:00 p.m. Pulmicort Flexhaler Aerosol Powder Breath Activated 180 mcg/act inhaler, at 8:00 p.m. Zyrtec-D, and at 10:00 p.m. Mupirocin Calcium cream. (continued on next page)

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	525604	A. Building B. Wing	04/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southpointe Care and Rehab Center LLC	4500 W Loomis Rd Greenfield, WI 53220

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R238's January MAR on 1/25/22 Humulin R U-500 130 units and sliding scale at 8:00 a.m. are blank and are not initialed as being administered. Review of R238's January MAR reveals R238 at 6:00 a.m. did not receive Mupirocin Calcium Cream 2% on the 25th, 27th, 28th, 29th, & 30th. These dates at blank and not initialed indicating the medication was administered. On 3/30/22 at 1:35 p.m. Surveyor asked LPN (Licensed Practical Nurse)-E when the pharmacy delivers medication. LPN-E informed Surveyor between 2 & 4 in the afternoon and the next delivery is between 9 & 11 at night. Surveyor asked LPN-E if a new admission comes in the afternoon when would their medication be delivered. LPN-E informed Surveyor the pharmacy cuts off at 6:00 p.m. so if the orders aren't sent by this time the Resident won't get the medication until the following day between 2:00 p.m. & 4:00 p.m. LPN-E informed Surveyor medication can be pulled out of contingency and can also call the pharmacy to have the medication stat over. Surveyor asked LPN-E with a new admission can she ask the pharmacy to stat their medication. LPN-E replied yes and informed Surveyor the pharmacy is open 24 hours a day.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 20483 Based on observations, staff interview, and record review the Facility had an error rate of 30.77%%. There were 12 errors in 39 opportunities for 3 (R115, R244, & R243) of 5 Residents. * R115's Humalog 4 units & Gabapentin 100 mg (milligrams) were administered late. R115 did not receive Amlodipine Besylate 10 mg, Bumetanide 2 mg, Clonidine Patch 0.3 mg/24hr, and Sodium Bicarbonate 650 mg. * R244's Metoprolol Tartrate Tablet 25 mg was administered late. * R243's Aspart insulin, Acetaminophen 1,000 mg, & Morphine Sulfate Tablet 15 mg were administered late. Detemir insulin and Thiamine HCL 100 mg were not administered. Findings include: 1.) On 3/24/22 at 9:24 a.m. RN (Registered Nurse)-G informed Surveyor she was going to give R115 just his insulin as she doesn't have a blood pressure cuff. At 9:33 a.m. RN-G checked R115's blood sugar and informed R115 his blood sugar is 242. RN-G removed her gloves, cleansed her hands, and placed gloves on. At 9:35 a.m. RN-G informed R115 she was not going to give him his blood pressure medications as she doesn't have anything to check his blood pressure. RN-G then proceeded to prepare R115's oral medication which consisted of Atorvastatin 80 mg (milligrams) 1 tablet, Metolazone 5 mg 1 tablet, Clopidogrel 75 mg 1 tablet, Gabapentin 100 mg 1 capsule, and Acetaminophen 500 mg 2 tablets. R115 refused Potassium Chloride 20 meq Polyethylene Glycol 17 grams and artificial tears eye drops. At 9:46 a.m. RN-G removed her gloves, cleansed her hands and placed gloves on. RN-G cleansed the tip of the Humalog insulin pen with an alcohol pad, connected the needle, primed the insulin pen and dialed to 4 units. At 9:48 a.m. RN-G cleansed the back of R115's right upper arm and administers 4 units of Humalog insulin. At 9:49 a.m. Surveyor verified the number of pills in the medication cup with RN-G and then RN-G administered R115's medication whole with water. On 3/28/22 at 2:43 p.m. Surveyor reviewed R115's physician orders & March MAR (medication administration record). Surveyor noted Humalog Solution Cartridge 100 unit/ml (milliliter) (Insulin Lispro) Inject as per sliding scale if 150-200=2 units, 201-250=4 units, 251-300=6 units, 301-350=8 units, 351-400=10 units, 401-450=12 units over 450 16 units, subcutaneously three ties a day for Type 2 Diabetes Mellitus. According to the MAR, this insulin is scheduled for 0800 (8:00 a.m.), 1200 (12:00 p.m.) and 1700 (5:00 p.m.) Surveyor noted RN-G administered the correct dosage of Humalog insulin but should have been administered at 8:00 a.m. Administering the insulin at 9:48 a.m. resulted in a medication error for R115. (continued on next page)

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	525604	A. Building B. Wing	04/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southpointe Care and Rehab Center LLC	4500 W Loomis Rd Greenfield, WI 53220

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Gabapentin Capsule 100 mg Give 1 capsule by mouth three times a day for N/A (nerve activity) 1 Capsule PO (by mouth) 3 times daily. According to the March 2022 MAR Gabapentin 100 mg should be administered at 0800, 1200, & 1700. R115's Gabapentin 100 mg was administered at 9:49 a.m. which resulted in a medication error for R115. Amlodipine Besylate tablet 10 mg Give 1 tablet by mouth one time a day for Hypertension. Surveyor did not observe RN-G administer this medication to R115 and R115's March 2022 MAR is not checked as being administered. This resulted in a medication error for R115. Bumetanide Tablet 2 mg Give 4 mg by mouth two times a day for Edema/Hypertension 4 mg QAM (every morning) 2 mg QPM (every evening). Surveyor did not observe RN-G administer Bumetanide Tablet 4 milligrams to R115 and R115's March 2022 MAR is not checked as being administered. This resulted in a medication error for R115. Clonidine Patch weekly 0.3 mg/24hr (hour) Apply 1 patch transdermally every Thu (Thursday) for hypertensive heart disease without heart failure place one patch onto the skin every Thursday and remove per schedule. Surveyor did not observe RN-G apply the Clonidine Patch 0.3 mg/24 hour patch and R115's March 2022 MAR is not checked as being administered. This resulted in a medication error for R115. Sodium Bicarbonate Tablet 650 mg. Give 2 tablet by mouth two times a day for Health Supplement. Surveyor did not observe RN-G administer Sodium Bicarbonate 650 mg and R115's March 2022 MAR is not checked as being administered. This resulted in a medication error for R115. This observation resulted in 6 medication errors for R115. 2.) On 3/28/22 at 10:53 a.m. Surveyor observed RN (Registered Nurse)-F prepare R244's medication which consisted of Nitroglycerin Patch 0.2 mg/hr, Chewable aspirin 81 mg 1 tablet, Vitamin D3 1000 IU 2 capsules, Clopidogrel 75 mg 1 tablet, Ditiazem ER (extended release) 24 hour 120 mg 1 capsule, Fluoxetine 10 mg 1 capsule, Lisinopril 10 mg 1 tablet, and Metoprolol Tartrate 25 mg 1/2 tablet. At 11:02 a.m. Surveyor verified with RN-F the number of pills in the medication cup and then RN-F placed on a gown & gloves. At 11:06 a.m. RN-F administered R244's medication whole with water and at 11:09 a.m. RN-F placed on Nitroglycerin 0.2 mg/hr patch on R244's upper left chest. RN-F removed her PPE (personal protective equipment) and washed her hands. On 3/29/22 at approximately 8:00 a.m. Surveyor reviewed R244's physician orders & March MAR (medication administration record) and noted Metoprolol Tartrate Tablet 25 mg. Give 0.5 tablet by mouth two times a day related to Hypertensive heart disease with heart failure. According to R244's March MAR Metoprolol Tartrate 25 mg is scheduled to be administered at 0800 (8:00 a.m.) & 2000 (8:00 p.m.). This resulted in a medication error for R244. 3.) On 3/28/22 at 11:20 a.m. RN (Registered Nurse)-F washed her hands, placed gloves on and checked R243's blood sugar. RN-F informed R243 his blood sugar is 600. (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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 11:28 a.m. RN-F removed her gloves and informed Surveyor she was going to call R243's doctor. At 11:33 a.m. RN-F returned stating she was going to give R243 Aspart 25 units and recheck in 2 hours. Surveyor inquired if R243 was scheduled for insulin this morning. RN-F replied yes, I missed he was a blood sugar. At 11:36 a.m. RN-F washed her hands, placed gloves on, cleansed the tip of the Aspart insulin pen with an alcohol pad, attached a needle, primed the insulin pen and then dialed to 25 units. At 11:41 a.m. RN-F cleansed the back of R243's right upper arm and administered Aspart 25 units of insulin. RN-F removed her gloves and washed her hands. At 11:47 a.m. RN-F informed Surveyor she will have to call the pharmacy as she's unable to find R243's Detemir insulin. At 11:48 a.m. RN-F started to prepare R243's oral medication which consisted of Acetaminophen 500 mg 2 tablets, Chewable Aspirin 81 mg 1 tablet, Folic Acid 1 mg 1 tablet, & Multivitamin with Minerals 1 tablet. At 12:01 p.m. RN-F tipped the medication cup over. RN-F disposed of the medication on the med cart and re-poured the above medication along with Morphine Sulfate 15 mg 1 tablet, Pantoprazole Sodium 40 mg 1 tablet, and Zinc Sulfate 220 mg 1 tablet. At 12:08 p.m. RN-F informed Surveyor R243 gets 2 tablets of Thiamine 100 mg but will have to call the pharmacy as it's not available. At 12:12 p.m. Surveyor verified with RN-F the number of pills in the medication cup. At 12:13 p.m. RN-F entered R243's room with his medication and protein drink. At 12:14 p.m. R243 drank his protein drink, a sip of diet coke and then his medication whole. On 3/28/22 at 12:20 p.m. Surveyor asked RN-F why she is still passing medication. RN-F explained she usually works nights on long term care one unit and they didn't figure out a plan until 8:30 or 9:00 a.m. as there was a nurse who did not show up for the day shift and the other nurse on this unit didn't want to take the keys until there was a safe plan in place. RN-F informed Surveyor if she was prepared she would be looking through Resident's MARs but made a mistake and just started passing pills. Surveyor asked what time were the Residents suppose to receive their medication. RN-F informed Surveyor 8:00 & 9:00 a.m. On 3/29/22 at 8:33 a.m. Surveyor reviewed R243's physician orders and March MAR (medication administration record). Surveyor noted Insulin Aspart Solution Pen-injector 100 unit/ml (milliliter) Inject 8 unit subcutaneously three times a day related to Type 1 Diabetes Mellitus with Unspecified Complications (E10.8) and Insulin Aspart Solution Pen-injector 100 units/ml Inject as per sliding scale: 150-200=5 units, 201-250=6 units, 251-300=8 units, 301-350=11 units 351-400=13 units greater than 400 notify MD subcutaneously three time a day related to Type 1 Diabetes Mellitus with unspecified complications (E10.8) According to the MAR scheduled and sliding scale Aspart is to be administered at 0800 (8:00 a.m.), 1200 (12:00 p.m.) & 1700 (5:00 p.m.). Administering Aspart insulin late resulted in a medication error for R243. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Insulin Detemir Solution Pen-injector 100 unit/ml Inject 18 unit subcutaneously every 12 hours related to Type 1 Diabetes Mellitus with Unspecified Complications (E10.8). According to the MAR Detemir is to be administered at 0800 (8:00 a.m.) and 2000 (8:00 p.m.). Not administering Detemir resulted in a medication error for R243. Acetaminophen Tablet 500 mg Give 2 tablet by mouth three times a day for pain. According to the MAR Acetaminophen is scheduled at 0800 (8:00 a.m.), 1200 (12:00 p.m.) and 1700 (5:00 p.m.). Administering Acetaminophen late resulted in a medication error for R243. Morphine Sulfate Tablet 15 mg Give 1 tablet by mouth every 12 hours related to encounter for surgical aftercare following surgery on the skin and subcutaneous tissue (Z48.817). According to the MAR Morphine Sulfate is scheduled at 0800 (8:00 a.m.) and 2000 (8:00 p.m.). Administering Morphine Sulfate late resulted in a medication error for R243. Thiamine HCL Tablet 100 mg Give 2 tablet by mouth one time a day for supplement. Not administering Thiamine resulted in a medication error for R243. This observation resulted in 5 medication errors for R243. On 3/29/22 at 10:17 a.m. Surveyor asked LPN (Licensed Practical Nurse)-E when she would reorder a Resident's medication so they wouldn't run out. LPN-E informed Surveyor there is no policy for reordering medication and explained the pharmacy used to reorder the medication automatically but now they have to reorder medication. LPN-E informed Surveyor she would reorder when there were 3 or 4 pills left. On 3/29/22 at 10:18 a.m. Surveyor asked RN-D when she would reorder a Resident's medication so they wouldn't run out. RN-D informed Surveyor she would reorder when there is two thirds insulin or pills left. On 3/29/22 at 3:19 p.m. Surveyor informed Administrator-A and DON (Director of Nursing)-B of the above medication errors.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20483 Based on observation, interview and record review the Facility did not ensure 4 (R115, R43, R243, & R100) of 4 Residents were free of significant medication errors. * On 3/24/22 R115's Humalog insulin was scheduled at 8:00 a.m. and was administered at 9:48 a.m. R115 did not receive Amlodipine Besylate 10 mg, Bumetanide 4 mg, and Clonidine 0.3 mg/24hr Patch. * On 3/24/22 R43 did not receive Lispro insulin at 6:30 a.m., and did not receive Glargine insulin, Lisinopril 10 mg, & Bumetanide 4 mg which were scheduled at 8:00 a.m. * On 3/28/22 R243 did not receive Detemir insulin which was scheduled at 8:00 a.m. and received Aspart insulin late. * On 12/15/21 R100 was prescribed Ativan 0.5 mg every 12 hours as needed for anxiety behaviors. The order was transcribed incorrectly and R100 received Ativan 0.5 mg every 8 hours from 12/15/21-12/23/21. The nurses on R100 unit received training regarding transcribing orders correctly. Not all nurses received this training . Findings include: 1.) On 3/24/22 at 9:13 a.m. Surveyor informed RN (Registered Nurse)-G Surveyor would like to observe insulin being administered. RN-G informed Surveyor she just got to the Facility about 20 minutes ago and usually works in a hospital but the agency she works for told her the Facility needs help. RN-G informed Surveyor she wasn't sure who receives insulin as she didn't get report from anyone and they just threw her here. On 3/24/22 at 9:24 a.m. RN (Registered Nurse)-G informed Surveyor she was going to give R115 just his insulin as she doesn't have a blood pressure cuff. At 9:33 a.m. RN-G checked R115's blood sugar and informed R115 his blood sugar is 242. R115 stated that's kind of high. RN-G informed R115 his blood sugar is high because he ate. RN-G removed her gloves, cleansed her hands, and placed gloves on. At 9:35 a.m. RN-G informed R115 she was not going to give him his blood pressure medications as she doesn't have anything to check his blood pressure. RN-G then proceeded to prepare R115's oral medication. During this observation RN-G did not prepare or administer Amlodipine Besylate 10 mg, Bumetanide 4 mg, and Clonidine 0.3 mg/24hr Patch. At 9:46 a.m. RN-G removed her gloves, cleansed her hands and placed gloves on. RN-G cleansed the tip of the insulin pen with an alcohol pad, primed the insulin pen and dialed to 4 units. At 9:48 a.m. RN-G cleansed the back of R115's right upper arm and administers 4 units of Humalog insulin. On 3/28/22 at 2:43 p.m. Surveyor reviewed R115's physician orders & March MAR (medication administration record). (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor noted Humalog Solution Cartridge 100 unit/ml (milliliter) (Insulin Lispro) Inject as per sliding scale if 150-200=2 units, 201-250=4 units, 251-300=6 units, 301-350=8 units, 351-400=10 units, 401-450=12 units over 450 16 units, subcutaneously three ties a day for Type 2 Diabetes Mellitus. According to the MAR, this insulin is scheduled for 0800 (8:00 a.m.), 1200 (12:00 p.m.) and 1700 (5:00 p.m.) Surveyor noted RN-G administered the correct dosage of Humalog insulin but should have been administered at 8:00 a.m. Administering the insulin at 9:48 a.m. resulted in a significant medication error for R115. Amlodipine Besylate tablet 10 mg Give 1 tablet by mouth one time a day for Hypertension. Surveyor did not observe RN-G administer this medication to R115 and R115's March 2022 MAR is not checked as being administered. Not administering Amlodipine Besylate resulted in a significant medication error for R115. Bumetanide Tablet 2 mg Give 4 mg by mouth two times a day for Edema/Hypertension 4 mg QAM (every morning) 2 mg QPM (every evening). Surveyor did not observe RN-G administer Bumetanide Tablet 4 milligrams to R115 and R115's March 2022 MAR is not checked as being administered. Not administering Bumetanide 4 mg resulted in a significant medication error for R115. Clonidine Patch weekly 0.3 mg/24hr (hour) Apply 1 patch transdermally every Thu (Thursday) for hypertensive heart disease without heart failure place one patch onto the skin every Thursday and remove per schedule. Surveyor did not observe RN-G apply the Clonidine Patch 0.3 mg/24 hour patch and R115's March 2022 MAR is not checked as being administered. Not administering R115 Clonidine patch resulted in a significant medication error for R115. 2.) On 3/24/22 at 10:06 a.m. RN-G informed Surveyor she has another blood sugar and insulin for R43. At 10:07 RN-G entered R43's room, checked R43's blood sugar and stated the blood sugar is 366. While in the room, R43 stated she had already had her blood done. RN-G asked R43 if she already received her medication as there is medication in a cup which RN-G threw away. At 10:19 a.m. RN-G informed Surveyor she needs to speak with the scheduler to see if someone was here this morning. At 10:34 a.m. RN-G informed Surveyor there wasn't a nurse and she wasn't going to give R43 her insulin as she was suppose to have insulin at 6:30 a.m. and 8:00 a.m. Surveyor asked if R43 had received any of her insulin. RN-G replied no. As RN-G was speaking with Surveyor, ADON (Assistant Director of Nursing)-C approached the medication cart with RN-G and informed RN-G she is going to have to leave the medication as they are red on the screen and she can't give medication that is due at 8:00 a.m. ADON-C informed RN-G she needs to call the doctor for all the residents that didn't get their medication and see what the doctor says. Surveyor asked ADON-C when 8:00 a.m. medications can be administered. ADON-C informed Surveyor they can be administered an hour before or after. Surveyor noted a orders administration note for R43 on 3/24/22 at 11:00 a.m. which documents unable to administer due to time. Surveyor reviewed R43's physician orders and March MAR (medication administration record) and noted Insulin Lispro Solution Inject per sliding scale was not initialed on 3/24/22 as being administered at 0630 (6:30 a.m.). (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The following medication were not initialed on 3/24/22 & scheduled for 0800 (8:00 a.m.) as being administered: * Lisinopril 10 mg (milligrams) Give 1 tablet by mouth one time a day related to Hypertensive heart disease without heart failure. There is a X for R43's blood pressure and pulse. * Insulin Glargine Solution Pen Injector 100 unit/ml (milliliter) Inject per sliding scale. * Bumetanide Tablet 2 mg Give 2 tablet by mouth three times a day related to unspecified systolic (congestive heart failure). Not administering R43's Lispro insulin, Glargine insulin, Lisinopril 10 mg, & Bumetanide 4 mg resulted in significant medication errors for R43. 3.) On 3/28/22 at 11:20 a.m. RN (Registered Nurse)-F washed her hands, placed gloves on and checked R243's blood sugar. RN-F informed R243 his blood sugar is 600. At 11:28 a.m. RN-F removed her gloves and informed Surveyor she was going to call R243's doctor. At 11:33 a.m. RN-F returned stating she was going to give R243 Aspart 25 units and recheck in 2 hours. Surveyor inquired if R243 was scheduled for insulin this morning. RN-F replied yes, I missed he was a blood sugar. At 11:36 a.m. RN-F washed her hands, placed gloves on, cleansed the tip of the Aspart insulin pen with an alcohol pad, attached a needle, primed the insulin pen and then dialed to 25 units. At 11:41 a.m. RN-F cleansed the back of R243's right upper arm and administered Aspart 25 units of insulin. RN-F removed her gloves and washed her hands. At 11:47 a.m. RN-F informed Surveyor she will have to call the pharmacy as she's unable to find R243's Detemir insulin. Surveyor reviewed R243's physician orders and March MAR. Surveyor noted at 8:00 a.m. the following insulin were scheduled: * Detemir Solution Pen Injector 100 unit/ml Inject 18 units subcutaneously every 12 hours related to Type 1 Diabetes Mellitus with unspecified complications was not initialed as being administered. * Insulin Aspart Solution Pen-injector 100 unit/ml Inject 8 unit subcutaneously three times a day related to Type 1 Diabetes Mellitus with unspecified complications. Not administering Detemir insulin and administering Aspart insulin late resulted in significant medication errors for R243. 20025 4.) R100 was admitted to the facility on [DATE] with diagnoses of cerebral infarct, hemiplegia left side, dysphasia, gastronomy and anxiety. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The quarterly MDS (minimum data set) dated 2/18/22 which indicates R100 is cognitive intact, needs extensive assistance with two staff with bed mobility, extensive assistance with one staff with dressing, eating and hygiene. The facility self report dated 12/24/21 indicate on 12/15/21 LPN QQ received a physician order for R100 to receive Ativan 0.5 mg every 12 hours as needed. LPN QQ transcribed the physician order incorrectly into the MAR (medication administration record) as Ativan 0.5 mg every 8 hours. The psychiatric note dated 12/22/21 indicate He is seen lying in bed. He is noted to be confused and soft spoken. He does not appear to be himself. Talked with nurse who reports that he has been this way since the Ativan was added. The psychiatric recommendations indicate PCP (primary care physician) team to address Ativan and possible consider changing to PRN (as needed) to address behavior outbursts as they occur. On 12/24/21 the facility assessed R100's medications because of R100's lethargy. The investigation revealed MD JJ sent the pharmacy a prescription for Ativan 0.5 mg every 12 hours as needed. The pharmacy filled the prescription as ordered. LPN QQ transcribed the physician order as Ativan 0.5 mg every 8 hours. The MAR indicates R100 received Ativan 0.5 mg every 8 hours from 12/15/21-12/23/21. The nurses note dated 12/23/2021 indicate Provider clarified Ativan orders, order is for Ativan 0,5 mg PO Q12HPRN and stated it was called into pharmacy. Provider discontinued order d/t resident intolerance. LPN QQ was provided education regarding transcribing physician orders and to use read back to confirm orders. Education regarding the 5 rights of medication administration was also conducted. Education provided was Narcotics are to be checked against the medication administration record, if it's a discrepancy notify provider/pharmacy to clarify dosing/order. Education provided on 5 rights of medication administration. Education was provided to LPN QQ and 3 other LPNs and a medication tech. No other nursing staff were provided this education. On 3/30/22 at 1:30 p.m. Surveyor interviewed NHA (nursing home administrator) A. Surveyor asked NHA A if other nursing staff were educated. NHA A stated only the nurses on R100's unit were educated. Surveyor explained to NHA A that other nurses weren't educated on this medication error and there are current issues with medication errors. NHA A stated she understood the concern and had no additional information.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 20483 Based on food complaints/interviews from R20, R66, R84, R29, R23, R135, R27, R70, R79, R104, R136, R11, R34, R64, R92 and testing lunch food items on 3/28/22, the Facility did not ensure Resident's food was palatable. This has the potential to affect 134 Residents who receive their meals from the Facility's kitchen. Findings include: 1.) On 3/22/22 at 10:08 a.m. Surveyor asked R20 how the food is at the Facility. R20 informed Surveyor the food is lousy. R20 explained last night the chicken tenders were so hard he couldn't cut them. R20 stated the food doesn't look good and thought breakfast is the best. 2.) On 3/22/22 at 10:58 a.m. R66 informed Surveyor the food is terrible, you're better off dumpster diving, can't even tell what it is and the menu doesn't add up to what's on the plate. R66 also informed Surveyor the food is not hot, never gets what he is suppose to get on the ticket and a lot of times they run out. R66 stated If I'm lying I'm dying. R66's quarterly Minimum Data Set (MDS) with an assessment reference date of 2/1/22 documents under Section C, Cognitive Patterns, a Brief Interview for Mental Status (BIMS) score of 15, indicating R66 is cognitively intact. On 3/24/22 at 12:59 PM Surveyor observed R66 sitting in his wheelchair in his room with his lunch tray sitting on his bedside table. R66 stated he finished eating his lunch. R66's food ticket read, Au gratin potatoes, seasoned green peas, dinner roll/bread with 1 margarine, sliced peaches, 2% milk. Surveyor ask R66 how his lunch was. R66 stated that he got what he was supposed to for lunch. R66 also stated The peas are cold. The coffee is cold. The meatloaf is okay. It's edible. On 3/28/22 at 1:25 PM Surveyor observed R66 sitting in his wheelchair in his room with his lunch tray sitting on his bedside table. R66's food ticket read, Chicken [NAME] with Spaghetti, dinner roll/bread, vanilla ice cream, hot coffee, 2% milk. Surveyor asked R66 how his lunch was. R66 stated that he got what he was supposed to for lunch. R66 also stated that it was warm, but bland and plain. It's so simple. 3.) On 3/22/22 at 11:10 a.m. R84 informed Surveyor she doesn't get served the food which is listed on the meal ticket. At 1:06 p.m. Surveyor asked R84 how the food is at the facility. R84 informed Surveyor the food is not hot, it's warm & salty. 4.) On 3/22/22 at 11:20 a.m. Surveyor asked R29 how the food is at the facility. R29 informed Surveyor the food is cold and doesn't taste good but has to eat something. 5.) On 3/22/22 at 11:52 a.m. Surveyor asked R23 how the food is at the facility. R23 informed Surveyor he doesn't like the food as the portions are really small and the food doesn't have much taste. R23 informed Surveyor he asked about the food and was told they have to make the food bland because of other people's diet. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6.) On 3/22/22 at 12:08 p.m. Surveyor asked R135 how the food is at the facility. R135 informed Surveyor the food is too tough to eat and she can't even cut the meat. R135 informed Surveyor she usually just eats the fruit and vegetables. Surveyor asked R135 if she has said anything to staff about the meat being too tough to cut. R135 replied oh yes and explained they try to cut it or they say don't tell us we don't work in the kitchen. 7.) On 3/22/22 at 1:53 p.m. Surveyor asked R27 how the food is at the facility. R27 informed Surveyor her food comes cold, not hot. 8.) On 3/22/22 at 2:31 p.m. Surveyor asked R70 how the food is at the facility. R70 informed Surveyor he doesn't like the food too much as there is too much pasta served and not enough baked potatoes. R70 informed Surveyor the food doesn't taste good and is not served hot. The food is always served warm or cold. 9.) On 3/28/22 at 1:07 PM Surveyor observed the food truck being delivered to Long Term Care (LTC) 1 unit. Surveyor requested a replacement food tray for R245, the last tray to be served off the food truck. On 3/28/22 at 1:17 PM Surveyor took the food tray for R245 at the time it was going to be served. Surveyor sampled the food tray for R245. The chicken alfredo spaghetti is cool and has no taste. The green beans are barely warm and bland. The lemonade is cold and tastes good. The ice cream feels cold in the container. Surveyor noted R245's meal ticket indicated R245 was to receive broccoli instead of the green beans R245 was served. On 3/28/22 at 2:47 PM Surveyor interviewed Kitchen Director (KD)-BB and Kitchen Assistant Director (KAD)-CC. KAD-CC stated that the food is temperature checked before they start, then it is put on the plates. KAD-CC also stated that the plates are heated as well as placed on hot bottoms, but that the food carts are not heated. KD-BB stated that KD-BB has received complaints about the food. KD-BB stated that KD-BB has been at the facility for 3 weeks and that they are using the hot bottoms now. Surveyor informed KD-BB R245's meal ticket indicated she should have received broccoli but was served green beans. Surveyor was informed they ran out of broccoli and served green beans instead. 38146 10.) R79 is on a regular diet, regular texture/regular consistency. R79's BIMS (Brief Interview for Mental Status) dated 2/6/22 documents a score of 15, indicating R79 to be cognitively intact. On 3/22/22 at 10:54 AM Surveyor spoke with R79, who reported she eats meals in her room. R79 reported she did not like the facility food, especially the powdered eggs, and stated: The food is usually cold. On 3/24/22 at 8:34 AM Surveyor observed R79 in her room eating breakfast, which consisted of hard boiled egg, omelet and toast. R79 reported the eggs and toast were cold when tray was delivered. Surveyor asked R79 if she ever asked staff to re-heat food if it's cold. R79 stated: No, it will take too long, it always does. I just eat it cold. It don't taste great, but it's better than nothing. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/30/22 at 9:11 AM Surveyor observed R79 in her room eating breakfast, which consisted of scrambled eggs, hard-boiled egg, toast and oatmeal. R79 reported the eggs and toast were cold, but the oatmeal was hot. 11.) R104 is on a Renal diet, regular texture/regular consistency. R104's BIMS dated 2/22/22 documents a score of 15, indicating R104 to be cognitively intact. On 3/22/22 11:35 AM Surveyor spoke with R104 who reported he eats meals in his room and is on a renal diet. R104 stated: The food is usually cold. R104 reported he does not like the food re-heated because It tastes bad then. R104 reported he keeps nuts and snacks in his room to eat between meals. On 3/29/22 at 1:40 PM Surveyor asked R104 how his meals were today. R104 stated: Lunch was OK, but I was hungry. Breakfast sucked, it was cold as usual. Surveyor asked R104 which breakfast items were cold. R104 stated: The whole thing, there wasn't a hot piece of food on my plate. 12.) R136's BIMS dated 3/24/22 documents a score of 15, indicating R136 is cognitively intact. On 3/24/22 at 8:41 AM Surveyor observed R136 in her room eating breakfast which consisted of scrambled eggs, toast and oatmeal. R136 reported the eggs and toast were cold. R136 stated: Have you ever eaten cold eggs and toast? It's not good. R136 reported she does not ask for food to be re-heated because I know they're passing other people's trays. If they have to stop to re-heat mine, it will just make everyone else's cold and I don't want to do that. On 3/28/22 at 8:33 AM Surveyor obtained a test tray, which was the last tray on the cart of room trays. The meal consisted of scrambled eggs, (2) pancakes, oatmeal, bacon and 2% milk. Surveyor touched the scrambled eggs (which felt cold) and the pancake (which felt warm). The eggs were cold and tasted rubbery. The pancakes and bacon were warm and palatable. The oatmeal was hot and palatable. On 3/28/22 at 10:30 AM Surveyor advised Director of Nursing (DON)-B of the above food concerns, and the test tray obtained. Surveyor advised DON-B of the determination the eggs were cold, tasted rubbery, and were not palatable. No additional information was provided. 44063 13.) On 3/22/22 at 12:19 PM, Surveyor asked R11 how the food was. R11 stated breakfast was cold and the only thing eats off the breakfast tray are the cold items like cereal as the other items that are supposed to be warm, such as the toast and eggs, are cold always. On 3/23/22 at 8:18 AM, Surveyor observed R11 eating breakfast in her room. R11 stated that the french toast and the bacon was cold so won't eat it. On 3/24/22 at 10:51 AM, Surveyor interviewed R11 who stated breakfast was cold again so just ate my cereal and milk. On 3/28/22 at 11:26 AM, Surveyor interviewed R11 about food temperatures. R11 stated breakfast was okay today, but should of been warmer. It is always breakfast for some reason that the warm items are cold. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	14.) On 3/22/22 at 11:02 AM, Surveyor asked R34 how the food was. R34 stated the food is often cold and it is disappointing because I like food. R34 indicated she asks for her tray early because then hopefully the hot items will still be hot and it makes it taste so much better. On 03/24/22 at 12:01 PM, Surveyor interviewed R34. R34 stated it was her favorite breakfast today, but it was lukewarm at best which was disappointing. On 03/28/22 at 4:23 PM, Surveyor interviewed R34 who stated lunch was cold - chicken alfredo was not as warm as should be and it didn't taste right. R34 stated was so disappointed as it is one of the best lunch items. R34 stated breakfast is usually cold and it was today too. On 03/30/22 at 10:05 AM, Surveyor interviewed R34. R34 said she didn't get her breakfast tray early so that is why it was cold, but it was okay. R34 said yesterday all the meals were cold. R34 wishes she could have hot food so it tastes better. 15.) On 03/23/22 at 12:22 PM, Surveyor asked R64 how the food is. R64 stated the food is not great as it is cold so I have to get alternates often. R64 indicated there are certain foods like oatmeal that come hot so he just gets that often. On 3/28/22 at 11:23 AM, Surveyor interviewed R64. R64 stated he does not like most of the food here. It can be cold, but it doesn't taste good. There are only a few items R64 indicated he will eat and they usually are an alternative menu choice like a salad which doesn't need to be warm anyway. 16.) On 3/22/22 at 11:23 AM, Surveyor asked R92 how the food was at the facility. R92 stated breakfast was always cold and does not taste good. R92 thought dinner was okay for food temperature sometimes. R92 indicated he eats a lot of his own snacks since the food doesn't taste very good. On 3/28/22 at 4:30 PM, Surveyor interviewed R92. R92 said he didn't eat much today because of a doctor's appointment, but he was okay with just eating his snacks as he doesn't love the food at the facility anyway. On 3/29/22 at 10:50 AM, Surveyor interviewed R92. R92 stated breakfast was actually warmer today then usual. R92 indicated breakfast is warm maybe 20% of the time which makes it terrible. R92 said the other meals are not as bad as far as temperature goes, but often don't taste great. On 03/28/22 at 02:46 PM, Surveyor interviewed Kitchen Director-BB about food temperatures. Kitchen Director-BB stated food trays need to be delivered right away to keep the food warm. Kitchen Director-BB indicated the plates are warmed and then the warming bottoms are underneath the plate to try to keep warm, but the carts are not heated. Kitchen Director-BB stated they know about the problem of cold food and are continuing to work on it. Eggs seem to lose their heat the quickest so will look into that. On 03/30/22 at 10:19 AM, Surveyor interviewed Licensed Practical Nurse (LPN)-LL and asked if heard complaints about food temperatures. LPN-LL states it does take awhile to pass out trays since usually there are only two aides helping so by the time get them all passed out, I am sure they do get a little cold. Surveyor asked LPN-LL how long does food sit on cart before passing out. LPN-LL stated it depends on the day. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525604	A. Building B. Wing	04/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southpointe Care and Rehab Center LLC	4500 W Loomis Rd Greenfield, WI 53220

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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 03/30/22 at 10:36 AM, Surveyor interviewed Certified Nursing Assistant (CNA)-RR. CNA-RR stated she passed out trays today and takes about 20-30 minutes so I am sure it gets cold for the last few residents getting trays. The cart isn't warm. CNA-RR stated we can warm up their food, but it would take some time before we could get to all the residents. On 03/30/22 at 12:25 PM, Surveyor informed Nursing Home Administrator (NHA)-A of the concern of complaints from residents regarding cold and palatable food. NHA-A stated they did bring in some food service help in order to work on this issue and hoping that consistent food service staff will help. No further information was provided.