STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525434	A. BUILDING _____ B. WING _____	**08/06/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HAYWARD HEALTH SERVICES	**10775 NYMAN AVE HAYWARD, WI 54843**

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 0553 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Allow resident to participate in the development and implementation of his or her person-centered plan of care.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility did not ensure 2 of 4 residents' (R1 and R4) legal representatives were involved in the decision-making process of a care plan conference to discuss resident's goals and cares. R1 and R2's last care conference was held on March 12, 2020. The June 2020 Care Plan Conference was missed. This is evidenced by: On 8/4/20 at 10:36 AM, the surveyor interviewed RN-D (Registered Nurse) regarding the care plan process. RN-D is the MDS (Minimum Data Set) and care planning coordinator. RN-D stated that she works 1-2 days each week. She stated that she arranges care plan sessions according to her MDS schedule, normally 1 week after the Assessment Reference Date of the MDS. She stated since the Covid-19 Pandemic, .It's been hard . we have no social worker or director of nurses in the building anymore. On days that I am not here, there is no MDS Coordinator in the building. The Surveyor asked how she was handling the Care Plan meetings since the Pandemic. RN-D stated that she completes the MDS assessment then sets up a meeting with the resident, either in their room or in the conference room. If the resident has a legal decision-maker, she sets up a phone call meeting with them. RN-D stated, . It's been hit and miss because I'm not always here and without a social worker and director of nursing, well, it's been rough. The Assistant Director of Nursing (ADON) hasn't been able to help, she's too busy . RN-D stated that if she does hold a care conference, she would normally document in the resident's medical record that one was held but , . I haven't been putting them in. I barely have the time to do the care conference . Example 1: R1 was admitted to the facility on [DATE]. Medical [DIAGNOSES REDACTED]. According to R1's Medical Record, Power of Attorney (POA) was activated on 9/10/19 after the signature of two physicians had deemed R1 incompetent to make his own decisions. POA-G (Power of Attorney) was listed as R1's legal decision maker. In an interview with POA-G on 8/3/2020 at 1:23 PM, the surveyor learned that R1 had not had a care plan conference since March. POA-G stated I am concerned that we haven't had a care plan conference since the facility has locked down for the Pandemic. We had one on March 12, then none. They should be having them every three months or so . they called me and were very rude to me. They said they'll schedule one the end of August, but didn't give me a date . Prior to the Covid-19 Pandemic, POA-G was very involved in R1's care and would visit 4-5 times each week. POA-G has been R1's significant other for many years and stated, . Since the Pandemic, I receive very few updates on (R1) . we have no other means of knowing how our loved ones are doing, if they don't contact us. Care Planning is a very important part of his life. I wish to direct his care the way he would want. The Surveyor interviewed RN-D on 8/4/20 at 10:36 AM. RN-D stated R1's care conference was one that she had missed. In reviewing R1's Medical Record, care plan sessions were held on 12/12/2019 and on 3/12/2020. Another should have been conducted in June, however, there is no evidence that this was held. Example 2: R4 has medical [DIAGNOSES REDACTED]. R4's legal decision-maker is her son POA-J (Power of Attorney). Attempts were made to contact POA-J to discuss R4's care, but this was unsuccessful. According to R4's Medical Record, the last care plan conference was held on March 12, 2020. There was no entry indicating whether POA-J was in attendance or declined to attend. However, there are no entries of another conference since then. On 8/4/2020 at 3:40 PM, the Surveyor asked RN-D if she recalled R4's care plan conference. RN-D stated that R4 also has not had a conference since the Covid-19 lockdown. . She was another one that I missed.
F 0580 **Level of harm** - Minimal harm or potential for 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** Based on staff and legal representative interviews and record reviews, the facility did not consistently consult 2 of 4 (R1 and R2) residents legal representatives when changes to their care were made. - R1's legal representative was not contacted when medications were added to his plan, when he had [MEDICAL CONDITION] activity or when he had a room change. - R2's legal representatives were not contacted with numerous changes to his care, including the development of wounds, falls, new medications, ordered transfers to the hospital and consultation appointments to specialized services. This is evidenced by: On 8/4/20 at 10:15 AM, the Surveyor interviewed the Assistant Director of Nursing (ADON). The facility currently does not have a Director of Nursing. The ADON stated the expectation for updating and notifying both doctors and family or legal representatives is whenever there is a change in condition or . something new with the resident, like a room change, new medications, ordered consultations, labs, or with skin changes or falls, we would call them. On this same date at 12:30 PM the Surveyor interviewed the Nursing Home Administrator (NHA) regarding family or legal representative notification expectations. The NHA stated the floor nurses are expected to notify the residents representatives whenever there is a change in condition or any updates with skin issues, new medications, falls. She stated . the floor nurses take the reigns . It falls on the nurses shoulders to make the calls . At 2:36 PM, the Surveyor interviewed RN-C regarding notification. RN-C stated We call the family or legal representative whenever there is a change in condition, a fall and we need to transfer them out, with any updates the emergency room may give us, any changes with doctor's orders, just about everything. It's our duty to call right away . Example 1: R2 has medical [DIAGNOSES REDACTED]. R2's medical decision-makers are court appointed guardians with the Helping Hands Family Services in which two guardian representatives oversee his care, Guardian-E and Guardian-F. R2 was transferred to another facility on 4/9/2020. On 8/3/2020 at 3:30 PM, the Surveyor called Guardian-F to interview her regarding R2's care. Guardian-F stated there were many opportunities the facility should have contacted their agency regarding changes in R2's cares, including new wounds he sustained, falls, new medications, transfers to the hospital, consultation appointments and lab work that the physician ordered be completed. Guardian-F stated she had demanded updates numerous times but the facility was not forthcoming on information. She stated, It was very upsetting . We just want to keep informed. How hard is it to shoot us an E-Mail or place a phone call to us?. We transferred (R2) out based on care and getting the run around from them . Guardian-F stated that she was aware R2 had many co-morbid conditions that made the development of new wounds possible or difficult to heal his wounds. Her concern was keeping their agency updated. On 8/4/2020 and 8/5/2020, the Surveyor completed a record review of R2's Medical Record. There were several entries noted in the documentation where it wasn't clear whether the facility made the appropriate updates to either Guardian. On 8/7/2020 at 1:08 PM a telephone conference call between the surveyor and both Guardian representatives (Guardian-E and Guardian-F) was held. The surveyor explained the need for clarification on what they were and were not informed about regarding R2's cares. The Guardians stated We know (R2) has a lot of medical things going on that make wounds difficult to heal or easy to a get new ones. Our main issues are that they didn't ever keep us in the loop. Getting updates from them was so difficult. We would make repeated requests and it would always be two to three weeks before information was received. It's hard to be their advocate or to jump on things when we learn of them two to three

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 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) weeks after the facts. Below is the list of events or incidents in which the Guardians indicated they were not informed about and their responses: - 9/18/19 R2 consultation with Orthopedics and Urology: Guardian-F stated We didn't know of this right away. They didn't give us the opportunity to not have (R2) have the consultations. We learned of these the day afterwards. I was called by the Orthopedic Surgeon after he did the consultation. I did go with (R2) to the Urologist consult, but again, learned of it after the appointments were made. - 9/20/19 Bruise noted to R2's buttocks as a result of a slide board transfer: Both guardians stated they were not aware of a bruise. Guardian- F stated, We were not given any notice on this, never a call or documentation. We never knew he had a wound on his buttocks back then. Guardian-E indicated the same. - 9/26/19 Swollen and irritated penis as a result of a Foley catheter AND blister to R2's Achilles' tendon Both guardians stated No, gosh, no we didn't know that either. We were never notified of the blister either. - 10/4/19 Decrease in [MEDICATION NAME] medication; [MEDICATION NAME] added; Antibiotic therapy for Urinary Tract Infection [MEDICAL CONDITION]: Both guardians stated, Nope, they never called us with any medication changes, not even if they were calling the doctor to update on his condition. - 10/23/19 Nephrology consultation: Both guardians stated, No, we were not notified that a referral was made. We were never offered the opportunity to consent or not to consent to this. - 10/24/19 Right leg splint was removed from a fracture and two new wounds were identified on the knee area: Both guardians indicated to the surveyor that rarely were they notified of any new wounds. - 10/26/19 R2 developed a new wound to his right calf area: Both Guardians stated they were not aware of these new wounds. - 11/5/19 Two new wounds identified on R2's left hip: Both guardians stated they were not aware of these and stated, This is so sad. - 11/25/19 and 12/9/19 R2 was receiving iron injections Guardian-F stated that she was aware that R2 was receiving these injections but stated We never really received information. We did know his iron levels were low. I'm a little fuzzy on the dates, but I don't believe it was this early on (November/December) that we were made aware. It was more like January/February time frame. - 1/21/20 Medication changes were made: Both guardians again reiterated that they were never made aware of medication changes. - 1/23/20 Treatments to the wounds were changed Guardian-F stated, Nope. Again, no updates were ever given to us with his wounds. That's why we were so shocked when he was admitted to (new facility) and they said he had seven wounds on admission. - 2/10/20 Labs and an X-ray was ordered to R2's right great toe: Guardian- F stated they were not informed initially of the great toe wound and were not asked if they consented to the lab work or the X-ray. - 2/12/20 R2 developed Gastrointestinal upset. A stool sample was sent for testing of [MEDICAL CONDITION]: Both guardians indicated they were not aware of this. Note: The stool culture revealed [MEDICAL CONDITION]. In addition, R2 also was positive for Norovirus. Antibiotics were changed. The wound culture revealed [MEDICAL CONDITION] Resistant Stapyhlococcus Aureus infection. R2 was placed into Contact and Droplet precautions. - 2/17/20 R2 was seen out of the state (just over the state border) for a wound debridement; Fall (lowered to the floor by staff): Both guardians stated they did not give consent to this procedure. Neither acknowledged knowing of a fall - 3/9/20 [MEDICATION NAME] Gel was added for R1's left shoulder: Both guardians stated they were unaware of this new order. - 3/20/20 R2's right great toe wound healed: Both indicated they were not made aware of this. - 3/22/20 R2 developed incontinence [MEDICAL CONDITION] to his buttocks: Both guardians stated they were not aware of this. - 3/31/20 R2's Hemoglobin was noted to be at a critical level: Both guardians stated they were never updated on this. Guardian-E stated that she attended the 01/02/2020 Care Conference. She stated, During that conference, they never said anything about the severity of (R2's) wounds or that he had an antibiotic because of infection to them. They only said that he has a wound that they are treating. I didn't think it was severe or they would have mentioned it. I was wrong. Guardian-F then stated, It's so sad. Our concern is that we have another resident there. I'm concerned that they aren't keeping us updated with them either. It's just so bad. How can I be the resident's voice if I am not informed? The practices of not keeping the guardians informed prevented them from making informed choices regarding R2's care and treatments. Example 2: R1 was admitted to the facility on [DATE]. Medical [DIAGNOSES REDACTED]. According to R1's Medical Record, Power of Attorney (POA) was activated on 9/10/19 after the signature of two physicians had assessed R1 incompetent to make his own decisions. POA-G (Power of Attorney) was listed as R1's legal decision maker. In an interview with POA-G on 8/3/2020 at 1:23 PM, the surveyor learned that prior to the Covid-19 Pandemic, POA-G was very involved in R1's care and would visit 4-5 times each week. POA-G has been R1's significant other for many years and stated, . Since the Pandemic, I receive very few updates on (R1) . we have no other means of knowing how our loved ones are doing, if they don't contact us . In reviewing R1's Medical Record, there were instances in which updates to POA-G should have been given but the documentation did not clarify whether this was completed. The Surveyor placed a telephone call to POA-G on 8/6/20 at 2:38 PM for these clarifications. Following are the events and POA-G's responses: - 5/9/20 R1 had episodes of vomiting: POA-G stated that she did not know of this. - 6/29/20 [MEDICATION NAME] Gel ordered to R1's right shoulder POA-G stated she wasn't aware of this new order, stating, I would remember this because he always has had pain to that shoulder. - 7/16/20 R1 had a room change: POA-G stated No, I was told of that while I was doing a window visit. (RN-C) told me and was upset that I wasn't called about it. I wasn't given any explanation. - 7/25/20 R1 had [MEDICAL CONDITION] activity: POA-G stated she was unaware of this. She further stated, (R1) has a lot of [MEDICAL CONDITION], some of which I think get missed because he may have them when staff aren't around him. She stated, I am not made aware of each [MEDICAL CONDITION] they see him having. The practices of not keeping POA-G updated and informed prevented her from making informed choices regarding R1's care and treatments.