STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525418	A. BUILDING _____ B. WING _____	03/09/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
EVANSVILLE MANOR NURSING AND REHAB, LLC	470 GARFIELD AVE EVANSVILLE, WI 53536

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

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F 0585 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not make prompt efforts to resolve resident grievances for 1 resident (R3) out of 16 residents reviewed for grievances. Surveyor interviewed NHA A (Nursing Home Administrator) and SW D (Social Worker), NHA A and SW D were aware that R3's left hearing aid has been missing for a couple of months. The facilty did not document R3's APOAHC's (Activated Power of Attorney for Healthcare's) grievance regarding the missing hearing aid, did not investigate, and did not provide resolution for R3's APOAHC. This is evidenced by: The facility Policy and Procedure, Grievance/Concerns, with a revision date of 12/3/18, includes, in part: All residents have the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination, interference, coercion, reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns of their stay at the facility. Procedure: Facility will make prompt efforts to resolve all grievances. Residents have the right to file grievances orally or in writing; and they have the right to file grievances anonymously. At any time, comments, suggestions or complaints by the residents and/or their representatives are encourage to direct their concerns to: The Administrator, Social Service Director, Director of Nursing or designee, or any appropriate manager. The facility Administrator or designee is the Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading the necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances. The grievance form includes the date the grievance was received, a summary statement of the resident's grievance, the steps being taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the residents' concerns, whether the grievance was confirmed or not confirmed, corrective action taken, or to be taken, and the date the written decision was issued. R3 was admitted to the facility, on 4/30/14, with [DIAGNOSES REDACTED]. R3's comprehensive care plan, with a revised date of 8/19/19, includes, in part, Focus: R3 has a communication problem r/t (related to) hearing deficit. He wears hearing aids but you may still need to repeat what you have said or adjust the tone of your voice when speaking to him. Goal: R3's communication deficit will not interfere with daily living skills and activities through next review. Interventions: .Ensure hearing aids are in place and working (revised 1/30/19). Surveyor reviewed the facility's grievance log. There is no grievance on the log from R3's APOAHC regarding his lost hearing aide. On 2/25/20, SW D entered the following note as a result of R3's care conference: Needs to have glasses and hearing aids in at all times. He should have 2 left hearing aids and currently only has 1. On 3/2/20 at 2:30 PM, Surveyor observed R3 wearing his right hearing aid, but no hearing aid in his left ear. On 3/2/20 at 2:35 PM, Surveyor spoke with CNA E (Certified Nursing Assistant). Surveyor asked CNA E if R3's wears hearing aids. CNA E stated, He was wearing two but one went missing so he's wearing one is his right ear. Surveyor asked CNA E how long R3's left hearing aid has been missing. CNA E stated At least a couple months. CNA E stated she remembers working on a Tuesday (date unknown) and R3 had his left hearing aid and when she returned to work on Wednesday R3's left hearing aid was missing. CNA E stated I told the Nurses, Laundry Dept, and Housekeeping. CNA E stated she thinks she told Social Worker D and the previous NHA but cannot recall for certain. On 3/2/20 at 3:05 PM, Surveyor spoke with SW D. Surveyor asked SW D are you aware of any residents that are missing a hearing aid(s)? SW D stated that R3 is missing his left hearing aid. SW D stated she became aware of this on 2/25/20 during R3's care conference when his APOAHC brought it up. Surveyor asked SW D was it reported to you prior to that date? SW D stated she does not recall if she was notified of the missing hearing aid previously. Surveyor asked SW D do you document grievances? SW D stated, It's just word of mouth. Surveyor stated you don't document the grievance? SW D stated, That's something I asked about. SW D stated she has it in a note from the meeting on 2/25/20. On 3/2/20 at 3:10 PM, Surveyor spoke with NHA A. Surveyor asked NHA A are you aware of any residents that are missing a hearing aid(s)? NHA A replied, R3, yes. Surveyor asked NHA A when did you find out about R3's missing hear aid? NHA A stated she, Found out less than 3 months ago. Right after she started working at the facility. NHA A stated the ADON, who is no longer working here as of mid January, was helping with this. Surveyor asked NHA A if she has any documentation regarding R3's missing hearing aid. NHA A stated she would check. NHA A later followed up stating she has no documentation regarding R3's missing hearing aid. Surveyor asked NHA A what did you do when you were made aware R3's hearing aid was missing? NHA A stated she made the floor aware, checked standard hiding spots, and notified the family. NHA A stated, I'm not sure where it got left off. Surveyor asked NHA A should R3's APOAHC's grievance regarding his missing hearing aid been documented? NHA A stated, yes. Surveyor asked NHA A should the facility have followed up with R3's missing hearing aid and provided a resolution to R3's APOAHC who filed the grievance? NHA A stated yes.
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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility did not ensure a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for 1 of 16 sampled residents Resident (R) 13. R13 only received two showers from 2/10/2020 through 3/9/2020. This is evidenced by: The Facility's Policy and Procedure entitled Bath/Shower, dated [DATE] documents, in part: The purpose of this procedure is to promote cleanliness, provide comfort to the resident and to observe the condition of the resident's skin .Document in Point of Care that shower/bath was complete, and the level of assistance needed . R13 is a long term resident of the facility. R13 has the following [DIAGNOSES REDACTED]. Per R13's most recent MDS (minimum data set) dated [DATE], it documents that R13 scored an 11 on the BIMS (brief interview of mental status) which indicates that resident is moderately impaired cognitively. R13's care plan for ADL (activities of daily living) self-care performance deficit), with a revised date of [DATE], documents, in part: .BATHING/SHOWERING The resident requires total assistance of 1 staff with bathing/showering . According to the facility's shower schedule, R13's scheduled shower day is Wednesday PM. R13 should have received showers on 2/11/2020, 2/18/2020, 2/25/2020 and [DATE]20. R13's POC (point of care) CNA (Certified Nursing Assistant) documentation, documents R13 was given a shower on 2/14/2020 and 2/21/2020. Of note, these two documented showers were both given on Saturdays. On 3/9/2020 at 11:02 AM, Surveyor interviewed R13. Surveyor asked R13 if she receives her showers as scheduled, R13 said nope. Surveyor asked R13 when her shower is scheduled R13 replied Tuesday or Wednesday on the PM shift. Surveyor asked R13 how often she does not receive her shower, R13 stated one to two times per month I do not get a shower. R13 went on to state I feel like a piece of garbage in here, I feel like they don't care. On 3/9/20 at 12:22PM, Surveyor interviewed

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

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

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F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) CNA S (Certified Nursing Assistant) and asked if there are any tasks that are unable to be completed due to concerns with not having enough staff. CNA S stated showers can be missed, she is able to get hers done but others can't. On 3/9/2020 at 2:33 PM, Surveyor interviewed DON B (Director of Nursing). Surveyor asked DON B how the CNA's know who needs a shower and what day to give the shower. DON B replied they look at the daily sheet which reflects who gets their showers and what day to give the shower. Surveyor asked DON B how often are showers typically given, DON B said usually once per week. Surveyor asked DON B what happens if on the day of a scheduled shower, it is unable to be given, DON B said then it should be done on another day that week. Surveyor asked DON B if the shower is not documented, was the shower given, DON B said if it is not documented it was not done.
F 0686 **Level of harm** - Actual harm **Residents Affected** - Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility did not ensure residents do not develop pressure ulcers/injuries (PU/PI) unless clinically unavoidable and did not ensure residents are provided cares and services consistent with professional standards of practice to prevent the development of PU/PI and to promote the healing of existing PI's for 4 of 4 Residents reviewed for PI's out of a total sample of 10 Residents (R7, R8, R12 and R13). R7 is at risk for developing PI's and developed a PI. R7's PI was not staged appropriately and interventions were not put into place timely to prevent further deterioration of R7's wound. R7 was not repostioned per his Care Plan. R8 did not have the appropriate wound care completed on 3/9/2020 and R8's care plan is not current for his skin impairment. R12 did not have heels floated twice on 3/9/2020. R13 does not have an appropriate treatment in place and when wound worsened there was no consultation with Physician. This is evidenced by: Facility Policy entitled 'Wound/Skin Alteration Care Policy,' dated 10/17/19 states, in part: Purpose: to promote a systematic approach and monitoring process for the care of residents with existing wounds and for those who are at risk for skin breakdown. To promotoe healing of existing wounds and/or skin alterations. Procedure: .2. Residents with a Braden Scale score of 12 or less should be considered to be at high risk for pressure ulcer development. .5. Resident's skin will be examined at least weekly by a licensed nurse. .7. Skin impairments, including pressure ulcers, non-pressure ulcer wounds (venous, arterial, and diabetic), surgical wounds, MASD, burns, blisters, significant skin tears and abrasions, and significiant bruises should be assessed and documented weekly by a licensed nurse, in (computer system) If a skin alteration is present, at least weekly there should be documentation of an assessment or evaluation of the wound characteristics. Documentation should include: the date the wound is observed, location, staging (or description of appears of wound extent) {sic}, size (length, width, depth, tunneling or sinus tract measurements if present), color, odor, approximate amount of exudate if present. Pain if present (nature and frequency, episodic or continuous), wound bed (color and type of tissue, granulation, necrosis, slough). Description of wound edges and surrounding tissue (rolled edges, redness, maceration). .13. Wound and skin care interventions will be monitored and evaluated for effectiveness. Care plans will include specific and measurable goals and interventions. The care plan will be reviewed and revised at least quarterly, or with significant change in condition. Per the National Pressure Injury Advisory Panel, Pressure Injury: A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue. .Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence associated [MEDICAL CONDITION] (IAD), intertriginous [MEDICAL CONDITION] (ITD), medical adhesive related skin injury (MARSI), or traumatic wounds (skin tears, burns, abrasions). Stage 3 Pressure Injury: Full-thickness skin loss Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury. Stage 4 Pressure Injury: Full-thickness skin and tissue loss Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury. Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar (i.e. dry, adherent, intact without [DIAGNOSES REDACTED] or fluctuance) on the heel or ischemic limb should not be softened or removed. Deep Tissue Pressure Injury: Persistent non-blanchable deep red, maroon or purple discoloration Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or [MEDICATION NAME] separation revealing a dark wound bed or blood filled blister. Pain and temperature change often precede skin color changes. Discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury, or may resolve without tissue loss. If necrotic tissue, subcutaneous tissue, granulation tissue, fascia, muscle or other underlying structures are visible, this indicates a full thickness pressure injury (Unstageable, Stage 3 or Stage 4). Do not use DTPI to describe vascular, traumatic, neuropathic, or dermatologic conditions. Per the National Center for Biotechnology Information, Moisture-associated skin damage (MASD) is caused by prolonged exposure to various sources of moisture, including urine or stool, perspiration, wound exudate, mucus, saliva, and their contents. MASD is characterized by inflammation of the skin, occurring with or without erosion (loss of the outerlayer of skin) . Per Merriam Webster Dictionary, the ischial tuberosity is a bony swelling on the posterior part of the superior ramus of the ischium that gives attachment to various muscles and bears the weight of the body in sitting. Drive Manufacturer Mattress information for Med-aire assure, foam base alternating pressure and low air loss mattress system, indicates the mattresses are intended to help reduce the incidence of pressure ulcers while optimizing patient comfort. Active mattress replacement system provides both alternating pressure and low air loss to optimize pressure redistribution, shear/friction reduction, and microclimate control. Designed to prevent, treat and heal pressure ulcers in the home or long term care setting. Broda manufacturer website indicates Broda's unique Comfort Tension Seating system provides pressure redistribution and airflow for increased sitting comfort and support. Comfort Tension Seating states Broda's proprietary Comfort Tension Seating conforms to the body, providing enhanced pressure redistribution and long-term seating comfort. Each strap conforms individually to the patients' body, thus suspending the weight of the patient across multiple points. Comfort Tension Seating works in conjunction with tilt-in-space seating system to provide therapeutic pressure relief, enhance postural support and maintain skin integrity. The seating base used in this system is a heavy gauge [MEDICATION NAME] chloride strapping installed under tension and riveted to the seating frame of the chair. With memory retention, the straps return to their original shape within seconds providing consistent seating comfort and pressure redistribution. The Facility's Policy and Procedure entitled Dressing Change- Clean dated 9/17/18 documents, in part: .1. Adjust bedside stand to wait level. Clean bedside stand. Establish a clean field. 2. Place the clean equipment on the bedside stand. Arrange the supplies so they can be easily reached. 3. Tape a biohazard or plastic bag on the bedside stand or open on the bed 5. Adjust the height of the bed to waist level 19. Apply the ordered dressing and secure with tape. 20. Discard disposable items into the designated container . Example 1: R7 was admitted on [DATE] with [DIAGNOSES REDACTED]. R7 previously had an open skin impairment to the Left Ischial Tuberosity from [DATE] - 11/22/19, which was indicated as healed on 11/22/19. R7's Care Plan, indicated to be in place in December 2019 states in part: I have an actual impairment to skin integrity of the left medial thigh r/t (related to) continued sitting/pressure/MASD date initiated: 07/25/2019. Revision on: 12/14/2019. Goal: The resident will have no complications r/t pressure ulcer of the left ischial tuberosity through the review date. .Revision date: 08/19/2019. The Resident's skin injury of the left ischial tuberosity will be healed . Revision on: 08/19/2019. .Interventions: Administer my wound care as ordered (12/14/2019) .Avoid scratching and keep hands and body parts from excessive moisture. Keep fingernails short .Encourage good nutrition and hydration in order to promote healthier skin . monitor/document location, size and treatment

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F 0686 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 2) of [REDACTED]. to MD Use caution during transfers and bed mobility to prevent striking arms, legs , and hands against any sharp or hard surface . Wash wound with wound cleanser, pat dry, place honey hydrogel over wound then cover with boarder gauze . weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate and any other notable changes or observations. Date initiated: 07/25/2019. (R7) is at risk for alteration in skin integrity related to Braden Score of 15, impaired mobility, and he chooses to sleep in his recliner rather than a bed. His safety awareness is also poor .Revision on: 08/22/2019 . Interventions: .Position my body with pillows/support devices, and protect bony prominences as needed. Date initiated: 0[DATE]8/2019 . Re-position me at least every 2 hours. Date initiated 0[DATE]8/2019 . Use a pressure relieving cushion for my recliner. Date initiated: 0[DATE]8/2019. R7's current 'At Risk for alteration in skin integrity,' Care Plan, indicates the same interventions as the Care Plan above, which was in place in December of 2019. R7's Care Plan revised on 1/29/20 states in part: I have an actual impairment to skin integrity of the MASD to left ischium r/t continued sitting/MASD. Goal: The resident's will have no complications r/t pressure ulcer of the left ischial tuberosity through the review date. Revision on [DATE] . The resident's skin injury of the left ischial tuberosity will be healed by review date .Revision on: [DATE]. Target Date: 0[DATE]20. Interventions are indicated to be the same as Care Plan initiated on 7/25/2019. R7'S CNA (Certified Nursing Assistant) Care Plan (Kardex) printed on 3/9/20, indicates to reposition R7 at least every 2 hours. To check for incontinence every 2 hours and as needed. R7 needs extensive assist of 1 with bed mobility. R7 is totally dependent on staff for locomotion. R7 transfers with a mechanical lift and assist of 2 (two). R7 is dependent for toileting. R7's Braden Scale for Predicting Pressure Sore Risk, dated 11/2[DATE]9 indicates R7 has a score of 15, which indicates R7 is at risk for PI's. The Braden scale indicates that R7's skin is very moist, he's chair fast, mobility is very limited, his nutrition is adequate and there is potential for friction and shearing to be a problem. On 12/2/19, R7's weighed 152.4 pounds. On 12/6/19 R7's Wound Evaluation, indicates an in house acquired Moisture Associated Skin Damage (MASD) to left thigh. Measuring 1.93 cm (Centimeters) by 1.61 cm. Wound bed is indicated as 40% [MEDICATION NAME] tissue and 60% granulation tissue. Progress notes indicate acute full thickness MASD, initial wound encounter measurements are 2cm in length by 2.5cm in width and 0.1cm depth. No slough and no eschar present. The periwound skin moisture is normal and skin color is normal. Treatment section indicates additional care of air flow pad, cushion, incontinence management, moisture control, moisture barrier, and turning/repositioning program. On 12/13/19 R7's Wound Evaluation, indicates MASD to left thigh. Measuring 1.99cm by 2.44cm with a wound bed of 30% [MEDICATION NAME] tissue and 70% granulation tissue. Progress note indicates measurements are 1.5cm by 2.5cm by 0.1cm. No slough and no eschar present, wound is improving. On [DATE] R7's Wound Care order indicates left medial thigh, wash wound with wound cleanser, pat dry. Apply Zeroform and cover with border gauze. Perform wound care every other day until healed. (Discontinued (D/c'd) 12/29/19) On 12/19/20, R7's Weekly Skin Check form indicates skin alteration of a left gluteal fold skin tear indicated as being a stage II. It's important to note that the facility interchangeably describes R7's wound location as left gluteal fold, left lower buttock/upper medial thigh, left thigh, and left ischial wound. Based on an interview with DON B, the left gluteal, left thigh and left ischial wound are all the same wound. On 12/20/19 R7's Wound Evaluation, indicates MASD to left thigh. Measuring 2.2cm by 1.36cm with Wound bed of 30% [MEDICATION NAME] and 70% granulation tissue. Progress indicates the wound is stalled. R7's Quarterly MDS (Minimum Data Set) dated 12/21/19, indicates the following: R7 has a BIMS (Brief interview of Mental Status) of a 9 out of 15 indicating moderate cognitive impairment. R7 needs 1 person extensive assistance for bed mobility, transfers and toileting. R7 is indicated as needing 1 person extensive assist to ambulate in his room. R7 needs limited 1 person assistance with locomotion on and off the unit. R7 is indicated as being frequently incontinent of bowel and bladder and is not indicated as being on a toileting program. Section M indicates that R7 is at risk for PI's and does not currently have any unhealed PI's, but has MASD (Moisture Associated Skin Damage). R7's Braden Scale on 12/2[DATE]9 indicates R7 has a score of 13, which indicates that R7 is at moderate risk for pressure injuries. On 12/27/19 R7's Wound Evaluation, indicates MASD to left thigh. Measuring 0.69 cm by 0.93 cm with a wound bed of 30% [MEDICATION NAME] and 70% granulation tissue. Wound progress is indicated as stalled. On 12/29/19 R7's Wound Care order indicates left lower buttock/upper medial thigh MASD sore cleanse area with wound cleanser. Pat dry. Apply Zeroform and cover with border gauze. Perform every other day until healed. On [DATE], R7's Wound Care order indicates left lower buttock/upper medial thigh MASD sore. Cleanse area with wound cleanser. Pat dry. Mix small amount of cologne and hydrogel and cover sore. Cover with border gauze. Perform on days every other day until healed. (D/c'd 1/6/20) On 1/2/20 R7's weight was 136.4 pounds. This is a 16 pound/10.4% weight loss in 1 month. R7 is receiving supplements. R7's weight loss puts him at a greater risk for pressure injury development. The Role of Nutrition in Pressure Ulcer Prevention and Treatment: National Pressure Ulcer Advisory Panel White paper, Dated 2009, states in part: .general consensus indicates that nutrition is an important aspect of a comprehensive care plan for prevention and treatment of [REDACTED]. Adequate calories, protein, fluids, vitamins, and minerals are required by the body for maintaining tissue integrity and preventing tissue breakdown .compromised nutritional status such as unintentional weight loss, undernutrition, protein energy malnutrition (PEM), and dehydration deficits are known risk factors for pressure ulcer development. On 1/3/20 R7's Wound Evaluation, indicates MASD to left thigh. Measuring 0.99cm by 1.92 cm. Wound bed is 100% granulation. Periwound skin texture is normal and periwound skin moisture is normal. There is no change in wound progression. Goal indicates healable. R7's wound appears to Surveyor, based on a photo, to have macerated wound edges and the wound bed appears a pale pink almost white/yellow in color in some areas throughout the wound bed based on the picture attached to R7's Wound Evaluation. On 1/4/20, R7's Wound Care order indicates wound care to left medial thigh. Wash wound with wound cleanser and pat dry. Mix together collagen and hydrogel apply to wound. Cover with a border gauze daily until healed. (D/c'd 1/15/20) On 1/7/20 at 11:09 AM, R7's Nurses Note states, in part: Open wound to upper left thigh/gluteal fold area yellow/radish (SIC) wound bed with scant of serisan (SIC) drainage. Peri wound slightly reddish but no s/sx (signs or symptoms) of infection. Dressing and tx (treatment) applied per order. On [DATE] R7's Wound Evaluation, indicates MASD to left thigh. Measurements are 2.57cm by 0.97cm. Wound bed is indicated as being 100% granulation tissue. On [DATE], R7's Wound Care orders indicate: wound care for pressure ulcer to left ischium. Clean with saline or wound cleanser. Skin prep to surrounding skin and border of dressing once placed. Cover with foam or [MEDICATION NAME]. Change dressing three times per week. (D/c'd 1/21/20) On [DATE] R7's Wound Evaluation indicates MASD to left thigh. Measurements are 1.47cm by 1.76cm. Wound bed is indicated as 100% [MEDICATION NAME] tissue and periwound is blanchable. Treatment indicates [MEDICATION NAME] with additional care of air flow pad, cushion, incontinence maintenance, moisture control, moisture barrier and turning/repositioning program. Goal of care indicates healable. Progress note indicates Resident admitted to Hospice service today. New wound care orders. Wound care performed and weekly assessment and wound picture updated. The picture associated with this measurement per Surveyors review of this photo the area does not look 100% [MEDICATION NAME] as wound bed has an appearance of white/yellow tissue in the wound bed based on photo documentation. On [DATE], R7's Hospice Note, states in part: Problem: Skin risk. .patient has identified factors that result in the increase in risk for skin breakdown. .indwelling urinary catheter. May insert 14-22 French Foley catheter PRN for [MEDICAL CONDITION] or obstruction; to assist healing or perineal and sacral wounds in incontinent patients; or for end-of-life palliative care comfort . Wound Care order: orders wound care for pressure ulcer to left ischium: clean with saline or wound cleanser. Skin prep to surrounding skin and border of dressing once placed. Cover with foam or [MEDICATION NAME] (duoderm). Change dressing 3 times per week. .was very kyphosed Has pressure wounds on left hip and back. Has lost 15 pounds in the last 3 months . Hospice is identifying R7's wound as being a pressure injury at this time. R7's Admission MDS dated [DATE], indicates R7 has moderate cognitive impairment. R7 is dependent on two person extensive assist from staff for bed mobility and toileting. R7 requires two person extensive assist with transfers. R7 did not walk in his room during the look back period. R7 is dependent on a one person physical assist for locomotion on the unit and is dependent on a two person physical assist for locomotion off the unit. R7 is at risk for PI's and does not currently have PI's, but is indicated as having MASD. Section H indicates that R7 has a Catheter and is frequently incontinent of stool and is not on a toileting program. On 1/22/20, R7's Wound Care orders indicate: Wound care for pressure ulcer to left ischium, clean with saline or wound cleanser. Skin prep to surrounding skin and border of dressing once placed. Apply [MED] then cover with foam dressing. Change dressing three times a week. (D/c'd 1/27/20) On 1/24/20 R7's Wound Evaluation indicates MASD to left thigh. Measurements are 2.49cm by 1.7cm. Wound bed indicates 50% granulation tissue and 50 % eschar tissue with a normal periwound. Additional care indicates turning/repositioning program. Goal of care states healable. Progress note states in part: .76-100% pink granulation tissue, no slough, no eschar and no epithelization present. There is no change noted in the wound progression. This measurement indicates that R7's wound has changed from 100% [MEDICATION NAME] tissue to 50 % necrotic tissue in a week. MASD areas do not acquire slough or eschar. Once slough or eschar is present the wound is now

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NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
EVANSVILLE MANOR NURSING AND REHAB, LLC	470 GARFIELD AVE EVANSVILLE, WI 53536

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 0686 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 3) indicated as being a pressure injury. The facility has not identified R7s wound as being a PI. R7's Braden Scale dated 1/24/20 indicates R7 has a score of 12 which makes R7 at high risk for developing a PI. On 1/27/20, R7's Wound Care orders indicate cleanse wound with wound wash. Apply thera honey gel to wound bed, apply skin prep wipe to peri-skin. Cover with [MEDICATION NAME] gentle dressing. (D/c'd 1/30/20) On 1/31/20, R7's Wound Care orders indicate: Wound care MASD to left ischium cleanse with wound wash, apply santyl to wound bed, apply [MED], apply skin prep wipe to peri-skin then cover with [MEDICATION NAME] gentle dressing. (D/c'd 2/4/20) On 1/31/20 R7's Wound Evaluation indicates MASD to left thigh. Measurements are 2.61cm by 3.54cm. Wound bed is indicated as 30% granulation and 70% eschar. This is a decline in R7's wound. Goal of care slow to heal and indicates R7's wound is stable. Progress note, states in part: .Moderate amount of serous drainage noted which has no odor. .There is no change noted in the wound progression. This measurement indicates that R7's wound went from 50% eschar to 70% eschar which indicates a decline in R7's wound. The picture associated with this measurement per Surveyors review of this photo the area appears greater than 70% eschar and less than 30% granulation tissue. On 2/2/20 R7's weight was 131.5 pounds. On 2/4/20, R7's Wound Care orders indicate wound care to pressure ulcer to left ischium every 5 days and as needed. Cleanse with wound wash. Cover the wound bed with calcium alginate dressing cut fit to size. Apply skin prep to the intact peri-skin, cover with [MEDICATION NAME] gentle dressing. (D/c'd on 2/11/20) On 2/7/20 R7's Wound Evaluation indicates MASD to left thigh. Measurements are 4.07cm by 2.21 cm. Wound bed is indicated as being 10% granulation tissue, 20% slough tissue and 70% eschar tissue. Goal of care is slow to heal. Progress note states left, posterior thigh is an acute full thickness MASD, IAD (incontinence associated [MEDICAL CONDITION]), stable, slight change, hospice to manage treatment orders. The picture associated with this measurement per Surveyors review of this photo the area appears 100% necrotic tissue made up of eschar and slough. On 2/11/20, R7's Wound Care orders indicate left ischial tuberosity wound cleanse daily with soap and water, apply santyl, calcium alginate and foam bordered dressing daily and prn until heals. (D/c'd on 2/13/20) On 2/13/20, R7's Weekly Skin Check form indicates skin alteration of left gluteal fold being an Unstageable ulcer. Form indicates no new skin alterations identified. On 2/13/20, R7's Wound Care orders indicate wound care to pressure ulcers to left ischium daily and prn. Remove old dressing, cleanse with wound wash, pat dry, and apply skin prep to intact skin. Apply mesalt dressing cut to fit the eschar tissue. Apply only to dark black dead tissue. Apply alginate wound dressing to cover open skin for drainage absorption. Cover with bordered gauze. (D/c'd 2/17/20) On 2/14/20 R7's Wound Evaluation indicates Unstageable (slough and/or eschar) to left thigh. Measurements are 2.84 by 3.5cm. Wound bed is 100% slough. Treatment section for additional care indicates a cushion, mattress with pump and a turning/repositioning program. Progress note states superficial and not over a bony area but with the decline of the patient leading to hospice and patient not eating it deteriorated. Pressure wound is Unstageable due to slough, wound was examined and debrided by (MD D) (Medical Doctor), recommendations is to do wet to moist soaked with full strength Dakins solutions. R7's wound has had eschar/slough in it since 1/17 or 1/24/20 and has had turning/repositioning program in place since [DATE]8/19. R7's wound is now being called an Unstageable PI due to eschar/slough when R7's wound has been at least an Unstageable PI from 1/24/20 to current based on photos associated with R7's wound. Measurements and photos associated with R7's wounds indicated that R7's wound has became larger and has deteriorated since 12/6/19. As of 2/14/20 this is the first time a mattress with a pump has been identified as being in place for R7. Facility staff are unable to say when R7's mattress was placed on his bed. R7 has a history of skin break down in the same area as R7's current wound. R7 had a regular standard mattress in place prior to receiving a mattresss with a pump on it. On 2/14/20 R7's Wound Note from MD G (Medical Doctor) states, in part: Etiology: Pressure. .Unstageable necrosis. Wound Size (L x W x D): .3.5 x 3.5 x not measurable. Slough: .100%. This wound is in an [MEDICAL CONDITION] stage and is unable to progress to a healing phase because of the presence of a biofilm. Additional wound details: Wound started as moist as it was superficial and not over boney (SIC) area but with the decline of patient, leading to hospice and patient not eating, it deteriorated. Full strength Dakin's wet to moist to kill and prevent return of black slough. If hospice want to continue their current treatment (Collagen mesalt and alginate), I would remove the collagen for now. .surgically excise 12.25cm of devitalized tissue including slough, biofilm and non-viable subcutaneous fat and surrounding connective tissues were removed at a depth of 0.1cm and healthy bleeding tissue was observed . My goal for this wound is healing as evidenced by a decrease in surface area of the wound and/or a decrease in percentage of necrotic tissue within the wound bed. On 2/17/20 R7's Wound Care Orders indicate Wound care to pressure ulcer to left ischium daily and as needed. Remove old dressing, cleanse with wound wash, pat dry, apply skin prep to intact skin, apply wet to moist gauze full strength dankins solution. Cover with bordered gauze. It is important to note that prior to 2/17/20, R7's wound care has been changed 11 different times between [DATE] and 2/17/20. During that time R7's wound has not been given time to respond to each treatment before being changed to a different treatment. Therefore the staff are unable to evaluate the effectiveness of those treatments. National Pressure Ulcer Advisory Panel, 'Prevention and treatment of [REDACTED].Assessment of Pressure Ulcers and Monitoring of Healing. .Assessment of the individual with a Pressure Ulcer. .2. Reassess the individual, the pressure ulcer and the plan of care if the ulcer does not show signs of healing as expected despite appropriate local wound care, pressure redistribution, and nutrition. .2.1 Expect some signs of pressure ulcer healing within two weeks. .If progress toward healing is not seen within two weeks, the individual, the pressure ulcer, and the plan of care should be re-evaluated. On 2/21/20 R7's Wound Evaluation indicates Unstageable to left thigh. Measurements are 3.27cm by 3.46cm by 0.5cm (depth). Wound bed is 100% slough. Progress note states, in part: Wound size . 6 x (by) 4 x 0.5cm .exudate moderate serous. Slough: 100% this wound is in an [MEDICAL CONDITION] stage and is unable to progress to healing phase because of the presence of a biofilm. Wound progress: deteriorated. R7's Braden Scale on 2/24/20, indicates R7 scores an 11 which means R7 is at high risk for PI's. On 2/28/20 R7's Wound Evaluation indicates Unstageable to left thigh. Measurements are 3.59cm by 5.19cm by 1.5cm. Wound base is indicated to be 10% granulation tissue and 90% slough. Goal of care indicates slow to heal and progress of wound indicates improving. On 3/2/20 R7's weight was 130.5 pounds. On 3/6/20 R7's Wound Evaluation indicates Unstageable to left thigh, in house acquired and that it's 3 months old. Measurements are 5.66cm by 6.07cm by 1.5cm. There is no assessment of the wound bed tissue or periwound. The evaluation indicates progress is slow to heal and improving. The picture associated with this measurement per Surveyors review of this photo the area appears significantly larger. The area appears to have at least 75% necrotic tissue with periwound having dark discoloration along with red and pale tissue along the wound edges. On 3/9/20 at 9:20 AM, Surveyor observed R7's room. R7 was not in his room at this time. R7 has an alternating mattress which was set to 150 pounds. R7 was out to an activity at this time. On 3/9/20 at 9:26 AM, Surveyor interviewed LPN F regarding wounds down her hallway. LPN F indicated that she has R1 to do wound care on yet. LPN F indicated that she called hospice over the weekend related to R1's wound as she thought they needed to be cultured. LPN F indicated that R1's wound is deep, I can't believe how deep his wound has gotten. LPN F indicated that she thinks R1's wound is infected because it stinks terribly, and that she was the nurse over the weekend. On 3/9/20 at 10:40 AM, Surveyor observed R7 not to be in his room at this time as he is out in the lounge area. On 3/9/20 at 11:00 AM, Surveyor observed R7 to be in his broda chair in the lounge near bird aviary. R7 has a pillow under his feet and black socks on without shoes on. R7 has a full body sling under him and a thin blue cushion. On 3/9/20 at 12:00PM, Surveyor observed R7 to be in his chair at the dining room table for lunch at this time. On 3/9/20 at 12:15 PM Surveyor interviewed CNA I regarding R7. CNA I indicated that R7 will be laid down after lunch and then gotten back up into his chair. CNA I indicated that she hasn't been back to check R7 since after breakfast. On 3/9/20 at 1:20 PM, Surveyor observed CNA I and CNA C transfer R7 from his broda chair into bed. R7 was sitting in his broda chair with a full body sling under him. R7's broda chair was observed to have a thin light blue cushion filled with air. R7's cushion appears to be a waffle cushion. R7's dressing is intact to Left ischial area with drainage shadowing, showing through on half of the dressing thats dated 3/8. CNA I indicated that R7 was last laid down and checked between 8:45 AM and 9:00AM. CNA I indicated R7 was gotten back up right away as he doesn't like to lay down. CNA C indicated that R7 used to stand up and pivot transfer and now he no longer does. CNA C indicated now that R7 is in his bed or chair all the time it's gotten worse, (refering to R7's wound). CNA C indicated that R7 is now a full body lift for transfers. CNA C indicated that R7's full body lift sling, is always left under him when he is in the chair, but not when he's in the bed. On 3/9/20 at 1:45 PM, Surveyor observed Agency LPN F provide wound care for R7. R7's wound appears to be on his left ischial tuberosity area as it's between the thigh/gluteal fold and near the perineum area. Before beginning wound care LPN F stated it's pretty deep. LPN F performed wound care on R7, while packing Dakins soaked gauze into R7's wound LPN F stated it's hard when I push it in (referring to gauze), there is bone and it tunnels in. LPN F indicated to Surveyor that there is a large amount of necrotic tissue present. LPN F indicated that there may be 20% granulation
F 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.**

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F 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 4) **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility did not ensure that the resident environment remains as free of accident hazards as is possible for 1 of 3 residents reviewed for falls Resident (R8) out of 16 sampled residents. R8 had two falls where a new intervention was not put into place. This is evidenced by: The Facility's Policy and Procedure entitled Fall Reduction Policy dated 12/[DATE]8 documents, in part: .7. Document in the clinical record a summary of the fall including, but not limited to, assessment, intervention and resident response. 8. Immediate intervention will be added to the plan of care and communicated to caregivers 13. The care plan should be reviewed after every fall and updated with a new intervention . R8 is a long term resident of the facility and a recent admission to hospice services. R8 has the following Diagnoses: [REDACTED]. Per R8's medical record, documents unwitnessed falls on 2/18/2020 and 3/7/2020. Per R8's care plan entitled at risk for falls there are no interventions put into place for either of these falls. On 3/9/2020 at 4:18 PM, Surveyor interviewed LPN Q (Licensed Practical Nurse). Surveyor asked LPN Q what the process is when a resident has a fall, LPN Q explained the resident is assessed for injury, pain and vital signs before moving them, if there is no injury or suspicion of an injury then the resident can be moved, if the resident is in pain or there is suspicion of injury then 911 is called and resident is not moved. Surveyor asked LPN Q who is responsible for putting a new intervention in place, LPN Q said they are (nurses). Surveyor asked LPN Q how I would see what immediate intervention would have been put into place, LPN Q said it is documented in the progress notes. Surveyor asked LPN Q how the interventions get onto the residents' care plan, LPN Q said the DON (Director of Nursing) adds to care plan. On 3/9/2020 at 5:30 PM, Surveyor interviewed DON B. Surveyor asked DON B who is responsible for putting a new immediate intervention into place after a fall, DON B said the nurse does the immediate intervention then the IDT (interdisciplinary team) discusses and may come up with something else. Surveyor asked DON B how does the intervention get onto the care plan, DON B said she is responsible for putting interventions on the care plan the next AM or Monday AM following a weekend fall. Surveyor asked DON B if R8 should have interventions from his falls on 2/18/2020 and 3/7/2020, DON B said yes.
F 0726 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility did not ensure staff had the proper qualifications to administered medications. This has the potential to affect approximately 36 of 56 residents. CMA C (Certified Medical Assistant) was passing medications in a skilled nursing facility without the appropriate qualifications. On [DATE], CMA C administered ten times the prescribed dose of [MEDICATION NAME] to R1. Review of facility schedules finds CMA C routinely passed medications on the 300/400 units and had been doing so since July 2019. The facility's failure to ensure staff had the appropriate credentials to perform the tasks assigned to them created a finding on immediate jeopardy that began on 7/31/19. NHA A (Nursing Home Administrator) was notified of the immediate jeopardy on 3/3/20 at 10:30 AM. The facility removed the jeopardy on 3/3/20; however, the deficient practice continues at a scope/severity level of E (potential for more than minimal harm/pattern) as the facility continues to implement its action plan. This is evidenced by: According to Wisconsin Administrative Code for Nursing Homes, DHS 132.60(5)(d)2, `Personnel who may administer medications.' In a nursing home, medication may be administered only by a nurse, a practitioner, as defined in s. 450.01 (17), Stats., or a person who has completed training in a drug administration course approved by the department. The Facility's Policy and Procedure entitled Administering Medications with a revision date of 2/6/17 documents, in part: .1. Only person licensed or permitted by this State may prepare, administer or record the administration of medications. Nursing personnel who are authorized to administer medications include: Registered Nurses and Licensed Practical Nurses .3. Medications shall be administered in physician's written/verbal orders upon verification of the right medication, dose, route, time and positive verification of the resident's identity when no contraindications are identified and the medication is labeled according to accepted standards . A CMA (Certified Medical Assistant) does not hold the credentials needed to pass medications in a skilled nursing facility. In order to pass medications in a skilled nursing facility, a person must be a Certified Medication Assistant, a licensed nurse, or be currently enrolled in a nursing school and have completed certain courses in pharmacology. Certified nursing assistants who become certified medication aides in Wisconsin must, per DHS 129.24(1), Wis. Administrative Code, complete coursework that includes: (c) Legal and ethical considerations. 1. Federal and state nursing home standards, regulations, statutes, and administrative rules. 2. Standards of Practice for Registered Nurses and Licensed Practical Nurses, ch. N 6 specific to registered nurse delegation. 3. Professional and staff roles and liabilities. 4. Resident rights regarding administration of medications. 5. Confidentiality of information related to residents. 6. Facility policies and procedures for administration of medications. (d) Overview of body systems related to routes of medication administration and the classes of medications. 1. Anatomy of body structures that pertain to medication administration, including structure of the eye, ear, nose, mouth, vagina, rectum, and skin, which are necessary to administer medication correctly via these routes. 2. Functions of these body structures that impact medication administration and effectiveness. 3. Diseases of these body structures that impact medication administration and medication effectiveness. Note: Examples of anatomy, function and diseases are provided in the curriculum development guide. (e) Medication fundamentals, including: 1. Medication orders. 2. Medication mathematics, weights and measures. 3. Dosage forms, including pills, capsules, ointments, patches, and suppositories. 4. Drug effects and actions. 5. Classes or types of commonly used medications in nursing homes. 6. Use of the drug or drug indication. 7. Side effects of the medications. 8. Specific medication administration requirements. Note: [MEDICAL CONDITION] is not part of the basic medication aide course. 9. Medication packaging systems. 10. Medication storage, destruction or return of medication. (f) Medication administration. 1. Techniques and procedures of various routes of medication administration. Note: Injections, and medications administered via a tube, a nebulizer, or an [MED]gen route will not be evaluated as part of the basic nursing home medication aide curriculum. 2. Six rights of medication administration, including right patient, right drug, right dose, right route, right time, and right documentation. (g) Observations, communication, and reporting. Requirements for timely reporting and documenting the administration of all medication, including the need for PRN medications and the resident's response, refusal to take medication, omission of medications, errors in the administration of medication and drug reactions and any change in the condition of a resident. (h) Medication safety. 1. Prevention of medication errors. 2. Causes and reporting of medication errors. Surveyor requested Policy and Procedure for CMAs from NHA A (Nursing Home Administrator) on [DATE] at 4:50 PM. At 5:27 PM on [DATE] NHA A reported that they do not have a Policy and Procedure for CMA's but they had been utilizing the Medication Aide Responsibility Job Description undated. CMA C has been employed at this facility since 12/11/13 when she was hired as a CNA (Certified Nursing Assistant). CMA C obtained the Medical Assistant certification 6/29/15. She began passing medications sometime in July 2019. Per the Facility's 2020 schedules, CMA C worked in the capacity of passing medications 19.5 shifts in January, 21 shifts in February, and 2 shifts in March. On [DATE], CMA C administered [MEDICATION NAME] to R1. R1 was to receive a 5 mg dose. Instead, CMA C administered a 50 mg dose. Part of the Facility's investigation into R1's medication error was a statement from CMA C (Certified Medical Assistant). It documents: On Wednesday [DATE] around 10:00 AM. I drew up [MEDICATION NAME] for resident (R1), as instructed by the hospice nurse. The order on the MAR indicated [REDACTED]{sic} I've never given that much [MEDICATION NAME] before, so I questioned it. I asked the nurse I was working with, DON B (Director of Nursing), Is this the right order on the MAR? She stated that it was and I asked again. She was unaware of the change of dose and/or different bottle we had received from the pharmacy. The order should have been changed and confirmed on the MAR indicated [REDACTED]. This did not happen. I thought I was giving the right dose as instructed. I mixed it with applesauce after asking if this was okay. The patient refused the medication. I left it with the hospice nurse so that she could try to re-attempt. She was successful and she informed me of this. I was still questioning this dose after the fact and this is when DON B called NP (Nurse Practitioner) and made interventions. {sic} Per R1's Nurses Note dated [DATE]20 at 17:00 (5:00 PM), documents: At approximately 1450 (2:50 PM) I (DON B) was alerted by the med tech, she stated that the residents' family had concerns of a possible change in her breathing pattern. While walking to room the med tech alerted me of a possible suspected drug overdose involving [MEDICATION NAME]. As the pharmacy sent two different [MEDICATION NAME] orders with different concentration amounts. This writer immediately went to residents room to assess her heart rhythm, breathing patterns and O2 ([MED]gen) saturations. Upon arrival resident was lying in bed resting peacefully, no signs of distress or cyanosis, no use of accessory muscles.

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F 0726 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 5) During entire ordeal the resident never lost consciousness and was alert and responsive to speech, She made eye contact when name was called. Pulse ranged from 60 to 68, respirations 16 to 18 even, non labor, blood pressure 135 / 73, O2 saturation 93 to 95% on Room air. This writer immediately contacted hospice to let them know of the possible overdose, hospice nurse then instructed me to call NP. I received a verbal order to give [MEDICATION NAME] after I had given report of resident condition and vital signs. I administered [MEDICATION NAME] and called 911 per order. Residents family in agreement, Resident transferred out via ambulance to ER (emergency room). DON B was given an order to administer [MEDICATION NAME] to R1 as a result of this medication error. [MEDICATION NAME] is a narcotic antagonist which is used to counteract the effects of narcotics (it can treat narcotic overdose in an emergency situation). Of note, from 1/1/20 through 3/2/20 there were 3 of 6 residents with orders for [MEDICATION NAME] Solution that resided on the 300/400 units where CMA C was scheduled to work. On 3/2/20 at 4:00 PM, Surveyor interviewed NHA A. Surveyor asked NHA A when CMA C began working in the role of passing medications, NHA A said July of 2019. Surveyor asked NHA A for all CMA C's training records related to medications. NHA A returned with a folder that did not include any training records. Folder did include a job description for a Nurse Technician and a job description for a Certified Medication Assistant. Surveyor asked NHA A if CMA C was in nursing school, NHA A said no. On [DATE]20 at 4:50 PM, Surveyor interviewed NHA A. Surveyor asked NHA A if CMA C had any training on medications prior to R1's medication error, NHA A said Not that I can find. Surveyor asked NHA A if CMA C was working anywhere else, NHA A stated, No, she is full time here. Surveyor asked NHA A how she is scheduled, NHA A explained that she is scheduled to work in a nurse slot however if a CNA calls in, she may be pulled from that role into working as a CNA. Surveyor asked NHA A when she is scheduled, does she work on a designated unit, NHA A said yes, 300/400 units. Surveyor asked NHA A how many residents that could potentially serve, NHA A said approximately 36 residents. Surveyor asked NHA A if the facility had any other CMAs, NHA A stated not as of today. Surveyor asked NHA A when CMA C last worked passing medications, NHA A said today. Surveyor asked NHA A if CMA C worked the entire shift passing medications, NHA A stated no about noon, she was pulled from that task and put into role of CNA. Surveyor asked NHA A if CMA C had any other medication errors, NHA A explained that she was unsure if she would be able to find that information as they track the medication errors as part of QA (quality assurance) but didn't include staff names involved. Surveyor asked NHA A if she knew what CMA C's jobs were prior to being hired here, NHA A said she would look in her file. NHA A returned with part of CMA C's resume which documents that her previous job history was as event coordinator and marketing manager. The Facility's failure to ensure staff have the appropriate credentials and training created a finding of immediate jeopardy. The facility removed the immediate jeopardy on 3/2/20 when it had completed the following: 1. CMA C was removed from passing medications 2. Audit tool distributed to Human Resources to ensure proper licensure and contents of employee files 3. Administrator, Director of Nursing, and Human Resources educated on scope of CMA's 4. CMA C educated on scope of practice for CMAs 5. Facility policy reviewed and revised for proper utilization of Medication Technicians/Aides 6. Facility reviewed and revised Medication aide Job Description 7. All facility licensed personnel credentials were reviewed and validated as appropriate 8. The HR (Human Resource) Director, Administrator, or Designee will conduct audits of 2 employee files to ensure ongoing and sustained compliance. Adverse findings will be immediately addressed. Findings will be reported to QAPI (quality assurance process improvement) Committee and Corporate Compliance.
F 0730 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Observe each nurse aide's job performance and give regular training.** Based on interview and record review, the facility did not ensure Certified Nursing Assistant (CNA) staff completed 12 hours of annual inservicing for 3 of 5 staff members selected for review. CNA C was hired on 2/11/13. CNA C did not complete 12 hours of in-service training. CNA I was hired 2/4/2019. CNA I did not complete 12 hours of in-service training. CNA M was hired 4/23/18. CNA M did not complete 12 hours of in-service training. This is evidenced by: On 3/9/20 at 3:40 PM, Surveyor interviewed HR N (Human Resources) who indicated she is not aware of anyone monitoring the number of CNA inservice hours. HR N indicated that CNA's should be meeting the 12 hour requirement. On 3/9/20 at 3:45 PM, Surveyor interviewed NHA A (Nursing Home Administrator) who indicated that 12 hours are required for CNA continuing education. Example 1 CNA C was hired on 2/11/13. CNA C did not complete 12 hours of in-service training. Example 2: CNA I was hired on 2/[DATE]9. CNA I did not complete 12 hours of in-service training. Example 3: CNA M was hired 4/23/18. CNA M did not complete 12 hours of in-service training.

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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility did not ensure medication error rates are not 5% or greater during medication administration, this affected 3 of 3 Residents (R15, R16, and R14) observed for medication administration. The facility's medication error rate is 70% for 14 errors out of 20 opportunities. R15 received her scheduled medications over an hour late, resulting in 9 out of 13 medications being received late and 1 medication given without an order. R16 received his scheduled insulin over an hour late. R14 received 4 of 6 scheduled medications over an hour late. This is evidenced by: Facility Policy entitled 'Liberalized Medication Administration,' dated 1/2/20, states, in part: implemented liberalized medication administration times to improve the quality of life and respect the individual preferences of the residents. Liberalized medication times will be implemented following physician orders [REDACTED]. .Liberalized medication times will only apply to medication that are ordered daily or twice a day. Medications are to be administered at appropriate times per pharmacy regulation. Medications ordered at prescribed times will be given as ordered. .A physician's orders [REDACTED]. Facility Policy entitled 'Administering Medications,' dated 8/1/15, states, in part: Purpose: To ensure safe and effective administration of medication in accordance with physician orders [REDACTED]. Medications shall be administered in physician's written/verbal orders upon verification of the right medication, dose, route, time and positive verification of the resident's identity when no contraindications are identified and the medication is labeled according to accepted standards. .6. Medications should be administered within one (1) hour of the prescribed times. On 3/9/20 at 2:35 PM, Surveyor interviewed DON B (Director of Nursing) regarding Medication administration. DON B indicated that Medications should be given at the specific times indicated on the MAR. DON B indicated there is no Pharmacy formulary for over the counter medications. Example 1: R15 was admitted on [DATE] with [DIAGNOSES REDACTED]. R15's Physician Orders, provided to Surveyor on 3/9/20, states in part: Calcium [MEDICATION NAME] Antacid tablet chewable 1000 mg (milligram) give 1 tablet by mouth two times a day with morning and evening meal. .Carvediolol tablet 12.5 mg give 1 tablet by mouth two times a day. .[MEDICATION NAME] Capsule 1.25 mg (UT) give 1 capsule by mouth one time a day every Mon (Monday), Wed (Wednesday), Fri (Friday). .[MEDICATION NAME] sodium tablet 150 mcg (micrograms) give 1 tablet by mouth one time a day . before breakfast. .[MEDICATION NAME] tablet 1 gm (gram) give 1 tablet by mouth two times a day. .[MEDICATION NAME] Chloride tablet 5mg give 5 mg by mouth one time a day. .[MEDICATION NAME] [MED] ([MEDICATION NAME]) tablet 5 mg give 10 mg by mouth every 8 hours . [MEDICATION NAME] tablet 200 mg ([MEDICATION NAME] [MED]) give 200 mg by mouth two times a day . Vitamin D3 tablet ([MEDICATION NAME]) give 2000 IU (international units) by mouth one time a day . On 3/9/20 at 9:45 AM, Surveyor observed LPN F (Licensed Practical Nurse) prepare R15's morning medications for administration. During this observation LPN F prepared the following medications for administration which are indicated to be late: [MEDICATION NAME] 150 mcg tab (tablet), calcium [MEDICATION NAME] 500 mg two tabs, [MEDICATION NAME] Chloride 5 mg tab, [MED] 12.5 mg tab, [MEDICATION NAME] tab 1 gm, [MEDICATION NAME] tab 200 mg, [MEDICATION NAME] 5 mg two tablets, and Vitamin D3 1000 IU's two tabs, and Vitamin D3 IU cap. LPN F provided the prepared medications to R15 at 10:06 AM. LPN F stated I'm so late on pills it makes me sad. Surveyor asked LPN F if [MEDICATION NAME] and [MEDICATION NAME] are the same medications or if they can be interchanged, LPN F indicated she did not know. LPN F continued to give the Vitamin D3 at this time along with Vitamin D3 2000 IU's at this time. R15's MAR (Medication Administration Record) and orders indicate to give [MEDICATION NAME] 50,000 1 cap (Vitamin D2) not Vitamin D3. R15's MAR indicated [REDACTED]. [MEDICATION NAME] Chloride tablet 5 mg give 5 mg by mouth one time a day at 0800 (8:00 AM). Calcium [MEDICATION NAME] antacid tablet chewable 1000 mg time two times a day with morning and evening meal at 0800 and 1700 (5:00 PM). [MED] tablet 12.5 mg one tablet by mouth two times a day at 0800. [MEDICATION NAME] tablet 1 gm give by mouth two times a day at 0800 and 1700. [MEDICATION NAME] tablet 200 mg by mouth two times a day at 0800 and 1600 (4:00 PM). [MEDICATION NAME] [MED] tablet 5 mg give 10 mg by mouth every 8 hours at 0000 (12:00 AM), 0800, 1600. Example 2: R16 was admitted on [DATE] with [DIAGNOSES REDACTED]. R16's Physician order [REDACTED]. R16's blood sugar taken prior to breakfast by RN O (Registered Nurse) per RN O was 146. On 3/9/20 at 9:37 AM, Surveyor observed RN O prepare and Administer 1 unit via [MEDICATION NAME]pen. RN O injected 1 unit into R16's right upper quadrant of the abdomen. R16's MAR (Medication Administration Record) indicates Humalog Solution ([MEDICATION NAME]) inject per sliding scale at 0800 (8:00 AM).

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	525418	A. BUILDING _____ B. WING _____	**03/09/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
EVANSVILLE MANOR NURSING AND REHAB, LLC	**470 GARFIELD AVE EVANSVILLE, WI 53536**

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 0759 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 6) Example 3 On 3/9/20 at 10:19 AM, Surveyor observed RN O prepare and provide the following medications to R14. [MED] 25mg; [MEDICATION NAME] 17 grams; Oxybutin 5mg; Vitamin B12; [MEDICATION NAME] 20mg; and Levetiracetam 500mg. R14's physician orders, provided to Surveyor on 3/9/20, state, in part, the following: 1) B-12 Tablet ([MEDICATION NAME]) Give 1000mcg by mouth one time a day . 2) [MEDICATION NAME] Tablet 500mg (LevETIRAcetam) give 500mg by mouth two times a day . 3) [MEDICATION NAME] Powder (Polyethylene [MEDICATION NAME] 3350) Give 17 gram by mouth one time a day . 4) [MEDICATION NAME] Tablet Delayed Release 20mg Give 20 mg by mouth two times a day . 5) [MEDICATION NAME] tablet 25mg (QUEtiapine [MEDICATION NAME]) give 1 tablet by mouth two times a day . 6) [MEDICATION NAME] Chloride Tablet 5mg by mouth every day and evening shift . R14's MAR (Medication Administration Record) indicates to give these medications at the following times: 1) B-12 Tablet ([MEDICATION NAME]) Give 1000mcg by mouth one time a day between 7AM and 9AM. 2) [MEDICATION NAME] Tablet 500mg (LevETIRAcetam) give 500mg by mouth two times a day .between 7AM and 9AM 3) [MEDICATION NAME] Tablet Delayed Release 20mg Give 20 mg by mouth two times a day .between 7AM and 9AM 4) [MEDICATION NAME] tablet 25mg (QUEtiapine [MEDICATION NAME]) give 1 tablet by mouth two times a day .at 8AM. 5) [MEDICATION NAME] Chloride Tablet 5mg by mouth every day and evening shift .at DAY and EVE (Of note: This dose was administered timely) On 3/9/20 at 12:30PM, Surveyor interviewed RN O and asked if the medications, [MEDICATION NAME], [MED], Vitamin B12, and [MEDICATION NAME], given to R14 during the 10:19AM observation, would be considered given late? RN O stated, yes. On 3/9/20 at approximately 2:50PM, Surveyor interviewed DON B. Surveyor reviewed, with DON B, the physician orders [REDACTED]. DON B stated, no. Surveyor asked DON B if she would expect the medications to be given on time. DON B state, yes.

F 0760 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Ensure that residents are free from significant medication errors.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility did not ensure residents were free from significant medication errors for 1 of 6 sampled residents (R1). R1 had an order to receive 5 mg (milligrams) of [MEDICATION NAME] sulfate. On [DATE], CMA-C (Certified Medical Assistant) administered ten times the dose that was ordered. [MEDICATION NAME] had to be administered to reverse the effects of the medication and R1 was sent to the emergency room . The facility's failure to ensure that a resident was free from a significant medication error created a finding of immediate jeopardy that began on [DATE]. NHA A (Nursing Home Administrator) was notified of the immediate jeopardy on [DATE] at 10:30 AM. The immediate jeopardy was removed [DATE]; however, the deficient practice continues at a scope/severity level of D (potential for more than minimal harm/isolated) as the facility continues to implement its action plan. This is evidenced by: The Facility's Policy and Procedure entitled Administering Medications with a revision date of [DATE] documents, in part: .3. Medications shall be administered in physician's written/verbal orders upon verification of the right medication, dose, route, time and positive verification of the resident's identity when no contraindications are identified and the medication is labeled according to accepted standards . R1 was a long term resident of the facility with [DIAGNOSES REDACTED]. R1 sustained a right femur fracture during a fall on [DATE]. R1 had a steady decline in her health status from then on. R1 was admitted to hospice on [DATE]. R1 had an active physician's orders [REDACTED]. This calculates to a dosage of 5 mg. R1's MAR (Medication Administration Record) had two [MEDICATION NAME] orders: 1) [MEDICATION NAME] Solution 20 mg/ml, give 5 mg by mouth every 2 hours as needed for pain, SOB (shortness of breath). This order was started on [DATE] and was discontinued on [DATE]. 2) [MEDICATION NAME] Solution 2 mg/ml, give 2.5 ml by mouth every 2 hours as needed for pain. This order was started on [DATE]. Pharmacies supply medications as concentrations based on availability, including [MEDICATION NAME]. Oftentimes, these concentrations are different than previously supplied. All bottles look the same but the concentration of its contents may be very different. Manufacturers change the concentration often without notification. It is the responsibility of the professional administering the medication to review the concentrations on the bottle and complete the calculations in order to administer the correct dosage to the patient. According to the facility investigation, there were two bottles of [MEDICATION NAME] in the medication cart: 1) [MEDICATION NAME] Oral Solution 100 mg per 5 ml (20 mg/ml), take 0.25 ml (5 mg) by mouth every 2 hours as needed for pain. 2) [MEDICATION NAME] Solution 10 mg/5 ml 2.5 ml (5 mg) by mouth every 2 hours as needed for pain or SOB. It is important to note that the first order for [MEDICATION NAME] Solution with a concentration of 100 mg per 5 ml (20 mg/ml) was discontinued on [DATE] but remained in the medication cart. Surveyor reviewed the facility's investigation into this medication error. A statement from CMA C (Certified Medical Assistant) states, On Wednesday [DATE] around 10:00 AM. I drew up [MEDICATION NAME] for resident (R1), as instructed by the hospice nurse. The order on the MAR indicated [REDACTED]. I asked the nurse I was working with, DON B (Director of Nursing), 'Is this the right order on the MAR?' She stated it was and I asked again. She was unaware of the change of dose and/or different bottle we had received from the pharmacy. The order should have been changed and confirmed on the MAR indicated [REDACTED]. This did not happen. I thought I was giving the right dose as instructed. I mixed it with applesauce after asking if this was okay. The patient refused the medication. I left it with the hospice nurse so that she could try to re-attempt. She was successful and she informed me of this. I was still questioning this dose after the fact and this is when DON B called NP (Nurse Practitioner) and made interventions. Of note, R1 had two bottles of [MEDICATION NAME] in the medication cart, one with a higher concentration (100 mg/ 5 ml) with instructions to administer 0.25 ml and one with a lower concentration (10 mg/5 ml) with instructions to administer 2.5 ml. CMA A drew up 2.5 ml of the higher concentration bottle which resulted in R1 receiving ten times the dose she should have received. It is important to note that CMAs are unlicensed in the state of Wisconsin and are not allowed to pass medications unless they successfully complete coursework and become certified medication assistants. (Refer to F726.) R1's nurses note dated [DATE] at 5:00 PM, states, At approximately 1450 (2:50 PM) I (DON B) was alerted by the med tech, she stated that the residents' family had concerns of a possible change in her breathing pattern. While walking to room the med tech alerted me of a possible suspected drug overdose involving [MEDICATION NAME]. As the pharmacy sent two different [MEDICATION NAME] orders with different concentration amounts. This writer immediately went to resident's room to assess her heart rhythm, breathing patterns and O2 ([MED]gen) saturations. Upon arrival resident was lying in bed resting peacefully, no signs of distress or cyanosis, no use of accessory muscles. During entire ordeal the resident never lost consciousness and was alert and responsive to speech, She made eye contact when name was called. Pulse ranged from 60 to 68, respirations 16 to 18 even, non labor, blood pressure ,[DATE], O2 saturation 93 to 95% on room air. This writer immediately contacted hospice to let them know of the possible overdose, hospice nurse then instructed me to call NP. I received a verbal order to give [MEDICATION NAME] after I had given report of resident condition and vital signs. I administered [MEDICATION NAME] and called 911 per order. Residents family in agreement, Resident transferred out via ambulance to ER (emergency room). DON B was given an order to administer [MEDICATION NAME] to R1 as a result of this medication error. [MEDICATION NAME] is a narcotic antagonist which is used to counteract the effects of narcotics (it can treat narcotic overdose in an emergency situation). While R1 was in the ER she had her vital signs (temperature, pulse, respirations, blood pressure and [MED]gen saturation) monitored, she had lab work drawn and had an EKG (electrocardiogram which measures electrical activity of the heartbeat) conducted. R1 then returned to the facility. R1 expired on [DATE]. R1's cause of death is not known at this time; the Facility, Hospice nor Physician Office have death certificate as of [DATE]. On [DATE] at 4:50 PM, Surveyor interviewed NHA A. Surveyor asked NHA A if she would expect the staff that passes medication to ensure they are giving the correct dose of medication, NHA A said yes. Surveyor asked NHA A if someone passing medications asks a co-worker who also passes medications to verify an order, would you expect that to happen, NHA A said well, I'm not a nurse, but I would think they would check. Surveyor asked NHA A if she would expect one person to pass off medication to another person to administer, NHA A reiterated, I'm not a nurse so I'm not exactly sure of the protocol but I would feel more comfortable if there were documentation around the situation. The facility's failure to ensure staff administer the correct dose of [MEDICATION NAME] created a finding of immediate jeopardy. The immediate jeopardy was removed [DATE] when the facility completed the following: 1. Report was run to audit and clarify all liquid [MEDICATION NAME] orders in facility 2. All orders reviewed and clarified 3. DON validated transcription of orders is consistent with medication concentration available 4. Carts were audited to ensure liquid medications available are appropriate to active orders only 5. Pharmacy consultants completed med cart audits 6. Pharmacy informed of facility updated practice of providing one consistent formulary, specifically in regards to [MEDICATION NAME]: 100 mg/5 mL (20 mg/ 1 mL) 7. Hospice informed of facility desired practice of providing one consistent formulary, specifically in regards to [MEDICATION NAME]: 100 mg/5 mL (20 mg/ 1 mL) 8. Licensed professionals given education on avoiding common medication errors - Initiated on: [DATE] and ongoing 9. Licensed professionals reviewed dosing calculation, specifically related to liquid medication, including [MEDICATION NAME]; with quiz and re-education 10. Return demonstration competency completed with staff licensed professionals, to include three checks of order to label 11.

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F 0760 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 7) Licensed professions re-educated specifically pertaining to checks of medication orders to label 12. Regional Nurse Consultant re-educated DON specifically pertaining to checks of medication orders to label 13. QA (quality assurance)/QI (quality improvement) Tools were developed and implemented to ensure ongoing and sustained compliance. Adverse findings will be immediately addressed. compliance and maintenance with this plan. To be completed on-going by DON or designee, using the following increments: