STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525573	A. BUILDING _____ B. WING _____	09/10/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
RENNES HEALTH AND REHAB CENTER-DEPERE	200 S NINTH ST DE PERE, WI 54115

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 0684 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure that 1 of 1 sampled residents (R1) received an RN (Registered Nurse) assessment and appropriate medical care when R1 had a significant change in his medical condition. On 6/9/20 CNA (Certified Nursing Assistant)-C reported to LPN (Licensed Practical Nurse)-D that R1 was exhibiting signs of a stroke with left sided weakness, left sided eye droop and left sided facial droop. LPN-D failed to properly evaluate R1 and failed to notify an RN to assess R1. R1 went a full day without a comprehensive assessment until 6/10/20 when assessed by LPN-E and RN-G. R1 was sent to the ED (Emergency Department) then returned later that afternoon on 6/10/20 with a [DIAGNOSES REDACTED]. R1 ultimately passed away at the facility on 6/15/20. As a result of the facility's failure to properly assess R1 on 6/9/20 R1 waited a full 24 hours later before being sent to the ED on 6/10/20 for treatment of [REDACTED]. This created a finding of Immediate Jeopardy that began on 6/9/20. NHA (Nursing Home Administrator)-A was notified of the immediate jeopardy on 8/26/20 at 3:00 PM. The jeopardy was verified to be removed later that day on 8/26/20; however, the deficient practice continues at a scope/severity of D (potential for more than minimal harm/isolated) as the facility continues to implement its action plan. Findings include: According to the Stroke Association, Quick Stroke Treatment Can Save Lives .If you're having a stroke, it's critical that you get medical attention right away. Immediate treatment may minimize the long-term effects of a stroke and even prevent death. Thanks to recent medical advances, stroke treatments and survival rates have improved greatly over the last decade. http://www.strokeassociation.org/STROKEORG/General/Why-Getting-Quick-Stroke-Treatment-Is-Important_UCM_ 0_Article.jsp. Timely intervention may reduce or minimize the most common types of disability after stroke, which include impaired speech, slowed ability to communicate, weakness or paralysis of limbs on one side of the body, restricted physical abilities, and difficulty gripping or holding things. According to the Wisconsin Nurse Practice Act, Chapter N6, a licensed practical nurse (LPN) can perform the following duties: N6.04(1) In the performance of acts in basic patient situations, the L.P.N. shall, under the general supervision of an R.N. or the direction of a provider: (a) Accept only patient care assignments which the L.P.N. is competent to perform. (b) Provide basic nursing care. (c) Record nursing care given and report to the appropriate person changes in the condition of a patient . (e) Perform the following other acts when applicable: 1. Assist with the collection of data. 2. Assist with the development and revision of a nursing care plan . The Wisconsin Nurse Practice Act, N6.03(1), when describing the duties of a registered nurse (RN), notes, An R.N. shall utilize the nursing process in the execution of general nursing procedures in the maintenance of health, prevention of illness or care of the ill. The nursing process consists of the steps of assessment, planning, intervention and evaluation. By law and training, an LPN cannot assess an individual. R1 was admitted to facility on 11/14/18 with the [DIAGNOSES REDACTED]. On 6/9/20 during the AM shift CNA-C notified LPN-D that R1 was exhibiting signs of change of condition including left sided weakness, left sided eye droop and left sided facial droop. R1's medical record indicated a nursing note from LPN-D on 6/9/20 at 10:19 AM recorded as a late entry on 6/12/20 at 6:19 AM, Writer called to room due to resident very lethargic. Resident able to move extremities independently. Resident was afebrile (having no fever). Lung sounds clear. No shortness of breath. Oxygen levels and all other vitals at baseline. Resident chief concern is lethargy. Resident does have a history of this issue. Will continue to monitor. There was no evidence of an RN assessment. A nursing note from LPN-D on 6/9/20 at 1:21 PM recorded as a late entry on 6/12/20 at 6:21 AM indicated, Resident remains lethargic throughout shift with some episodes of more activity at times. Vitals all remain at baseline. Output for shift is somewhat decreased but will be receiving a flush catheter. There was no evidence of an RN assessment, A nursing note from LPN-F on 6/9/20 at 9:01 PM recorded as a late entry on 6/16/20 at 4:02 PM indicated, Resident noted to be sleeping all shift. Would wake for staff and took medications without incidence. Choosing not to eat dinner tonight. No neurological deficits noted. There was no evidence of an RN assessment. Surveyor interviewed CNA-C on 8/26/20 at 10:20 AM. CNA-C indicated she had reported to LPN-D on the AM shift that R1 was exhibiting left sided weakness, left sided eye droop and left sided facial droop. LPN-D and CNA-C went into R1's room. CNA-C indicated LPN-D sat R1 up on edge of bed and took his vitals. CNA-C indicated that's all LPN-D did, she kind of just brushed it off and did not document his current condition. CNA-C also indicated that LPN-D did not communicate R1's current condition to the next shift. CNA-C also indicated that R1 could not swallow or keep liquids in his mouth and did not eat that AM shift. Surveyor interviewed LPN-D on 8/26/20 at 11:53 AM. LPN-D indicated that she remembered CNA-C coming to her on 6/9/20 with concerns for R1 with left sided weakness and facial droop. LPN-D indicated she took R1's vitals and did not notice any facial droop and could move both arms and legs. LPN-D indicated that lethargy was the key symptom. LPN-D indicated she did not notify an RN to assess R1 but communicated to the next shift. LPN-D also indicated that she did not document R1's assessment that day because she had forgotten. When she returned on 6/12/20 her unit manager requested she make a late entry of her assessment. Surveyor interviewed CNA-C on 8/26/20 at 10:20 AM. CNA-C indicated that when she returned to her AM shift the next day, 6/10/20, R1 was exhibiting the same signs of left sided weakness, left sided eye droop and left sided facial droop. CNA-C at this time notified LPN-E to evaluate R1. LPN-E concluded he was exhibiting signs of a stroke with no hand strength and left sided facial droop with drooling. LPN-E then contacted the unit manager RN-G. RN-G assessed R1 and agreed with LPN-E. LPN-E then contacted R1's POA (Power of Attorney) and the Physician. R1 was then sent to the ED (Emergency Department). LPN-E indicated R1 returned that afternoon with a [DIAGNOSES REDACTED]. A nursing note from LPN-E on 6/10/20 at 8:52 AM indicated, With cares this AM (R1) left side flaccid. Responds to painful stimuli by grimacing. Pupils are equal and reactive however slow to react. Vital signs stable at this time. Left side of mouth is drooping. Mouth breathing. Call placed to POA and she stated if provider would like him sent to ED she would like (R1) sent. Call placed to provider. A nursing note from LPN-E on 6/10/20 at 9:10 AM indicates MD (Medical Doctor)-H stated to send R1 to the ED for evaluation and treatment. POA was called and updated on plan to send R1 to the ED. On 8/26/20 at 12:10 PM Surveyor interviewed MD-H. MD-H indicated that she was not at the facility on 6/10/20 as she was in the Hospital at the time due to having surgery. MD-H indicates she does not remember if she received a call for R1 on 6/10/20 and that she would have to review her notes and charting, but would not be returning to the facility until Monday the 31st of August. On 8/26/20 at 12:28 PM Surveyor interviewed DON (Director of Nursing)-B. DON-B indicated that an RN would not necessarily assess a resident if an LPN had already done an assessment with a resident who was at baseline. DON-B also indicated that CNA-C had come to her with concerns for R1 and the stroke he had. DON-B indicated that's when she directed the unit managers to see if there was an assessment done with R1. DON-B also indicated the unit managers then had the LPN's document their assessments as a late entry. Please note that an LPN can collect data but cannot assess a resident. Collected information needs to be given to an RN who can assess and develop a nursing plan of care and interventions. On 8/26/20 at 1:02 PM Surveyor interviewed DON-B. DON-B verified that R1 had passed away at the facility on 6/15/20 at 1:29

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 0684 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 1) AM. DON-B also indicated that she can only assume R1 passed away from a stroke. The facility's failure to provide care consistent with current standards of practice for completing an RN assessment for a resident with a significant change in condition delayed treatment options and created a reasonable expectation that serious harm could occur, and thus created finding of IJ that began on 6/9/20. The immediate jeopardy was verified to be removed on 8/26/20 when the facility began implementing the following: ~educate all RN/LPN's prior to their next shift on RN assessments for changes of condition, including neurological changes, and timely documentation. ~educate all staff prior to their next shift on reporting changes in condition and discussing any situation they feel has not been resolved/addressed with the supervisor, DON, or NHA.