STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525604	A. BUILDING _____ B. WING _____	03/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SOUTHPOINTE HEALTHCARE CTR	4500 W LOOMIS RD GREENFIELD, WI 53220

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 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 observation, interview and record review the Facility did not ensure 1 (R47) of 3 dependent residents reviewed received the necessary services to carry out their activities of daily living. R47 was observed on multiple days with facial hair. Findings include: R47's [DIAGNOSES REDACTED]. The ADL (activities daily living) care plan initiated & revised on 12/29/19 documents an intervention Personal Hygiene/Oral Care: The resident is an assist of 1 to complete task. initiated and revised on 1/8/20. The admission MDS (minimum data set) with an assessment reference date of 1/3/20 documents a BIMS (brief interview mental status) score of 9 which indicates moderately impaired. R47 requires extensive assistance with one person physical assist for hygiene which includes shaving. On 3/1/20 at 10:37 a.m. Surveyor observed R47 sitting in the dining area outside the nursing station holding onto a microphone singing with the music being played on the television. Surveyor observed R47 with facial hair appearing to be more than a day of growth. On 3/1/20 at 12:04 p.m. Surveyor observed R47 sitting in a wheelchair in the lounge area outside the nurses station. Surveyor observed R47 continues to have facial hair appearing to be more than a day of growth. On 3/1/20 at 3:33 p.m. Surveyor observed R47 sitting in a wheelchair in the lounge area watch television. Surveyor observed R47 continues to have facial hair appearing to be more than a day of growth. On 3/2/20 at 8:21 a.m. to 8:30 a.m. Surveyor observed CNA (Certified Nursing Assistant)-M provide morning cares for R47, dress and transfer R47 from the bed into the wheelchair. During this observation CNA-M did not offer or ask R47 if he would like to be shaved. Surveyor observed R47 continues to have facial hair appearing to be multiple days of growth. On 3/2/20 at 11:04 a.m. Surveyor observed R47 sitting in a wheelchair participating in an exercise activity. Surveyor observed R47 still has not been shaven. On 3/3/20 at 9:39 a.m. Surveyor observed R47 sitting in a wheelchair in the lounge. Surveyor observed R47 still has not been shaven. Surveyor asked R47 if he likes to have facial hair or does he like to be clean shaven. R47 replied clean, clean shaven. On 3/3/20 at 9:48 a.m. Surveyor asked CNA-M when R47 gets shaved. CNA-M replied I don't know when he gets shaved. On 3/3/20 at 10:40 a.m. Surveyor asked RN (Registered Nurse) Manager-L when R47 gets shaved. RN Manager-L informed Surveyor the aides do have razors and are to offer to shave residents during morning cares. RN Manager-L also informed Surveyor she received permission from the previous administrator to send Residents to the beauty shop to be shaved. Surveyor informed RN Manager-L of the observations of R47 with facial hair and during morning cares on 3/2/20 CNA-M did not ask or offer to shave R47. RN Manager-L informed Surveyor CNA-M needs re-education. On 3/3/20 at 3:00 p.m. Administrator-A and DON (Director of Nursing)-B were informed of the above.
F 0684 **Level of harm -** Minimal harm or potential for actual harm **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 1 of 33 residents received the necessary skin care and treatments. R103 was admitted on [DATE] with incontinence [MEDICAL CONDITION] on the buttocks area. R103 did not have any treatment ordered until 2/3/20 and those orders were not followed through on until 2/21/20. R103 received a change in the treatment order on 2/17/20 and those orders were not followed through. Findings include: The state agency received a complaint indicating R103 wounds had worsened. R103 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The admission MDS (minimum data set) dated 2/3/2020 indicates R103 was alert and oriented and able to make her needs known. R103 required limited supervision with one staff assist for bed mobility, transfer, dressing and personal hygiene. It also indicates R103 is continent of bladder and bowel. The section M Skin Condition section indicates R103 is at risk for pressure injuries. Section M1040 Other ulcers, wounds and skin problems has an area for moisture associated skin damage (MASD) (e.g., incontinence-associated [MEDICAL CONDITION] (iad), perspiration, drainage). This is not marked as being applicable for R103. The CAA (care area assessment) dated 2/4/2020 indicates Urinary incontinence CAA triggered. This CAA indicates Recent decline in condition-[MEDICAL CONDITION]. fall in 30 days. Dig, [MEDICATION NAME] daily, Eliquis daily. sched and PRN (as needed) pain meds. Monitored q (every) shift.[MEDICATION NAME]. O2, [MEDICATION NAME] X1 PRN, SOB (shortness of breath) w (with) exertion and flat. Labs 2/3/20-RBC (red blood cells), H&H (hematocrit and hemoglobin) (L) (left) pleurex drain. Inhalers. Monitor for changes. Update MD (medical doctor) as needed. Therapy PPOC. Items in reach. Well-lit area. The admission nursing evaluation indicates R103 had incontinent [MEDICAL CONDITION] over a large area of the buttock. The tissue analytics dated 2/3/2020 conducted by Wound MD G indicate R103 incontinence associated [MEDICAL CONDITION] measuring 9.6 cm by 9.91 cm. The periwound described as excoriated. The 2/3/2020 orders indicate, cleanse wound with saline, protect periwound with skin prep, apply xeroform gauze (cut to size) to wound bed, cover wound with ABD, change daily, Change PRN (as needed) for soiling and/or saturation. It also indicates discussed nutrition and its impact on wound healing. Follow facility pressure ulcer prevention policy/protocol, pressure redistribution mattress per facility policy/protocol, wheelchair pressure redistribution cushion per facility policy/protocol, offload heels per facility policy/protocol plan of care discussed with facility staff. The tissue analytics dated 2/17/2020 conducted by Wound MD G indicate R103 has incontinence associated [MEDICAL CONDITION] measuring 3.74 cm by 4.93 cm. The periwound described as excoriated. The orders indicate cleanse wound with saline, protect periwound with skin prep, cover wound with foam, change MWF (Monday, Wednesday and Friday), change PRN (as needed) for soiling and/or saturation. The facility skin weekly non pressure condition record dated 2/25/20 indicate the incontinence [MEDICAL CONDITION] had healed. The nurses note dated 2/29/2020 11:26 p.m. indicate Resident is alert. she is compliant with her medication but she refusing care. noted that her coccyx wound was draining and attempted on several times asking her to let nurse change dressing .she said no she just don't want to do it. no respiratory distress no pain. she sit most of the shift watching tv and talking to her roommate. The care plan for actual skin issues related to: prolong hospitalization w/debility and decreased mobility with date initiated 1/31/2020. The interventions indicate; notify MD of changes in wound or emerging wounds. Observe wound healing. Provide wound care/preventative skin care per order. Skin checks weekly per facility protocol, document findings. Turn and reposition frequently to decrease pressure. All interventions dated initiated on 1/31/2020. An intervention for check function of alt air mattress QS (every shift) and prn (as needed) for pressure relief date initiated 2/3/2020. The TAR (treatment administration record) indicate Buttock: NSW (normal saline wash) pat dry skin prep periwound f/b (followed by) xeroform gauze f/b border foam dressing every day shift for wound care with order date of 2/20/2020. This treatment was signed out by staff everyday from 2/21/20 through 3/3/2020 when R103 was discharged to inpatient hospice. The TAR indicate Buttock: [MEDICATION NAME] to entire buttock every shift for skin care with order date of 2/11/2020. This treatment was signed out every shift from 2/11/20 through 3/3/2020. On 3/5/2020 at 11:03 a.m. Surveyor interviewed DON

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525604	A. BUILDING _____ B. WING _____	03/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SOUTHPOINTE HEALTHCARE CTR	4500 W LOOMIS RD GREENFIELD, WI 53220

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0684 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) (Director of Nursing) B regarding R103 skin condition. Surveyor explained the concern the facility staff did not follow through on Wound MD G orders on 2/3/20 until 2/21/20. The Wound MD G treatment order changed on 2/17/20 was not followed though at all. Surveyor also explained the facility assessment on 2/25/20 indicate the buttock wound was healed but the 2/29/20 nurses note indicate the coccyx wound was draining. DON B stated she understood the concern but is not sure what happened with the treatment orders and the nurses note date 2/29/20 describing the wound as draining. Surveyor also explained the MDS did not capture the incontinence [MEDICAL CONDITION]. DON B had no additional information.
F 0686 **Level of harm -** Immediate jeopardy **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 failed to ensure that 6 of 11 (R410, R71, R96, R131, R9 and R10) residents did not develop avoidable pressure injuries. R410 was admitted to the facility on [DATE] and developed an avoidable Stage 4 PI (Pressure Injury) to the Coccyx with transfer and admission to the hospital with an infected Stage 4 PI on 12/30/19 following the facility's failure to implement measures to prevent the development as identified with the following: * R410'S skin was not assessed until 3 days after admission. * The facility did not implement R410's skin care plan until 3 days after admission. * The facility did not assess the R410's skin until 11/25/19 when two RN's separately assessed the resident. One RN indicated there was shearing on the left iliac crest and redness stage 1 on the sacrum while the other RN indicated there was a stage 2 pressure injury on the left buttock measuring 4 x 0.3 x 0 cm. * R410's 11/22/19 Admission Braden score was completed on 1/14/20 after discharge. Weekly Braden scores were not completed per facility protocol. * The facility implemented a generic care plan for skin care including reposition frequently, bowel and bladder per facility protocol, and check nutritional status. The facility did not implement an individualized care plan. The facility did get an air mattress for the bed and a cushion for her wheelchair. * The facility did not follow through with physician's orders [REDACTED]. * The facility did not document how frequently staff was turning the resident or if it was ensuring the resident remained up only for the amount of time prescribed by the physician. Facility staff did not put the resident to bed on 11/28/19 until after the resident and her friend had called the police. * The facility did not prevent the complication of an associated soft tissue or systemic infection in R410's coccyx wound. DR-G had ordered a stat CBC on 12/23/19 but the facility did not follow through with this order. The facility's failure to provide necessary treatment and care to prevent R410's pressure injury and prevent it from worsening created a finding of Immediate Jeopardy for R410 beginning on 12/16/19. Administrator-A, Corporate Consultant-C, RN Consultant-C were informed of the Immediate Jeopardy on 3/5/20 at 12:10 p.m. The Immediate Jeopardy was removed on 3/5/20; however, the deficient practice continues at a scope and severity level of G (harm/isolated) for R71, R96, R131, R9, and R10, as evidenced below; * R71 developed an unstageable pressure injury on her left heel on 12/27/19. There was no RN (Registered Nurse) assessment until 12/30/19, 3 days later. R71 was hosptalized on [DATE]. The hospital history and physical dated 1/2/20 under plan states seen by surgery for [REDACTED]. R71's pressure injury was debrided down to the bone due to a concern of osteo[DIAGNOSES REDACTED]. On 1/10/20 R71 returned to the Facility. The admission data collection documents a Stage 3 with no assessment of the wound bed. Three days later R71's pressure injury is staged as a Stage 4. On 1/20/20 the R71's left heel pressure injury increased in length & width without any revision in R71's care plan. On 3/3/20 R71 was observed multiple times in bed without pressure relieving boots. * R96 developed two open areas on her sacrum on 3/1/20. The open areas were not staged and there are no descriptions of the wound bed. R96's skin care plan was not revised until 3/4/20. On 3/2/20 R96 was not repositioned in her Broda chair for approximately five hours * R131 was observed without pressure relieving boots in bed according to his care plan. * R9's heels were not floated as care planned. * R10 admitted with multiple pressure injuries and did not have consistent assessments that included measurements, staging and a description of each wound. R10's heels were not floated as care planned. Findings include: The state received a FRI (facility reported incident) which indicated R410's family expressed concerns regarding neglect related to pressure injury/wound care. Surveyor reviewed R410's closed records and conducted facility staff and administration interviews. The facility policy, Skin Management, revised July 2017, indicated in part . Policy: Residents receive care to aid in the prevention or worsening of wounds and/or pressure ulcers. Individuals at risk for skin compromise are identified, assess and provided treatment to promote healing, prevent infection, and prevent new ulcers from developing. Ongoing monitoring and evaluation are provided for optimal resident outcomes. Fundamental Information: A pressure ulcer is defined as any [MEDICAL CONDITION] caused by unrelieved pressure resulting in damage of underlying tissue. Pressure ulcers are usually over bony prominences and are staged to determine to degree of tissue damage observed. Unavoidable Pressure Ulcers: In accordance with CMS guidelines, unavoidable means that the resident developed a pressure ulcer even though the facility had evaluated the resident's clinical condition and pressure ulcer risk factors; defined and implemented interventions that are consistent with resident needs, goals, and recognized standards of practice; monitored and evaluated the impact of the interventions; and revised the approaches as appropriate. All of this must be clearly documented in the resident's medical record. The NPIAP (National Pressure Injury Advisory Panel) 2019 Guideline defines PIs as localized damage to the skin and underlying soft tissue as a result of intense pressure, prolonged pressure or pressure in combination with shear: A Stage 1 PI is non-blanchable [DIAGNOSES REDACTED] in a localized area of intact skin. A Stage 2 PI is partial thickness skin loss with exposed dermis. No fat or deeper tissues are visualized. A Stage 3 PI is full thickness skin loss with fat tissue visible. Muscles, bone, and tendons are not visualized. Slough or eschar (black necrotic tissue) could be present. A Stage 4 PI is full thickness skin and tissue loss with exposed or directly palpable muscle, bone, or tendon. An Unstageable PI is obscured full thickness skin and tissue loss in which the extent of damage cannot be determined. A DTI (Deep Tissue Injury) is persistent non-blanchable deep red, maroon, or purple discoloration from intense and/or prolonged pressure. R410 was admitted to the facility with [DIAGNOSES REDACTED].Sepsis due to E.Coli (blood infection from bacteria), [MEDICAL CONDITION] Bladder (inability to urinate without using a catheter-tube), and Need for assistance with Personal care. R410's Hospital Medical Records indicated admission on 11/18/19 with weakness and not being able to care for herself. R410 had been found on the toilet after a couple hours by case worker. R410's Hospital Medical Records indicated a PMH (Past Medical History) of Coccyx PI, dated 6/2014, which had been an ongoing issue since 2007. R410's Hospital Discharge Summary, dated 11/22/19, does not indicate a Coccyx PI or any Physician wound treatment orders. R410's 11/22/19 Hospital Transition Care Report, dated 11/22/19, indicated under skin assessment: left abdomen friction and shear. R410's 11/22/19 Hospital Paper Skin Integrity, completed by an RN, indicated a circle on left abdomen named friction/shear and a circle on the sacral/coccyx area named redness. R410's Admission assessment, dated 11/22/19, indicated a skin integrity section on the form, dated 11/25/19, which was 3 days after admission. R410's skin integrity section indicated no to pressure ulcers and left iliac crest (pelvis) shearing and sacrum redness as Stage 1. R410's weekly PI record completed by RN-O (Registered Nurse-Wound Care), dated 11/25/19, indicated left buttock PI measuring 4 x 0.3 x 0 cm, Stage 2, beefy red, no drainage, surrounding tissue intact, with date of onset 11/22/19. Plan specialty interventions: WC cushion, pressure relieving boots, Continue treatment which was Barrier Cream to Coccyx area and left buttock every shift for facility protocol. *Surveyor noted the 11/25/19 PI record and the 11/25/19 Admission skin integrity record completed by 2 different RN's have different assessments in size, site, and staging of PI. R410's Admission assessment, dated 11/22/19, indicated a Braden Scale for predicting pressure sore risk section on the form was dated 1/14/20 which was completed after R410's transfer to the hospital on [DATE] for an infected PI. R410's Braden score indicated 10-12 which was high risk. R410's 5 day Admission MDS (Minimum Data Set), dated 11/28/19, indicated clear speech, usually understood and usually understands, BIMS (Brief Interview Mental Status) score of 10 which indicates moderately cognitively impaired, no rejection of care, and no functional impairment of arms or legs. R410's MDS indicated it was very important to be able to choose own bedtime and required extensive assistance with 2+ staff physical assistance for bed mobility and transfers. R410's MDS Section M indicated R410 was at risk for skin breakdown, admitted with two Stage 2 PI's present on admission; and Interventions included a pressure reducing device for chair and bed, and No turning/repositioning program, (response locked 12/2/19). R410's Care plan, dated 11/25/19, indicated in part . R410's focus was coccyx pressure ulcer and a left butt ulcer. R410 has potential for pressure ulcer development r/t decreased mobility. The goal was R410's pressure ulcer would show signs of healing and remain free from infection, initiated 11/25/19, revised 12/5/19. R410's Interventions, dated 11/25/19, indicated: R410 requires the bed as flat as possible to reduce shear. Administer medications as ordered. Observe/document for side effects and effectiveness. Administer treatments as ordered and observed for effectiveness. Air mattress. Assist R410 to reposition and/or turn at frequent interval to provide pressure relief. Blue pressure relieving boots to be when in bed. Complete a full body check weekly and document. Follow facility policies/protocols for the prevention/treatment of [REDACTED]. Observe Nutritional status. Serve diet as ordered, observe intake and record. Observe/document/report PRN (as needed) any changes in skin status: appearance, color,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525604	A. BUILDING _____ B. WING _____	03/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SOUTHPOINTE HEALTHCARE CTR	4500 W LOOMIS RD GREENFIELD, WI 53220

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0686 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 2) wound healing, signs/symptoms of infection, wound size (length x width x depth), stage. Obtain and observed lab/diagnostic work as ordered. Report results to MD and follow up as needed. Provide incontinence care after each incontinence episode, or per established toileting plan. Reposition in chair frequently for comfort and pressure reduction. Provide resident/family education as needed. Teach resident/family the importance of changing positions for prevention of pressure ulcers. Encourage small frequent position changes. R410 needs staff assistance to turn/reposition at least every 2 hours, more often as needed or requested. Weekly treatment documentation to include measurement of each area of skin breakdown width, length, depth, type of tissue, and exudate. R410's focus was an ADL (Activities of Daily Living) performance deficit r/t Limited Mobility, initiated 11/25/19. R410's Interventions include: R410 would like to be up in WC (Wheelchair) by 10:00 AM and back to bed before dinner at 5:00 PM, initiated 11/29/19. Transfer: R410 requires mechanical lift sit to stand lift with 2 person assist for transfers, initiated 11/25/19. Encourage R410 to use bell to call for assistance. R410's Care plan, dated 1/14/20 (R410 was discharged [DATE]), indicated in part . R410's focus was potential/actual skin issues r/t: (nothing inserted). The goal was R410's skin would remain intact without signs of breakdown, initiated 1/14/20. R410's Interventions, dated 1/14/20, included: Provide wound care/preventative skin care per order. Skin checks weekly per facility protocol, document findings. Turn and reposition frequently to decrease pressure. *Surveyor noted the 1/14/20 date on the care plan for potential/actual skin issues after R410 was admitted to the hospital on [DATE]. R410's CNA Care Card, indicated in part .R410 would like to be up in WC by 10:00 AM and back to bed before dinner at 5:00 PM, Blue pressure relieving boots to be on when in bed, air mattress, and turn/reposition frequently to decrease pressure. Surveyor reviewed R410's facility weekly pressure ulcer record, facility skin-head to toe skin checks, and Wound Care Consultants TA (Tissue Analytics) evaluations. R410's 11/27/19 Head to toe check completed by LPN-DD (Licensed Practical Nurse) indicated a left buttock PI, beefy red. LPN-DD note a new order, dated 11/27/19, clean wound with NS (normal saline), pat dry, skin prep peri-wound, nickel thick Santyl to wound base followed by fluffed 4 x 4, covered with border foam, one time a day for open wound on bottom. R410's progress note, dated 11/28/19 at 7:00 PM indicated R410's friend came to visit the resident and complained R410 had been sitting up in the WC since the morning. R410's care plan indicated bed time at 5:00 PM and was 2 hours late going to bed as well as sitting all day. R410's friend called the police and the police responded to the call. The facility responded to R410's issue. *Surveyor noted the extensive length of time R410 was sitting in the WC. Pressure Ulcers in the Elderly, as a Public Health Problem notes, Lying in bed or sitting in a chair without movement induces pressure on the skin and sub-cutaneous tissues, and are predisposing factors for PU (pressure ulcer) .The pressure on the skin and subcutaneous tissue during prolonged lying on a bone prominence, as well as immobility without repositioning compresses the blood perfusion and induces oxygen deprivation. https://www.omicsonline.org/open-access/pressure-ulcers-in-the-elderly-as-a-public-health-problem-2329-9126XXX 74.php?aid= R410's 11/29/19 Braden score was 18 which indicated at risk for pressure sore risk. R410's 12/2/19 TA evaluation by NP-BB (Wound Care Nurse Practitioner) indicated Coccyx PI measured 3.55 x 2.23 x 0.7 cm, Unstageable, tan wound bed, small serous drainage, peri-wound clean, dry, intact. R410's physician orders [REDACTED]. strength Dakin's solution, protect periwound with skin prep, apply Santyl to wound bed, cover wound with bordered gauze, change daily, change PRN for soiling and/or saturation; ROHO cushion please, Up in WC 1 hour/day, [MEDICATION NAME] lab level now and in 3 weeks, and Prostat (liquid protein supplement) 300cc 2 times/day. * There was no documentation for how frequently staff turned R410 or monitored R410 being up in WC 1 hour/day. The physician ordered labs for a pre-[MEDICATION NAME], but the facility did not follow through with this. R410's 12/9/19 TA evaluation by NP-BB indicated Coccyx PI measured 2.86 x 4.38 x 1.2 cm, Unstageable, tan wound bed, small serous drainage. NP-BB debrided R410's PI noting wound undermining from 12-12 o'clock at 2 cm depth and indicated a wound treatment addition of lightly moistened gauze with strength Dakin's applied after Santyl and Bedrest except for 1 hour of PT (Physical therapy). R410's 12/9/19 weekly PI record completed by RN-O indicated Coccyx PI was a Stage 3 with Interventions now including side to side repositioning. * There was no documentation for staff performing side to side repositioning or monitoring R410's Bedrest. R410's 12/16/19 TA evaluation by NP-BB indicated Coccyx PI measured 3.2 x 5.68 x 1.5 cm, Unstageable, tan wound bed, small serous drainage. NP-BB noted undermining 12-12 o'clock at 3 cm depth and indicated a wound treatment of [REDACTED]. * NP-BB changed R410's treatment for [REDACTED]. R410's 12/23/19 TA evaluation by DR-G indicated Coccyx PI measured 5.66 x 5.56 x 2.2 cm, Stage 4 with early/partial granulation, moderate serous drainage. DR-G noted undermining 8-6 o'clock at 2 cm depth with wound treatment clarification to change gauze lightly moistened in strength Dakin's 2 times/day. DR-G ordered a stat CBC (Complete Blood Count) with a WBC (White Blood Cell-cells that fight infection by attacking bacteria). * DR-G ordered a pre-[MEDICATION NAME] for 12/23/19, but the facility, again, did not follow through with this order. R410's WBC increased from 12.8 (12/2/19) to 13.1 (12/19/19) to 17 (12/19/19) and 18.6 on 12/30/19. DR-G had ordered a stat CBC on 12/23/19 but the facility did not follow through with this order. R410's WBC was getting higher, and MD-R(Physician) ordered an IV antibiotic [MEDICATION NAME], on 12/25/19 and on 12/29/19 the IV antibiotic was changed to [MEDICATION NAME]. R410's 12/30/19 TA evaluation by DR-G indicated Coccyx PI measured 5.79 x 6.58 x 2.3 cm, Stage 4 with early/partial granulation, moderate serous drainage. DR-G debrided R410's PI noting wound undermining 8-5 o'clock with 3.5 cm depth. The physician transferred R410 to the hospital because the WBC was even higher than what it had been and the coccyx wound was infected. On 3/04/20, at 7:47 AM, Surveyor interviewed RN-O who stated R410 had some issues like agoraphobia and preferred staying up, and kicked off her boots so the facility had to float the heels. Surveyor asked RN-O about the increasing size of R410's Coccyx PI and the deterioration. RN-O stated DR-G debrided twice which is why the PI got bigger. RN-O stated she did not recall any admission issues. On 3/4/20, at 09:02 AM, Surveyor requested NHA-A provide R410's care plan with revisions and closed records. Surveyor reviewed R410's issues with NHA-A regarding discrepancy with dates on assessments and Bradens and requested further information and documents. On 3/4/20, at 1:10 PM, RN-O and NC-D (Nurse Consultant) requested to meet with Surveyor to review R401's information. RN-O pulled up the wound physician's TA records on R410's Coccyx PI in color on the computer. RN-O explained to Surveyor the interpretation of each week's assessments and facility's response and protocols. R410's 12/2/19 color coccyx wound picture demonstrated barely reddened area around the wound. Surveyor questioned RN-O how the facility followed the orders for ROHO cushion and Up in the WC 1 hour/day. RN-O stated it would be written as an order, and facility staff and therapy would be notified. Surveyor questioned RN-O how the facility would track the chair time and RN-O stated the order would be care planned, on the CNA Care card and should be documented in the task care tracker. R410's 12/9/19 color coccyx wound picture demonstrated some red/purplish induration around wound. RN-O stated she did not remember R410's medical history but RN-O thinks R410 had a DTI (Deep Tissue Injury) before admission. RN-O stated R410 had debridement when DR-G started to clean out the wound but [MEDICATION NAME] and slough were still attached to the coccyx wound with new undermining and epibole (rolled edges). Surveyor questioned RN-O how the facility followed the orders for Bedrest except 1 hour for therapy. RN-O stated it would be written as an order, and facility staff and therapy would be notified. RN-O stated the order would be care planned, on the CNA Care card and should be documented in the task care tracker. R410's 12/16/19 color coccyx wound picture demonstrated more pink/induration around wound. RN-O stated R410's coccyx wound had increased undermining, increased depth and the coccyx wound treatment was changed to 2 times/day due to slough returning. R410's 12/23/19 color coccyx wound picture demonstrated red/black new necrotic tissue increased depth, increased length. RN-O stated not much viable tissue, Stage 4. RN-O stated she did not note at the time the change in Staging otherwise she would have asked him. R410's 12/30/19 color coccyx wound picture demonstrated length decreased, width increased, and depth increased. RN-O stated there was moderate drainage and tough [MEDICATION NAME] slough with worsening undermining at 3.5 cm. RN-O stated DR-G [MEDICATION NAME] the coccyx wound made R410's wound bigger prior to hospitalization . RN-O stated the area surrounding the wound now had a decreased purplish look after Bedrest. RN-O stated R410 was discharged to the hospital on [DATE] with an infected coccyx wound. RN-O stated she used DR-G's assessments and measurements for the facility weekly tracking. Surveyor questioned RN-O regarding the Braden score 10-high risk, dated 1/14/20 after 12/30/19 discharge and RN-O stated she followed up and care planned the risk. Surveyor questioned RN-O regarding the Braden scores completed on 11/29/19 (18 at risk) and 12/6/19 (17 at risk) and the discrepancies in risk. RN-O stated the facility completes Braden scores every week for 4 weeks and that is facility protocol. RN-O stated there were no further Braden scores completed in R410's assessments. Surveyor questioned RN-O about R410 being up in the chair all day on 11/28/19 could be the causation of possible DTI. RN-O stated she did not know if R410 was repositioned. Surveyor questioned RN-O when she noted R410's wound was infected. RN-O stated the facility did a coccyx wound culture and R410 was started on IV (Intravenous) Antibiotics on 12/26/19 for an infected wound. RN-O stated R410's coccyx wound was not getting any better and getting worse with increase in size and increase in drainage. RN-O stated R410 was admitted to the hospital for deteriorating cocyx wound on 12/30/19. RN-O stated R410 had an indwelling foley catheter (tube inserted into bladder to drain urine) the whole time R410

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525604	A. BUILDING _____ B. WING _____	03/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SOUTHPOINTE HEALTHCARE CTR	4500 W LOOMIS RD GREENFIELD, WI 53220

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0686 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 3) was in the facility. *Surveyor noted R410 had an indwelling catheter inserted on 12/17/19. On 3/4/20, at 3:35 PM, Surveyor had requested R410's hospital records on 12/30/19 from the NHA-A and CC-C. NHA-A stated the facility was unable to obtain and provided fax confirmation of request to the hospital. On 3/5/20, at 7:38 AM, Surveyor met with NHA-A and CC-E to discuss discrepancies in documentation and paperwork that had been requested that was still pending including progress notes, task list for repositioning and bedrest, skin head to toe assessments, [MEDICATION NAME] results, foley order and policy. On 3/5/20, at 2:54 PM, Surveyor interviewed NHA-A and CC-C and requested task list again for repositioning and bedrest. CC-C stated the facility was having trouble finding documentation for bedrest and repositioning so we don't have it. CC-C stated the facility follows standard of practice for repositioning. A standard of practice is found in the NPIAP 2019 Guidelines which indicate strong positive recommendations/definitely do it for Repositioning and Early Mobilization: 5.1 Reposition all individuals with or at risk of PI on an individualized schedule, unless contraindicated. 5.2 Determine repositioning frequency with consideration to the individual's level of activity, mobility and ability to independently reposition. *Surveyor noted the facility did not follow a standard of practice for repositioning. No further information was provided by the facility. On 3/6/20, Surveyor obtained R410's 12/30/19 Hospital records which indicated R410 presented to the hospital for evaluation of an ongoing wound infection. R410 was positive for pain on her buttocks. Documentation on 12/30/19 indicated a large sacral ulceration extending to soft tissue, tendon, and bone. R410 received 2 new IV Antibiotics: [MEDICATION NAME] and [MEDICATION NAME]. Final Diagnosis: [REDACTED]. The Immediate Jeopardy was removed as of 3/5/20 when the facility: * Advised the Medical Director of the deficiency. * Completed a head to toe skin assessment on all in-house residents and skin incident reports completed for those residents with skin alterations. * Residents with skin alterations were evaluated, with updates made to the plan of care and interventions in place as appropriate. * Licensed and unlicensed staff were educated on the Skin Management program prior to their next scheduled shift. * Licensed staff were educated on assessment, documentation, and physician order [REDACTED]. * Identified Wound Care nurse received directed education on Skin Management program by the Wound physician. * The Director of Nursing or designee is reviewing the Point Click Care dashboard, the 24 hour board, and progress notes for all new admissions and skin incidents to ensure assessment completion, interventions initiated based on skin condition, and for the completion of physician orders [REDACTED]. The deficient practice continues at a scope and severity level of a G (harm/isolated) as evidenced by the following; 2. R71 was admitted to the facility on [DATE]. [DIAGNOSES REDACTED]. The potential skin issue care plan initiated 8/29/19 and revised on 1/28/20 documents interventions of; Provide wound care/preventative skin care per order. Inititated 8/29/19. Skin checks weekly per facility protocol, document findings. Inititated 8/29/19. Turn and reposition frequently to decrease pressure. Prevalon boots in place. Initiated 8/29/19 & revised 1/19/20. The admission MDS (minimum data set) with an assessment reference date of 9/4/19 documents a BIMS (brief interview mental status) score of 15 which indicates cognitively intact. R71 requires extensive assistance with two plus person physical assist for bed mobility, is dependent with two plus person physical assist for transfer, and does not ambulate. R71 is at risk for developing pressure injuries and is coded as not having any pressure injuries. The pressure ulcer/injury CAA (care area assessment) dated 9/5/19 under analysis of findings for nature of the problem/condition documents Resident admitted s/p (status [REDACTED]. Resident was on IV (intravenous) antibiotics in the hospital and has since competed her course of oral antibiotics while at the facility. She is working with therapy to help improve her functional ADL's (activities daily living). Resident was previously w/c (wheelchair) bound in her assisted living facility and has not been ambulatory for over 5 years. She has impaired ROM (range of motion) to her upper extremities but it does not interfere with function mobility. She is dependent on staff for transfers with the use of a full body lift. During the look back period she was frequently incontinent of both bowel and bladder. No falls while at the facility. No noted pressure injuries. She denies any pain or discomfort. The Braden Scale assessment dated [DATE] has a score of 13 which indicates moderate risk for pressure injury development. The pressure ulcer care plan initiated 12/29/19 and revised on 12/31/19 documents interventions of Administer treatments as ordered and observe for effectiveness. Inititated 10/1/19. Assess/record/observe wound healing: Measure length, width and depth where possible. Assess and document status of wound perimeter, wound bed and healing progress. Report improvements and declines to the MD (medical doctor). Inititated and revised on 1/12/20. Assist R71 to reposition and/or turn at frequent intervals to provide pressure relief. Inititated 1/12/20 & revised 1/21/20. Complete a full body check weekly and document. Inititated 9/5/19. Diathermy from therapy. Inititated 3/2/20. Educate the resident/family/caregivers as to causes of skin breakdown; including: transfer/positioning requirements; importance of taking care of ambulating/mobility, good nutrition and frequent repositioning. Inititated 10/1/19. Follow facility policies/protocols for the prevention/treatment of [REDACTED]. IDT (interdisciplinary team) referrals as indicated, i.e. RD (registered dietitian), PT (physical therapy) OT (occupational therapy) or other. Inititated & revised 9/5/19. Inform the resident/family/caregivers of any new area of skin breakdown. Inititated 9/5/19. Observe nutritional status. Serve diet as ordered, observe intake and record. Inititated 9/5/19. Obtain and observe lab/diagnostic work as ordered. Report results to MD and follow up as indicated. Inititated 10/1/19. Pressure relieving boots. initiated 3/2/20. Provide incontinence care after each incontinence episode, or per established toileting plan. initiated 9/5/19. Teach resident/family the importance of changing positions for prevention of pressure ulcers. Encourage small frequent position changes. initiated 10/1/19. The resident needs extensive staff assistance to turn/reposition at least every 2 hours, more often as needed or requested. initiated & revised 1/12/20. The resident requires a pressure relieving/reducing device on chair. initiated 1/12/20 & revised 3/2/20. Weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate. initiated 1/12/20. The head to toe skin check dated 12/27/19 under skin integrity is checked for new pressure ulcer. Under site documents left heel, type pressure, length 6.0, width 4.3 and stage unstageable. Under further description of skin issues documents appears to have been a blister, black in color, skin intact. This was completed by LPN (Licensed Practical Nurse)-Q. There is no RN (Registered Nurse) assessment. The SBAR (situation, background, assessment, request) dated 12/27/19 under assessment for LPNs documents Pressure ulcer noted to left heel. Area measures 6.0 x (times) 4.3. Appears as if it was a blister. Skin is intact. Area is black in color. Resident does c/o (complain of) pain to heel. Under nursing notes documents Physician-R updated. New orders received for [MEDICATION NAME] to heel and for wound care team to follow. This was completed by LPN-Q. The weekly pressure ulcer record with an effective date of 12/30/19 and signed on 12/31/19 for site of this assessment documents L (Left) Lat (lateral) heel. Date of onset is documented as 12/27/19. Under length documents 3.56, width 5.48 and stage Suspected Deep Tissue Injury. Description of site documents black. Surveyor noted this assessment was completed by a RN, 3 days after the identification of the pressure injury. The head to toe skin check with an effective date of 12/28/19 and signed on 1/12/20 under skin integrity is checked for existing pressure ulcer. Under site documents lt (left) heel, length 6 cm (centimeters), width 6cm, depth 0.5cm and stage III (3). Under notes documents lt heel open skin 6x6cm and depth 0.5cm, applied wound vac Dr. order and bilat (bilateral) hand/arm Iv inj. (injection) site remained bruise. Surveyor noted the wound vac was a treatment started during hospitalization . The hospital history and physical dated 1/2/20 under presenting complaint documents altered mental status-staring episode and weakness, fevers. Under skin documents left heel wound, black tissue, no surrounding [DIAGNOSES REDACTED] or fluctuance warm and dry. Under plan documents Seen by surgery for [REDACTED]. Altered mental status most likely secondary to [MEDICAL CONDITION] induced by left foot ulcer/wound. The infectious disease consultation dated 1/5/20 under history of present illness documents The patient is a [AGE] year old white female who is seen today at postoperative day #1 status [REDACTED]. The patient was admitted because of neurologic symptoms, primarily a staring episode and spasms in the neck. The patient has a chronic heel ulcer due to pressure of the left heel, which was discovered. The patient denies knowing any history that this has been cultured. It was evaluated by wound care and photos revealed a dense eschar/sclerotic blood blister appearance. The patient was also felt to have had a possible UTI (urinary tract infection), but had a polymicrobia urine, albeit with pyuria. Because of the appearance, the patient
F 0688 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility did not ensure 4 (R9, R10, R56 & R64) of 4 residents reviewed with limited range of motion received appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. * R9 was observed not wearing a palm guard to prevent a decrease in range in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525604	A. BUILDING _____ B. WING _____	03/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SOUTHPOINTE HEALTHCARE CTR	4500 W LOOMIS RD GREENFIELD, WI 53220

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0688 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 4) motion per R9's plan of care. * R10 was observed not wearing a palm guards to prevent a decrease in range in motion per R10's plan of care. * R56 was observed not wearing splints to prevent a decrease in range in motion per R56's plan of care. * R64 did not have physician orders for the wearing of splints to prevent a decrease in range of motion per R64's plan of care. Findings include: 1. R9 was admitted to the facility on [DATE] with a [DIAGNOSES REDACTED]. R9's Annual MDS (Minimum Data Set) dated 2/29/20 documents a BIMS (Brief Interview for Mental Status) score of 0, indicating that R9 has severe cognitive impairment. Section G (Functional Status) documents that R9 requires extensive staff assistance and a one person physical assist for his bed mobility needs. Section G also documents that R9 has total dependence on staff and requires a two person physical assist for his transfer needs. Section G0400 (Functional Limitation in Range of Motion) documents that R9 has impairment to one side of his upper and lower extremities. R9's Pressure Ulcer/Injury CAA (Care Area Assessment) dated 2/29/20 documents both under the Analysis of Findings and Care Plan Considerations section, Resident is non-verbal and requires a full body lift for transfers. He wears a palm guard to the R (right) hand. He is dependent on tube feedings for eating. R9's physician order dated 11/24/19 documents, Rt (Right) hand palm guard on AM off HS (hour of sleep) check skin under guard BID (twice a day) and report any changes to MD (medical doctor) every day and evening shift. R9's Musculoskeletal/Contractures plan of care dated as initiated on 2/22/19 documents under the Focus section, R9 has an alteration in musculoskeletal status r/t (related to) (R) (Right) hand contracture. Under the Interventions section it documents, Right hand palm guard on in AM and off at HS (hour of sleep). On 3/1/20 at 12:27 p.m., Surveyor observed R9 laying supine in bed with no palm guard on his right hand per R9's plan of care. On 3/2/20 at 11:14 a.m., Surveyor observed R9 laying supine in bed with no palm guard on his right hand per R9's plan of care. On 3/2/20 at 11:55 a.m., Surveyor observed R9 laying supine in bed with no palm guard on his right hand per R9's plan of care. On 3/2/20 at 2:11 p.m., Surveyor observed R9 laying supine in bed with no palm guard on his right hand per R9's plan of care. On 3/2/20 at 4:14 p.m., Surveyor observed R9 laying supine in bed with no palm guard on his right hand per R9's plan of care. On 3/3/20 at 7:44 a.m., Surveyor observed R9 laying supine in bed with no palm guard on his right hand per R9's plan of care. On 3/3/20 at 11:14 a.m., Surveyor observed R9 laying supine in bed with no palm guard on his right hand per R9's plan of care. On 3/3/20 at 1:27 p.m., Surveyor observed R9 laying supine in bed with no palm guard on his right hand per R9's plan of care. Surveyor asked R9 if he would usually wear a palm guard on his right hand. R9 informed Surveyor that he was not sure what Surveyor was referring to. On 3/3/20 at 3:38 p.m., Surveyor observed R9 laying supine in bed with no palm guard on his right hand per R9's plan of care. On 3/3/20 at 3:52 p.m., Surveyor informed RN (Registered Nurse) Manager-L of the above findings. Surveyor asked RN Manager-L if R9 was supposed to be wearing a palm guard on his right hand per R9's plan of care. RN Manager-L informed Surveyor that R9 should we wearing a palm guard on his right hand per R9's plan of care. No additional information was provided as to why R9 did not receive appropriate treatment and services to prevent further decrease in range of motion. 2. R10 was admitted to the facility on [DATE] with a [DIAGNOSES REDACTED]. R10's Admission MDS dated [DATE] documents a BIMS (Brief Interview for Mental Status) score of 13, indicating that R10 is cognitively intact. Section G (Functional Status) documents that R10 has total dependence on staff and requires a two person physical assist for his bed mobility and transfer needs. Section G0400 (Functional Limitation in Range of Motion) documents that R10 has impairment to both sides of his upper and lower extremities. R10's ADL (Activities for Daily Living) CAA (Care Area Assessment) dated 11/29/19 documents under the Care Plan Considerations section, Transfer from another facility .Spastic quad (quadriplegic) . States he has SOB (shortness of breath) though none documented. Unable to assist at all due to physical limitations . Palm guards. Broda chair. [MEDICATION NAME] to toes. Monitor for changes. Update MD (medical doctor)/hospice as needed. R10's physician order dated 11/22/19 documents, Palm guards to bilateral hands at all times except for cleansing every shift for contractures. Surveyor noted that the above physician order and intervention to prevent contractures was not documented as in place in R10's care plan or CNA (Certified Nursing Assistant) Kardex care card. On 3/1/20 at 12:33 p.m., Surveyor observed R10 laying supine in bed with no palm guards on his hands per R10's physician order. On 3/2/20 at 9:13 a.m., Surveyor observed R10 laying supine in bed with no palm guards on his hands per R10's physician order. On 3/2/20 at 9:23 a.m., Surveyor observed R10 laying supine in bed with no palm guards on his hands per R10's physician order. On 3/2/20 at 2:17 p.m., Surveyor observed R10 laying supine in bed with no palm guards on his hands per R10's physician order. On 3/2/20 at 4:14 p.m., Surveyor observed R10 laying supine in bed with no palm guards on his hands per R10's physician order. On 3/3/20 at 8:05 a.m., Surveyor observed R10 sitting in his Broda chair. Surveyor observed R10 not to be wearing palm guards on his hands per R10's physician order. On 3/3/20 at 1:30 p.m., Surveyor observed R10 sitting in his Broda chair. Surveyor observed R10 not to be wearing palm guards on his hands per R10's physician order. On 3/3/20 at 3:52 p.m., Surveyor informed RN (Registered Nurse) Manager-L of the above findings. Surveyor asked RN Manager-L if R10 was supposed to be wearing palm guards on both his hands per R10's physician order dated 11/22/19, as Surveyor was unable to locate the intervention to prevent contractures in R10's care plan or CNA Kardex care card. RN Manager-L informed Surveyor that she would review R10's medical record and implement the palm guard intervention for R10. No additional information was provided as to why R10 did not receive appropriate treatment and services to prevent further decrease in range of motion. 3. R56 was originally admitted to the facility on [DATE] and has active [DIAGNOSES REDACTED]. R56's Annual Minimum Data Set (MDS0, dated 1/4/20, indicated a BIMS (Brief Interview of Mental Status), score of 7 which is severely cognitively impaired, and Section O indicated no ROM (Range of Motion) and no splints. Surveyor noted R56's active care plan did not address Restorative care, ROM, or splint application. Surveyor noted R56's CNA (Certified Nurse Assistant) care card, dated 3/1/20, indicated palm guards to bilateral hands, on in am after hand cleaning and off at bedtime. On 3/01/20 at 9:54 AM, Surveyor observed R56 sitting in a WC (Wheelchair) with a WC cushion in the lounge area with one sheepskin palm protectors hanging off the back of the WC by the Velcro strap. R56 did not respond to Surveyor questions. On 3/02/20 at 9:54 AM, Surveyor observed R56 without any hand splints or palm protectors. On 3/03/20 at 10:11 AM, Surveyor observed R56 remaining in bed sleeping without palm guards or hand splints. CNA-V stated R56 likes to sleep in. Surveyor reviewed R56's Physician orders, dated 1/22/20 which indicated: Apply bilateral cylindrical hand splints after dinner for 4 hours/day, or as tolerated, every evening shift for bilateral hand contractures. Apply palm guards when splints are off. Remove palm guards/splints during meals, every shift for hand contractures. Surveyor reviewed R56's TAR (Treatment Administration Record) for February 2020. R56's TAR indicated documentation every day in February at 2:00 PM for the application of bilateral cylindrical hand splints. R56's TAR indicated documentation every day in February at 8:00 PM for palm guards at bedtime. On 3/3/20, at 10:15 AM, Surveyor interviewed Rehab-W (Rehabilitation program manager) who was an OT (Occupational Therapist) about the Surveyor's observation of 3 days of R56 not wearing splints or palm protectors. Rehab-W stated the OT evaluation, dated 4/15/19, indicated R56 to wear bilateral cylindrical hand splints for 4 hours daily or as tolerated. Bilateral palm guards should be on when splints are off. Right palm guard should be removed for self-feeding. Rehab-W stated OT does the staff training for residents with splints. Surveyor questioned Rehab-W if R56 has splints anymore. Rehab-W stated she did not know and nursing will let therapy know if R56 has any issues. On 3/3/20, the Survey team shared concerns with the facility administration regarding residents and splints including R56 during daily exit. On 3/4/20 at 8:09 AM, Surveyor observed R56 lying in bed with a left hand sheepskin palm protector, nothing noted on right hand. Surveyor interviewed CNA-Z about the observation and she demonstrated R56 had no splints noted in the drawer or at the bedside. On 3/4/20, DON-B (Director of Nursing) gave Surveyor a copy of R56's care plan regarding Restorative care, ROM, and splint application which indicated revision on 3/20/19, and resolved 3/20/19 so no further interventions as of 3/20/19. DON-B also provided R56's March 2020 TAR that splints and palm protectors were discontinued on 3/3/20 as well as an active physician order list that did not include splints or palm protectors. DON-B provided R56's OT evaluation and plan of treatment, dated 3/4/20, which indicated R56 was referred by nursing for bilateral hand contractures. R56's OT plan indicated short term goals for fabrication of bilateral hand splints and wearing the splints for 2 hours. R56's long term goals indicated wearing the splints for 4 hours and nursing staff will carryover ROM/splint programs with 100% accuracy. Surveyor noted R56's TAR documentation of splints in place when R56 did not have splints, and R56's care plan for splints discontinued on 3/20/19 when the 4/15/19 OT evaluation established a plan and orders for splints. On 3/5/20, at 8:03 AM, Surveyor discussed R56 splint issues with NHA-A (Nursing Home Administrator) and CC-E (Corporate Consultant) regarding discrepancies in assessments, orders, and documentation. No further information was provided. 4. R64 was admitted on [DATE] with [DIAGNOSES REDACTED].Diabetes, Muscle Wasting and Atrophy, and Hand Contractures. R64's Quarterly MDS, dated [DATE], indicated a BIMS score of 15 which indicated R64 was cognitively intact, and functional impairments of BUEs (bilateral upper extremities). On 3/01/20, at 9:36 AM, Surveyor observed R64's call light on and R64 stated takes forever to get help.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525604	A. BUILDING _____ B. WING _____	03/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SOUTHPOINTE HEALTHCARE CTR	4500 W LOOMIS RD GREENFIELD, WI 53220

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0688 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 5) Surveyor observed R64 had a splint on the right arm, and R64 stated the splint was supposed to be off a couple hours ago. Surveyor reviewed a 3/2/2020 Weekly Restorative Note on R64's Progress: R64 is on restorative program for ROM and splinting. R64 continues to tolerate PROM (Passive Range of Motion) to BUEs. R64 wears the right hand splint for up to 4 hours during the day and the left hand splint overnight. Patient participates well in the program. No changes. On 3/3/20, at 7:32 AM, Surveyor observed R64 remaining in bed without splints. Surveyor reviewed R64's Physician order, dated 10/10/19, which indicated: PROM to BUE daily during cares-10 of each shoulder flexion and abduction, elbow extension/flexion, wrist supination/pronation, flexion and extension and give R64 blue foams to squeeze, every day shift for restorative care. Surveyor noted R64 had no physician orders for splints. On 3/03/20, at 10:22 AM, Surveyor interviewed Rehab-W who stated R64 was active on restorative care with weekly and monthly progress notes. Rehab-W stated R64's OT evaluation, dated 3/15/19, indicated R64 to wear BUE modified resting splints alternately for 4 hours or as tolerated daily. On 3/3/20, the Survey team shared concerns with the facility administration regarding residents and splints including R56 during daily exit. On 3/4/20, at 12:51 PM, Surveyor observed R64 up in the WC chair with splint on the right hand and left arm in a resting gutter splint on the WC. R64 stated the WC is not comfortable and will tell the nurse. Surveyor reviewed R64's February and March 2020 and noted no documentation of splints being worn by R64. On 3/5/20, at 8:03 AM, Surveyor discussed R64 splint issues with NHA-A and CC-E regarding discrepancies in orders and documentation. NHA-A provided R64's OT evaluation and plan of treatment, dated 3/4/20, which indicated R64 was referred to OT to reassess/review splinting program.
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility did not ensure that 10 (R104, R24, R67, R47, R70, R9, R10, R71, R96, R156) of 16 residents reviewed and identified by the facility to be at risk for falls and/or smoking, had an environment free from accident hazards and received adequate supervision and assistance devices to prevent accidents. *R104 was assessed to be at risk for falls and fell from her wheelchair and sustained a 3.5 cm (centimeter) by 3.5 cm laceration to her forehead requiring sutures. The facility did not conduct a thorough investigation into this fall to determine a root cause analysis. *R24 was assessed to be at risk for falls and fell three times, twice from a Broda chair and once while being assisted with positioning by a staff member. The fall investigations do not address the reason for the falls nor did the facility conduct a root cause analysis for the falls *R67 fell from bed after staff left the head of the bed in the upright position after providing assistance with eating when R67's care plan states he should eat meals in the dining room. *R47 was observed being transferred without a gait belt when R47's care plan states R47 should be transferred with 1 staff member with a gait belt. *R71 fell from her wheelchair on 9/8/19. R71 sustained a broken nose and a laceration above the right eye requiring sutures. The Facility's investigation does not include staff statements as to when R71 was last seen or when R71 was provided with assistance. There is no statement from R71 as to what was she doing or trying to do at the time of the fall etc. The Facility did not determine a root cause analysis of R71's fall. *R96 fell from the broda chair on 10/26/19. The Facility did not determine a root cause analysis of R96's fall. On 2/3/20 R96 fell from the broda chair due to the CNA (Certified Nursing Assistant) leaving the broda chair in an upright position. Surveyor observed R96's broda chair in an upright position and did not observe dycem in the broda chair which is a fall intervention. *R70's fall investigation was not thorough. *R9 was assessed to bed at risk for falls and the call light was not within reach per falls care plan. *R10 was assessed to bed at risk for falls and the call light was not within reach per falls care plan. *R156 was assessed to require supervision while smoking and was observed smoking without staff supervision. Findings include: The facility policy, entitled: Falls Management, dated July 2017, states: The facility assists each resident in attaining/maintaining his or her highest practicable level of function by providing the resident with adequate supervision, associative devices and/or functional programs, as appropriate, to minimize the risk for falls. The Interdisciplinary Team (IDT) evaluated each resident's fall risk. A Care Plan is developed and implemented, based on this evaluation with ongoing review. . When a resident is found on the floor, the facility is obligated to investigate to determine how the resident got there and put into place an intervention to minimize it from recurring. 1. R104 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. R104's Quarterly, Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 1/2/2020, documents: A Brief Interview of Mental Status (BIMS) score of 0, indicating R104 has severely impaired decision making skill;, Patient Health Questionnaire (PHQ-9) score of 2, indicating R104 has minimal depressive symptoms; requires extensive assist of 2 staff for transfers and toilet use, extensive assist of 1 staff for locomotion on unit, dressing and personal hygiene; is unsteady and needs staff assistance to stabilize when moving from seated to standing position, moving on and off the toilet, and when moving from surface to surface; frequently incontinent of urine and always incontinent of bowel. R104's Care Plan, dated 12/17/15, Revised 6/8/18, documents: (R104) has actual fall risk related to: Hx (history) of fall, cognitive deficits from her dementia, and incontinence. Interventions include: Bed against wall for increased room to increase mobility in room, (dated 9/10/17, revised 3/21/19); Initiate safety check as indicated, (dated 12/17/15); Keep call light in reach, (dated 8/31/16, revised 12/15/16); Keep frequently used items in reach, (dated 8/31/16); Resident to be seated in a chair with arms; if not in wheelchair, (dated 1/7/16, revised 3/18/19); Therapy evaluation and treatment as needed, (dated 11/7/16) (R104) is at high risk for falls r/t (related to) deconditioning, gait/balance problems, incontinence, poor communication/comprehension, psychoactive drug use. . Date initiated 9/20/16, revised 3/14/19) Interventions include: Anticipate and meet the resident's needs, (dated 9/20/16); Anticipate and meet the resident's needs, (dated 3/14/19, revised 2/5/20); Check and change q (every) 2-3 hours; provide incontinence cream and apply barrier cream as needed, (dated 2/11/19, revised 3/21/19); Check on (R104) at beginning of each shift, if she is restless in bed, provide assistance to her wheelchair, (dated 12/22/17); During naps and at noc (night), place w/c (wheelchair) next to bed in a way that facilitates safe self transfer. Check frequently when resident in bed, (dated 1/29/19, revised 2/5/20); Encourage assistance to lay down after lunch; assist up prior to supper, (dated 8/6/18, revised 2/28/19); Encourage that the resident is wearing appropriate footwear when transferring or mobilizing in w/c, (dated 9/20/16); Follow facility fall protocol, (dated 9/20/16, revised 9/10/17); Low bed, mat next to bed, (dated 6/30/17, revised 1/10/18); More frequent checks especially in the evening, (dated 9/11/19); Review information on past falls and attempt to determine cause of falls. Record possible root causes. Alter, remove any potential causes if possible. Educate resident/family/caregivers/IDT as to causes, (dated 9/20/16); Resident needs safe environment with: even floors free from spills and/or clutter; adequate, glare-free light; a working and reachable call light, personal items within reach, (dated 9/20/16, revised 9/20/16. (R104) has had an actual fall related to unsteady gait. . Interventions include: Offer/Assist to toilet frequently and as accepted, (dated 1/7/16, revised 2/5/20); Place frequently used items in reach, (dated 1/7/16, revised 2/5/20); Resident to sit in chairs with arms, (dated 1/7/16, revised 2/5/20). R104's Fall Risk Assessment, dated 10/7/19, documents a score of 16, indicating R104 is at high risk for falls. R104's Fall Risk Assessment, dated 12/28/19, documents a score of 10, indicating R104 is at high risk for falls. R104's Fall Risk Assessment, dated 1/18/2020, documents a score of 14, indicating R104 is at high risk for falls. On 1/18/20 at 8:25 PM, R104's Medical Record documents: SBAR (Situation, Background, Assessment, Recommendation) Communication form and Progress Note, documenting: . Situation: Resident fell forward from wheelchair hitting forehead on floor. Resident obtained an open area measuring 3.5 cm x (by) 3.5 cm. . Things that make the condition or symptoms better: Holding pressure to stop the bleeding. . Resident transferred to the hospital. On 1/18/20 at 9:22 PM, R104's Medical Record documents: Fall/Attended form . Resident leaning forward in wheelchair, fell forward hitting head on floor. Resident obtained a 3.5 x 3.5 open area on forehead. . Resident was sent to ER (emergency room); . Mental status of oriented to person; . Resident unable to tell where the pain was, however would moan and move occasionally; . On 1/18/20 at 4:57 PM, R104's Medical Record documents: Interdisciplinary Post Fall Review form documented: Date and time of fall: 1/18/29 at 7:16 PM; witnessed fall, transferred to Acute Care; location of the fall was: common area near the dining room; . resident was in a wheelchair at the time of the fall; . at the time of the fall the resident was reaching up or down; . the resident has a history of falls; .footwear and assistive devices at time of fall: none; . environmental factors: none; .Intervention recommendations: IDT note: IDT reviewed fall and CP (Care Plan). Discussed to add anti rollbacks to wheelchair (w/c). Form was signed as completed on 2/5/20. There is no documentation as to when R104 was last seen by the staff, when last assisted to use the toilet or incontinence care provided, when last provided a meal or a snack or when R104 prefers to go to bed. There are no staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525604	A. BUILDING _____ B. WING _____	03/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SOUTHPOINTE HEALTHCARE CTR	4500 W LOOMIS RD GREENFIELD, WI 53220

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 6) statements related to the documented witnessed fall. The facility completed the IDT Post Fall Review form prior to the documented time of the witnessed fall. The IDT intervention of adding anti rollbacks to R104's wheelchair was not added to R104's care plan. On 3/05/20, at 10:37 AM, Surveyor interviewed Director of Nursing (DON)-B, who stated: she has been telling the facility staff the fall investigations need to start at the beginning, as staff are approaching the area where the resident fell . DON-B stated, she tells the staff they need to write a fall investigation just as you would want the police to investigate a break-in to your house. DON-B stated she could not speak to R104's fall but the facility staff do need to investigate all falls, obtain staff statements and implement interventions that would prevent future falls. DON-B stated she was aware the facility fall investigations do not include the information in regards to the last time a resident was seen prior to the fall, last assisted to the bathroom and DON-B stated she was aware R104's care plan did not address the IDT recommendation for anti rollbacks on the wheelchair. DON-B stated she is working on improving fall investigations at the facility. On 3/5/20, Surveyor informed Administrator-A and Corporate Consultant-C of the above concerns. 2. R24 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. R24's Quarterly Minimum Date Set (MDS) assessment, with an Assessment Reference Date (ARD) 12/11/19, documents: A Brief Interview of Mental Status (BIMS) score of 1, indicating severe impairment for daily decision making; no behavior concerns or resisting care concerns; extensive assistance of 1 staff for, bed mobility, transfers,dressing, eating, toilet use and personal hygiene; unsteady and only able to stabilize with staff assistance with moving from seated to standing, walking, moving off the toilet and transferring from surface to surface; frequently incontinent of urine and always incontinent of bowel. R24's Care Plan, dated 11/5/18, documents: I understand that I am at risk for falls but I prefer to transfer myself or sit down on the floor without help. Interventions include: I know the risks and prefer to self-transfer even if it leads to harm or injury or even death, (dated 11/5/18, revised 11/5/18); Resident my choose to transfer self or sit on floor despite safety risks, did this happen?, (dated 11/5/18, revised 12/19/19); Staff will continue to attempt redirecting and assisting resident, using calm soothing voice and gently taking (R24) by the hand, (dated 11/5/18); (R24) choose to resist redirection and assistance from staff r/t (related to) transfers, (dated 11/5/18). (R24) is at high risk for falls r/t Alzheimer's Dementia, weakness, incontinence, HOH (Hard of Hearing), [MEDICAL CONDITION] med (medication) use, Hx (History) of falls @ (at) home and fall in the hospital 7/10/18. . Interventions include: 4/26/19-The Resident needs activities that minimize the potential for falls while providing diversion and distraction-group activities, sit in DR (Dining Room) for meals and monitor her within the group, (dated 4/26/19, revision 4/26/19); 9/21/18-Med's reviewed with MD (Medical Doctor)- no changes made at this time; 4/11/19-Time change on [MEDICATION NAME] order per MD to provide dose in afternoon for safety provision due to inc (increased) anxiety, (dated 10/2/18, revised 5/2/19); Anticipate and meet the resident's needs, (dated 7/23/18); Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance, (dated 7/23/18, revised 7/23/18); Encourage resident to remain in common area when not in bed, (dated 9/21/18, revised 10/1/18); Encourage resident to participate in activities that promote exercise, physical activity for strengthening and improved mobility, (dated 7/23/18, revised 7/23/18); Ensure that the resident is wearing appropriate footwear when ambulating or mobilizing in w/c (wheelchair), (dated 7/23/18, revised 7/23/18); Follow facility fall protocol, (dated 7/23/18); Frequent reminders using hand on shoulder not to stand up, keep in Day Room unless in bed, (dated 2/7/19); Place bed against wall to facilitate transfers. Place fall mat on floor next to bed. Gripper socks on at all times; 9/19/18-Place body pillow when in bed, (dated 7/24/18, revised 10/1/18); PT (Physical Therapy) evaluate and treat as ordered or PRN (As Needed), (7/23/18); The resident needs a safe environment with even floors free from spills and/or clutter, adequate, glare free light, a working and reachable call light, handrails on walls, personal items within reach, (dated 7/23/18, revised 7/23/18). (R24) has had an actual fall with no injury, poor balance, psychoactive drug use, unsteady gait, dated 1/7/20, revised on 1/8/20. Interventions include: Continued interventions on the at-risk plan, (dated 1/8/20); Encourage resident to ask for assistance, (dated 1/8/29); For no apparent acute injury, determine and address causative factors for the fall, (dated 1/8/20); Interdisciplinary referral: PT (Physical Therapy), OT (Occupational Therapy), Restorative Nursing, Social Services, other, (dated 1/8/20); Neuro (neurological)-checks x (times) 72h (hours), (1/8/20, revised 1/8/20); Observe/document/report PRN (As Needed) x 72h to MD (Medical Doctor) for s/sx (signs and symptoms): Pain, bruises, change in mental status, new onset: confusion, sleepiness, inability to maintain posture, agitation, (dated 1/8/20); Offer/assist to toilet frequently and as accepted, (dated 1/8/20); Place frequently used items in reach, (1/8/20); Provide activities that promote exercise and strength building where possible. Provide 1:1 activities if bed bound, (dated 1/8/20). R24's Fall Risk Assessment, dated 4/12/19, documents a score of 14, indicating R24 is at high risk for falls. R24's Fall Risk Assessment, dated 4/25/19, documents a score of 14, indicating R24 is at high risk for falls. R24's Fall Risk Assessment, dated 1/7/20, documents a score of 11, indicating R24 is at high risk for falls. On 3/1/20, at 10:51 AM, Surveyor observed R24 in the unit dining room watching as staff are assisting peers with a table bowling activity. The staff's backs are to R24 when she attempted to stand up unassisted 2 times. During R24's second attempt to stand unassisted the wheelchair rolled way from her. Surveyor had to alert unit staff of R24's potential to fall and engage staff to intervene in the situation to prevent R24 from falling. On 4/11/19, at 1:54 PM, R24's Medical Record documents, SBAR (Situation, Background, Assessment, Recommendation) Communication form and Progress Note, documenting: .Resident fell on floor next to Broda chair attempting to ambulate w/o (without) assistance. There is no apparent injury, neuro (neurological) checks at baseline for resident. Resident assisted back to chair, she denies pain; . Things that make the condition or symptoms worse: Resident becomes anxious and tearful in the afternoon; . Assessment: Resident demonstrates increased anxiety in the afternoon, becomes tearful and shows increased attempts to self ambulate r/t anxiety. Resident is under hospice care. Plan: retime scheduled [MEDICATION NAME] to allow for a 2 PM dose. On 4/12/19 at 1:54 PM, R24's Medical Record documents: . Resident fell on floor next to Broda chair attempting to ambulate w/o assistance. There is no apparent injury, neuro checks are baseline for resident. Resident assisted back to chair; she denies pain. Resident was observed during fall, did not hit head. . Assisted back into Broda chair. Resident observed to be tearful, restless's and anxious in afternoon; [MEDICATION NAME] administered; resident not taken to the hospital. On 4/11/19, at 2:37 PM, R24's Medical Record documents: Interdisciplinary Post Fall Review . Description of fall: 4/11/19 at 1:56 PM; the fall was witnessed; no injuries; . The Resident fell on floor next to Broda chair attempting to ambulate w/o assistance. There is no apparent injury, neoro checks at baseline for resident. Resident assisted back to chair; she denies pain. The resident becomes anxious and tearful in the afternoon . Resident fell in the Dining Room. Broda chair manufactures information documents: Review of Broda's operating manual indicates: Before the chair is put into service, this manual must be read thoroughly by the caregiver(s) directly responsible for the resident's care. After the chair is put into service, this manual must be read thoroughly by any new caregivers prior to operating or moving the chair. For the purpose of this manual, a resident's family member who shares responsibility for their care is considered a caregiver and is subject to the same competency before being permitted by the resident's primary caregiver to operate of move the chair. Prior to first use, the customer must arrange for an in-service on the operation and safety requirements in this manual, must be given to the resident's caregivers by the local BRODA representative who supplied the chair. The primary caregiver must maintain a list of caregivers who have read this manual and who they have authorized to operate and move the chair. The resident's primary caregiver is responsible for ensuring that anyone who is unfamiliar with, unwilling, or unable to adhere to the safety and operating instructions, is not permitted to operate or move the chair. The operations of the chair must be performed by the resident's primary caregiver who is responsible for seating. All the operations and adjustments performed should be done in a manner to ensure the overall safety, comfort and well-being of the resident, caregiver and third party. All operations and adjustments required for the resident should be determined by the resident's primary caregiver who is responsible for seating. *The Broda Operating Manual also states: Position of chair - 'Danger of Falling': After a resident is transferred into a chair, assess the amount of tilt required. We recommend that the chair's seat be tilted sufficiently to prevent the resident from sliding or falling forward off the chair. The amount of seat tilt used should be determined by the resident's caregiver who is responsible for seating. We recommend that the resident's feet be correctly positioned on the footrests and slightly too fully elevated to prevent the resident from sliding or falling forward off the chair. The amount of elevation used should be determined by the resident's caregiver who is responsible for seating. . Improper Use: As outlined, the improper use of the chair is dangerous to the resident, caregivers, or third parties, and can consist of, but is not limited to the following: . 3) Inappropriate use of the chair for a resident who has not been assessed by a qualified caregiver responsible for their seating. . 7) Leaving the resident unattended in the chair near other objects. 8) Leaving an agitated resident in the chair in an unsupervised area. 9) Leaving a resident unattended. There is no documentation of when R24 was last seen prior to the fall, last assisted with toileting or

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525604	A. BUILDING _____ B. WING _____	03/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SOUTHPOINTE HEALTHCARE CTR	4500 W LOOMIS RD GREENFIELD, WI 53220

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 7) changing, when last provided a meal or a snack, last assisted to rest in bed due to receiving hospice services or if the Broda chair was in the upright or reclined position at the time of the fall. No staff statements even though it was documented as a witnessed fall. On 4/25/19, at 11:56 PM, R24's Medical Record document: SBAR form and Progress Note, . Resident was found on the floor in the Dining area. Neuro checks and VS (Vital Signs) WNL (Within Normal Limits). MD and family member were notified . No Fall Investigation form was provided by the facility. On 4/25/19, at 4:45 PM, R24's Medical Record documents: Interdisciplinary Post Fall Review from, which documents: 4/25/19, no time provided, R24 had an unwitnessed fall with no injuries. . Observed on the floor of dining room. No injury noted, resident on hospice care for dementia, frequently ambulates unaided and self transfers. . Interventions: Resident to be in Broda chair when out of bed. Monitor her for unassisted ambulation/transfers and redirect as needed. Engage (R24) in group activities. There is no documentation of when R24 was last seen prior to the fall, last assisted with toileting or changing, when last provided a meal or a snack, last assisted to rest in bed due to receiving hospice services, if activities were being provided at the time of the fall or if the Broda chair was in the upright or reclined position at the time of the fall. There is no documentation R24 was assessed to determine if the Broda chair was the correct chair for her as she fell from the Broda chair 14 days prior. On 1/7/20 at 3:50 PM, R24's Medical Record documents: SBAR Communication Form and Progress Notes . a fall; no time was documented. No information was documented as to the reason for the fall, if there were any injuries or what was done to prevent future falls. On 1/7/20 at 3:50 PM, R24's Medical Record documents: Fall investigation form Resident was assessed, assisted off the floor and back into wheelchair, vitals were taken and family, MD and supervisor were all updated. . Staff was attempting to help resident move back in her wheelchair because the resident was sitting on edge of wheelchair, and resident fell to the floor. On 1/7/20 at 4:00 PM, documents: Interdisciplinary Post Fall Review form, 1/7/20 3:50 PM resident had a witnessed fall; . Staff CNA (Certified Nursing Assistance) was attempting to move resident in her wheelchair, because resident was sitting on the edge of her wheelchair, and resident fell to the floor. . Interventions Recommended: Staff educated on safe transfer practices. There is no documentation of when R24 was last seen prior to the fall, what R24 was attempting to do at the time of the fall, last assisted with toileting or changing, when last provided a meal or a snack, if activities were being provided at the time of the fall or if the staff providing assistance was using a gait belt at the time of the fall. On 3/05/20, at 10:37 AM, Surveyor interviewed Director of Nursing (DON)-B, who stated: she has been telling the facility staff the fall investigations need to start at the beginning, as staff are approaching the area where the resident fell . DON-B stated, she tells the staff they need to write a fall investigation just as you would want the police to investigate a break-in to your house. DON-B stated she could not speak to R24's fall but the facility staff do need to investigate all falls, obtain staff statements and implement interventions that would prevent future falls. DON-B stated she was aware the facility fall investigations do not include the information in regards to the last time a resident was seen prior to the fall, last assisted to the bathroom and DON-B stated she is working on improving fall investigations at the facility. On 3/5/20, Surveyor informed Administrator-A and Corporate Consultant-C of the above concerns. 3. R67 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. R67's Change in Status, Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) 10/14/19, documents: A Brief Interview of Mental Status (BIMS) score of 0, indicating R67 has severely impaired daily decision making skills; totally dependent on 2 staff for bed mobility, transfers, dressing, toilet use, dependent on 1 staff for locomotion and personal hygiene; upper and lower body impaired range of motion on both sides; always incontinent or bowel and bladder. R67's Care Plan, dated 3/28/19, documents: (R67) is at risk for falls r/t (related to) dementia, [MEDICAL CONDITION], unaware of safety needs, Hx (history) of freq. (frequent) falls @ (at) ALF (Assisted Living Facility), [MEDICAL CONDITION] med (medications) used, gait and balance issues. Interventions: Anticipate and meet the resident's needs, (Dated 3/28/19); Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance, (dated 3/28/19, revised 3/28/19); Encourage the resident to participate in activities that promote exercise, physical activity for strengthening and improved mobility, (dated 3/28/19, revised 3/28/19); Follow facility fall protocol, (dated 3/28/19); PT (Physical Therapy) evaluated and treat as ordered or PRN (As Needed), (dated 3/28/19); The resident has a fall mat next to the bed. ensure the mat is in place as ordered and put away when he is out of bed, (dated 3/28/19, revised 3/28/19); The resident needs a safe environment with even floors free from spills and/or clutter; adequate, glare free light; a working and reachable call light handrails on walls, personal items within reach, (dated 3/28/19). (R67) has had an actual fall with minor injury, poor balance, (dated 2/6/20, revised 2/12/20); Interventions include: Encourage resident to ask for assistance, (dated 2/12/20); Ensure (R67) is centered in the bed when unattended. Fall Prevention Program, (dated 2/6/20); For no apparent acute injury, determined and address causative factors of the fall, (dated 2/12/20); Interdisciplinary referral: PT (Physical Therapy), OT (Occupational Therapy), Restorative Nursing, Social Services, other, (dated 2/12/20, revisions 2/12/20); Neuro-checks (neurological) x (for) 48 hours, (dated 2/12/20, revisions on 2/12/20); Observe/document/report/PRN x 72 hours to MD (Medical Doctor) for s/sx (signs and symptoms): Pain, bruises, change in mental status, new onset: confusion, sleepiness, inability to maintain posture, agitation, (dated 2/12/20). (R67) has an ADL (Activity of Daily Living) self care performance deficit r/t (related to) Dementia, unsteady gait, (dated 3/28/19). Interventions include: . Eating: The resident requires assist of 1 staff for eating. Alternate small bites with small sips; check mouth for pocketing during and after meals; up in w/c (wheelchair) in dining area for meals; added moisture to food (gravies, etc.); upright in Broda chair for meals; resident does not use utensils . (dated 3/28/19, revised 9/4/19). On 2/6/20, at 8:59 PM, R67's Medical Record documents: Interdisciplinary Post Fall Review: An unwitnessed fall on 2/6/20 at 7:00 PM; Resident was observed on floor in his room near his bed. He was in an upright position after feeding him and noted on right side on mat. Bruise to knee, forehead and shoulder noted. Neuro (neurological) checks with no change, no acute distress. X-ray ordered for shoulder; . IDT (Interdisciplinary note: Reviewed fall from bed and interventions to prevent further falls. Make sure resident is in safe position away from edge of bed. No Fall Investigation form was provided to Surveyor. There is no documentation of when R67 was last seen prior to the fall, what R67 was attempting to do at the time of the fall, last assisted with toileting or changing, when last provided a meal or a snack and why R67 was not provided assistance with the evening meal while up in a Broda chair in the dining room per care plan. There are no staff statements in regards to the fall and the care provided prior to the fall. On 3/05/20, at 10:37 AM, Surveyor interviewed Director of Nursing-B, who stated: she has been telling the facility staff the fall investigations need to start at the beginning, as staff are approaching the area where the resident fall. DON-B stated, she tells the staff they need to write a fall investigation just as you would want the police to investigate a break-in to your house. DON-B stated she could not speak to R24's fall but the facility staff do need to investigate all falls, obtain staff statements and implement interventions that would prevent future falls. DON-B stated she was aware the facility fall investigations do not include the information in regards to the last time a resident was seen prior to the fall, last assisted to the bathroom and DON-B stated she is working on improving fall investigations at the facility. On 3/5/20, Surveyor informed Administrator-A and Corporate Consultant-C of the above concerns. 4. R47's [DIAGNOSES REDACTED]. The ADL (activities daily living) care plan initiated and revised on 12/29/19 documents interventions of Transfer with assist of one and gait belt initiated 12/29/19 & revised 1/8/20 and Transfer: The resident is able to: transfer with assist of 1 and a gait belt. initiated & revised 1/8/20. The admission MDS (minimum data set) with an assessment reference date of 1/3/20 documents a BIMS (brief interview mental status) score of 9 which indicates moderately impaired. R47 requires extensive assistance with one person physical assist for bed mobility & toilet use, extensive assistance two plus person physical assist for transfer. R47 is coded as not having any falls. The fall CAA (care area assessment) dated 1/6/20 under analysis of findings for nature of the problem/condition documents No falls noted. Has dx (diagnosis) of [MEDICAL CONDITION] and has eye gtts (drops). Vision adeq. (adequate). Recent hospitalization due to decline in function. Dx of dementia. ROM (range of motion) to UES (upper extremities) limited due to rotator cuff dx per res. (resident). LES (lower extremities)-gd (good). ABT (antibiotic) for [MEDICAL CONDITION] (,[MEDICAL CONDITION]. defficile) [MEDICATION NAME] daily. [MEDICATION NAME] daily. Dep daily. Tyl (Tylenol) sched. (scheduled). Pressure reducing devices in place. Able to express needs. Monitor for changes. Therapy PPOC (per plan of care). Skin, pain, appetite and wts (weights) monitored. Well lit area. Consults as ordered. Update MD (medical doctor) as needed. On 3/2/20 at 8:21 a.m. Surveyor observed CNA (Certified Nursing Assistant)-M in R47's room wearing gloves with R47 in bed on his back. CNA-M raised the height of the bed, removed a pillow from under R47's feet, handed R47 a wet wash cloth so R47 could wash his face and placed tubi grips & gripper socks on R47. CNA-M informed R47 going to check and change you. Surveyor asked CNA-M if R47's product was wet. CNA-M replied yes. CNA-M went into the bathroom wet the end of a towel, provided incontinence

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525604	A. BUILDING _____ B. WING _____	03/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SOUTHPOINTE HEALTHCARE CTR	4500 W LOOMIS RD GREENFIELD, WI 53220

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 8) care to R47 and placed an incontinence product on R47. CNA-M placed shorts on R47, lowered the bed down, and brought the wheelchair over by R47's bed. CNA-M asked R47 if she could put his shoes on while he was in bed, placed the shoes on, and stated feet down positioning R47 so he was sitting on the edge of the bed. R47 stated he couldn't see out of one eye. CNA-M had R47 hold onto the wheelchair arm rest with his right hand, and then stood R47 up by placing a hand under R47's right under arm and on his back. While standing R47 CNA-M informed R47 he needs to stand up. CNA-M transferred R47 into the wheelchair. Surveyor noted CNA-M did not use a gait belt while transferring R47 from the bed into his wheelchair, as per R47's ADL care plan intervention which indicates R47 requires the assist of one and the use of a gait belt for transfers dated 12/29/19 and 1/8/20. CNA-M removed R47's gown, placed a sweatshirt on R47, removed her gloves and wheeled R47 out of his room. On 3/3/20 at 10:37 a.m. Surveyor asked RN (Registered Nurse) Manager-L how R47 should be tran
F 0690 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility did not ensure that 3 (R10, R96 & R36) of 4 residents reviewed received appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. * R10 was observed to his catheter drainage bag placed above the level of his bladder. R10 was also observed to have his catheter drainage bag and tubing on the floor. * R96 & R36 were not toileted per their plans of care. Findings include: 1. R10 was admitted to the facility on [DATE] with a [DIAGNOSES REDACTED]. R10's Admission MDS (Minimum Data Set) dated 11/29/19 documents a BIMS (Brief Interview for Mental Status) score of 13, indicating R10 is cognitively intact. Section G (Functional Status) documents that R10 has total dependence on staff and requires a two person physical assist for his bed mobility and transfer needs. Section G0400 (Functional Limitation in Range of Motion) documents that R10 has impairment to both sides of his upper and lower extremities. Section H (Bladder and Bowel) documents that R10 has an indwelling urinary catheter in place. R10's Urinary Incontinence and Indwelling Catheter CAA (Care Area Assessment) dated 11/29/19 documents under the Care Plan Considerations section, Transfer from another facility. Spastic quad (quadriplegic) .Suprapubic cath. (catheter) .Monitor for changes. R10's physician order [REDACTED]. Rotate site of securement daily and PRN (as needed) every day shift AND as needed for foley cares. R10's Suprapubic Catheter/[MEDICAL CONDITION] Bladder care plan dated as initiated on 11/25/19 documents under the Interventions section, CATHETER: The resident has Suprapubic Catheter. Position catheter bag and tubing below the level of the bladder. On 3/2/20 at 9:23 a.m., Surveyor observed R10 laying supine in bed with R10's catheter drainage bag and tubing on the floor. On 3/2/20 at 2:17 p.m., Surveyor observed R10 laying supine in bed with both the head and foot of the bed elevated. Surveyor could not locate R10's catheter drainage bag hanging off of R10's bed. Surveyor asked CNA (Certified Nursing Assistant)-GG where R10's catheter drainage bag was located. CNA-GG informed Surveyor that she was in the process of getting R10 but had gotten busy with other tasks. CNA-GG then lifted the sheet of R10's feet and showed Surveyor R10's catheter drainage bag sitting between R10's feet. Surveyor noted that R10's catheter drainage bag was above the level of R10's bladder and observed yellow urine back flowing from R10's catheter drainage bag into R10's catheter tubing. On 3/3/20 at 1:30 p.m., Surveyor observed R10 sitting in his Broda chair in the common area of the unit. Surveyor observed R10's catheter drainage bag and tubing to be resting on the floor. On 3/3/20 at 3:08 p.m., during the daily exit, Surveyor informed DON (Director of Nursing)-B of the above findings. At the time, no additional information was provided. On 3/3/20 at 3:52 p.m., Surveyor informed RN (Registered Nurse) Manager-L of the above findings. Surveyor asked RN Manager-L if R10's catheter collection bag should be placed below R10's bladder. RN Manager-L informed Surveyor that R10's catheter collection bag should be anchored below R10's bladder and that R10's catheter collection bag and tubing should not be touching the ground. No additional information was provided as to why R10 did received appropriate services to prevent urinary tract infections and to restore continence to the extent possible. 2. R96 has [DIAGNOSES REDACTED]. R96 receives hospice services. The bowel and bladder incontinence care plan initiated 11/25/15 and revised 3/11/19 documents interventions of: Activities: notify nursing if incontinent during activities initiated 2/19/16 & revised 2/23/16. R96 wears adult briefs. Staff will check her and provide incontinence care every 2 to 3 hours and prn (as needed). To be laid down after meals and incontinence care provided. initiated 3/13/18 & revised 1/7/19. Apply barrier cream to buttocks with cares. initiated 2/19/16 & revised 1/15/20. Clean peri-area with each incontinence episode. initiated 2/19/16 & revised 2/23/16. Encourage fluids during the day to promote prompted voiding responses. initiated 2/19/16 & revised 2/23/16. Ensure the resident has unobstructed path to the bathroom. initiated 2/19/16 & revised 2/23/16. Hand washing before and after delivery of care. initiated 2/19/16 & revised 2/23/16. Have call light within easy reach. initiated 2/19/16 and revised 2/23/16. Observe/document/report PRN (as needed) any possible causes of incontinence: bladder infection, constipation, loss of bladder tone, weakening of control muscles, decreased bladder capacity, diabetes, stroke, medication side effects. initiated 2/19/16 & revised 2/23/16. Provide adaptive devices as needed such as elevated toilet seat and grab bars. initiated 2/19/16 & revised 2/23/16. The quarterly MDS (minimum data set) with an assessment reference date of 1/28/20 documents a BIMS (brief interview mental status) score of 00 which indicates severe impairment. R96 is dependent with one person physical assist for bed mobility & toilet use, dependent with two plus person physical assist for transfers, does not ambulate, and is always incontinent of urine and bowel. On 3/2/20 at approximately 7:30 a.m. Surveyor observed R96 sitting in a broda chair in the lounge area with the TV dressed for the day. On 3/2/20 at 9:24 a.m. Surveyor observed ADON (Assistant Director of Nursing)-F wheeling R96's broda chair in the hallway from the dining room into the lounge area with the TV. On 3/2/20 at 9:46 a.m. Surveyor observed R96 continues to be in the broda chair in the lounge with the TV. On 3/2/20 at 10:00 a.m. Surveyor observed R96 continues to be in the broda chair in the lounge with the TV. On 3/2/20 at 11:00 a.m. Surveyor observed R96 continues to be in the broda chair in the lounge with the TV. On 3/2/20 at 11:21 a.m. Surveyor observed CNA (Certified Nursing Assistant)-M wheeling R96's broda chair out of the lounge & into her room and then CNA-M left R96's room. Surveyor asked CNA-M what she was going to do for R96. CNA-M informed Surveyor LPN (Licensed Practical Nurse)-K wanted her to check and change R96. Surveyor observed this is the first time staff has taken R96 out of the lounge and has been checked & changed this morning (since 7:30 a.m.). On 3/2/20 at 11:40 a.m. CNA-M and LPN-K entered R96's room. LPN-K stated I know she is a Hoyer. There's no sling around. CNA-M informed LPN-K hospice got R96 up this morning. LPN-K and CNA-M then left R96's room. On 3/2/20 at 11:48 a.m. Surveyor observed CNA-M and CNA-P in R96's room. CNA-P informed CNA-M the sling she has isn't the right sling that it's more of a sit to stand lift sling. CNA-M indicated that's the only sling she found. CNA-P informed CNA-M she would run down to the laundry otherwise they don't have any slings and left R96's room. On 3/2/20 at 11:50 a.m. Surveyor asked CNA-M if she got R96 up this morning. CNA-M replied no, hospice did but I signed off on sheet. Surveyor asked CNA-M if she is assigned to R96 today. CNA-M informed Surveyor she was. Surveyor asked CNA-M if she knew what time hospice got R96 up. CNA-M replied around 7. Surveyor asked CNA-M if this was the first time she was checking and changing R96 today. CNA-M replied yes this would be the first time. On 3/2/20 at 11:56 a.m. CNA-P returned to R96's room telling CNA-M there's absolutely no slings and she would go back to her unit to look for a sling. CNA-M removed her gloves and left R96's room. On 3/2/20 at 12:10 p.m. CNA-M returned to R96's room with a gray sling and placed gloves on. At 12:11 p.m. CNA-P entered R96's room, washed her hands and placed gloves on. At 12:13 p.m. CNA-P & CNA-M placed the sling under R96 in her broda chair, fastened the sling to the Hoyer lift and R96 was transferred into bed. The sling was removed from the Hoyer lift and CNA-M provided continence care to R96. Surveyor observed the incontinence product was wet and this was the first time R96 had been checked and changed, which was approximately 5 hours, from 7:00 a.m. until 12:10 p.m. Surveyor noted R96 did not receive incontinence care according to R96's care plan which had the following intervention; Staff will check her and provide incontinence care every 2 to 3 hours and prn (as needed). To be laid down after meals and incontinence care provided initiated 3/13/18 & revised 1/7/19. On 3/3/20 at 10:58 a.m. Surveyor asked RN (Registered Nurse) Manager-L how often should R96 be checked and changed. RN Manager-L informed Surveyor every two to three hours. Surveyor informed RN Manager-L of the observation of R96 not being checked and changed for approximately five hours. 3. R36 has [DIAGNOSES REDACTED]. R36's Admission MDS (Minimum Data Set), dated 12/17/19, indicated R36 is total dependence with 2+ person physical assistance for transfer and extensive assistance for toileting with 2+ person physical assistance. R36 is at risk for development of pressure injuries. R36's MDS indicated frequently incontinent and no toileting program. R36's Care plan, dated 12/11/19, indicated a focus: R36 has bladder incontinence r/t (related to) Stroke with left

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525604	A. BUILDING _____ B. WING _____	03/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SOUTHPOINTE HEALTHCARE CTR	4500 W LOOMIS RD GREENFIELD, WI 53220

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0690 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 9) paralysis. The goal indicated R36 will remain free from skin breakdown due to incontinence and brief use, dated 12/11/19, revised 12/19/19. The interventions include: Brief Use-R36 uses disposable briefs, Change every 2-3 hours and as needed, initiated 12/11/19, revised 1/15/20, Clean peri-area with each incontinence episode, initiated 12/11/19, Ensure R36 has an unobstructed path to the bathroom, initiated 12/11/19, Handwashing before and after delivery of care, initiated 12/11/19, Have call light within easy reach, initiated 12/11/19, Incontinent: Check every 2-3 hours and as required for incontinence. Wash, rinse and dry perineum. Change clothing as needed after incontinence episodes, initiated 12/11/19. R36's CNA (Certified Nurse Assistant) care card, dated 3/1/20, indicated Category: Toileting Check resident frequently and assist with toileting as needed. Provide pericare after each incontinent episode. Prompt toileting upon rising at bedtime and before meals. Incontinent: Check every 2-3 hours and as required for incontinence. Wash, rinse and dry perineum. Change clothing as needed after incontinence episodes, initiated 12/11/19. Brief Use-R36 uses disposable briefs, Change every 2-3 hours and as needed. Surveyor noted R36 is at risk for skin breakdown and developing pressure injuries. R36 currently has a left hip Pressure Injury. R36 had a Braden scale score of 12 on 1/15/20 which indicates high risk for skin breakdown. On 3/1/20, at 9:49 AM, Surveyor observed R36 in the common DR (dining room) in a high back reclining WC (wheelchair) with a blanket over his head. On 3/1/20, at 9:58 AM, Surveyor observed R36 remained in the DR with a blanket over his head while music was started. On 3/1/20, at 11:02 AM, Surveyor observed R36 remained in the DR with a blanket over his head. On 3/1/20, at 11:26 AM, Surveyor interviewed RN-O (Registered Nurse) who was called into the facility to do treatments. RN-O stated R36 is going to be put in bed so Surveyor can observe wound treatment. Surveyor did not observe R36 being checked, toileted, or repositioned in the WC during the morning. On 3/1/20, at 11:34 AM, Surveyor observed R36 transferred to the bed from the WC by CNA-X and CNA-Z. CNA-X and CNA-Z stated the staff usually lay R36 down after lunch. Surveyor observed R36 had a urine soaked brief. CNA-X and CNA-Z both stated R36 is a heavy wetter. On 3/1/20, at 12:03 PM, Surveyor interviewed RN-O about the urine soaked brief. RN-O stated R36 stays up all morning in his wheelchair and does not lie down until after lunch. On 3/2/20, at 7:30 AM, Surveyor observed R36 up in his WC and placed in the dining room at the table. Surveyor did not observe R36 being repositioned or R36's brief changed at any time during the morning. On 3/3/20, at 7:29 AM, Surveyor observed R36 brought to DR in WC. On 3/3/20, at 10:02 AM, Surveyor observed R36 remaining in the DR with a blanket over his head. Surveyor did not observe R36 being repositioned or R36's brief changed throughout the morning. On 3/4/20, at 11:57 AM, Surveyor observed R36 up in the DR with a blanket over his head. R36 has not been moved from the DR since getting up before breakfast. The facility did not ensure R36 was toileted, checked and changed for urinary incontinence when R36 was at high risk for skin breakdown and already being treated for [REDACTED].
F 0693 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview the Facility did not ensure 1 (R25) of 1 Residents reviewed for tube feeding received appropriate treatment and services to prevent complications. R25's head of bed was not elevated at least 30 degrees while the enteral feeding was running. Findings include: The Lippincott Procedures - Enteral feeding, gastrostomy feeding button revised November 15, 2019 under the section implementation documents Position the patient with the head of the bed elevated at least 30 degrees; if this position is contraindicated, consider a reverse Trendelenburg position to reduce the risk of aspiration. and Keep the head of the bed elevated at least 30 degrees for at least 1 hour after the enteral feeding to help prevent aspiration of stomach contacts and subsequent pneumonia. R25's [DIAGNOSES REDACTED]. The physician order [REDACTED]. The tube feeding care plan initiated 10/3/19 documents interventions of Discuss with the resident/family/caregivers any concerns about tube feeding, advantages, disadvantages, potential complications. Reinforce every contact to keep HOB (head of bed) elevated 30 degrees related to tube feeding as independently uses bed control to modify positioning for comfort. dated 3/2/20. Check for tube placement and gastric contents/residual volume per facility protocol and record. initiated & revised 10/3/19. Elevate head of bed 30-45 degrees (semi-fowler's position) during feedings and at least 1 hour after feeding to prevent aspiration/pneumonia. initiated 10/3/19 & revised 11/11/19. Listen to lung sounds. initiated 10/3/19. Observe/document/report PRN (as needed) any s/sx (signs/symptoms) of: Aspiration - fever, SOB (shortness of breath), tube dislodged, infection at tube site, self-extubation, tube dysfunction or malfunction, abnormal breath/lung sounds, abnormal lab values, abdominal pain, distension, tenderness, constipation or fecal impaction, diarrhea, nausea/vomiting, dehydration. initiated 10/3/19. Obtain and observe lab/diagnostic work as ordered. Report results to MD (medical doctor) and follow up as indicated. initiated 10/3/19. Provide local care to [DEVICE] site as ordered and observe for s/sx of infection. initiated 10/3/19. RD (registered dietitian) to evaluate quarterly and PRN. Observe caloric intake, estimated needs. Make recommendations for changes to tube feeding as needed. initiated 10/3/19. ST (speech therapy) evaluation and treatment as ordered. initiated 10/3/19. The resident is dependent with tube feeding and water flushes. See MD orders for current feeding orders. initiated 10/3/19. The resident needs assistance with tube feeding and water flushes. See MD orders for current feeding orders. initiated 10/3/19. The quarterly MDS (minimum data set) with an assessment reference date of 12/11/19 has a BIMS (brief interview mental status) score of 8 which indicates moderately impaired. R25 requires extensive assistance with two person physical assist for bed mobility, is dependent with two plus person physical assist for transfers, does not ambulate, requires extensive assistance with one person physical assist for eating and is checked for receiving tube feeding while a resident. On 3/1/20 at 10:22 a.m. Surveyor observed R25 in bed on his back with the head of the bed elevated high. R25's tube feeding of Fibersource HN is being instilled at 70 cc (cubic centimeters) per hour. On 3/1/20 at 3:43 p.m. Surveyor observed R25 in bed on his back with the head of the bed elevated 30 degrees. R25's tube feeding of Fibersource HN is being instilled at 70 cc/hour. On 3/2/20 at 7:19 a.m. Surveyor observed R25 in bed on his back with the tube feeding of Fibersource HN running at 70 cc per hour. Surveyor observed R25's head of the bed is not elevated at least 30 degrees. Surveyor observed the bed remote is along R25's left lower leg. On 3/2/20 at 7:59 a.m. Surveyor asked RN (Registered Nurse) Manager-L to accompany Surveyor to R25's room. Surveyor showed RN Manager-L R25's head of the bed which was not at 30 degrees and asked why R25's head of the bed was not at least 30 degrees while the tube feeding is being instilled. RN Manager-L informed Surveyor it's (referring to the head of the bed) is not very high and indicated she will go speak with the nurse & aide and educate them. On 3/2/20 at 8:02 a.m. RN Manager-L informed Surveyor the nurse said sometimes R25 lowers the head of the bed down. On 3/2/20 at 8:04 a.m. Surveyor observed the bed control continues to be along R25's left lower leg. Surveyor asked R25 if he lowered the head of his bed down this morning. R25 replied no. On 3/2/20 at 8:05 a.m. Surveyor observed RN Manager-L and LPN (Licensed Practical Nurse)-K in R25's room. LPN-K informed Surveyor sometimes R25 places the head down. Surveyor showed LPN-K the bed remote which was still by R25's left lower leg and informed LPN-K Surveyor didn't think R25 could reach the bed remote. RN Manager-L informed LPN-K she had placed R25's tube feeding on hold earlier. RN Manager-L raised the head of the bed to greater than 30 degrees, restarted R25's tube feeding and spoke to R25 about the importance of having the head of the bed up. On 3/2/20 at 8:40 a.m. Surveyor entered R25's room with CNA-J and CNA-M. CNA-J & CNA-M placed gloves on, CNA-M lowered the head of the bed while R25's tube feeding was running, removed the bedding off R25 and raised the height of the bed. At 8:42 a.m. CNA-J told CNA-M to pause R25's tube feeding. On 3/3/20 at 3:00 p.m. Administrator-A and DON (Director of Nursing)-B were informed of the above.
F 0757 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure each resident's drug regimen must be free from unnecessary drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility did not keep 1 (R131) of 5 residents reviewed free from unnecessary drugs. * R131 received an antibiotic when he did not have appropriate signs and symptoms for use of the antibiotic. Findings include: R131's [DIAGNOSES REDACTED]. The nurses note dated 12/15/19 documents Patient is febrile this A.M. (morning) - first temp 100.3 - after Tylenol - 99.6. The patient is complaining of dizziness and not feeling right. Will continue to monitor vital signs and temp. No nausea or vomiting. The nurses note dated 12/16/19 documents resident during the day lab CBC (complete blood count) and BMP (basic metabolic panel) result update with Physician-EE no new order and U/A (urinalysis) and culture sent lab resident urine drainage well amber color no c/o (complaint of) pain and ABT (antibiotic)/fluconazole po (by mouth) no adverse reaction. The nurses note dated 12/17/19 documents Resident being monitored for elevated Temp. (temperature) Prior to going to [MEDICAL TREATMENT] at 1320 (1:20 p.m.) temp was 98.7. Resident stated feeling better. The nurses note dated 12/18/19 documents UA pending foley OK patent. Page 1 of 2 Microbiology-Bacteriology report for urine culture with a collection date of 12/16/19 under final report documents >100,000

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525604	A. BUILDING _____ B. WING _____	03/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SOUTHPOINTE HEALTHCARE CTR	4500 W LOOMIS RD GREENFIELD, WI 53220

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0757 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 10) cfu/mL (colony forming unit/milliliter) Acinetobacter baumannii, >100,000 cfu/mL Escherichia coli, 7,000 cfu/mL Gram positive cocci in clusters. There is a handwritten note on the this lab report dated 12/19/19 which documents Update with Physician-EE N N Order (no new order) colonized. The nurses note dated 12/19/19 documents resident urine culture result update with Physician-EE dr. answer no symptomatic resident colorized no new order. The nurses note dated 12/20/19 documents resident during the evening no fever no c/o pain. Page 2 of 2 Microbiology-Bacteriology report for urine culture with a collection date of 12/16/19 has a handwritten documentation of sent to MD (medical doctor) 12/24/19 [MEDICATION NAME] mg (milligrams) BID (twice daily) x (times) 5 days. Surveyor noted physician order [REDACTED]. The nurses note dated 12/25/19 documents Resident is [MEDICATION NAME] UTI; no adverse reactions noted. urine is light yellow in color, cath (catheter) is patent. slept but easily awakened to verbal and tactile stimuli. Skin is warm and dry. xt: Res started on ABT (antibiotic) for UTI. No adverse effects noted. Temp 99.5, given PRN (as needed) Will continue to monitor. The nurses note dated 12/26/19 documents Asleep at intervals in between rounds. Alert when awake. Skin warm and dry. Continues on ABT for uti; no adverse reactions. No c/o of dysuria. Review of the December 2019 MAR (medication administration record) indicates R131 [MEDICATION NAME] mg one dose on 12/24, two doses from 12/25 to 12/28, and one dose on 12/29. On 3/3/20 at 2:02 p.m. Surveyor informed RN (Registered Nurse)-O, who was the infection control nurse in December, Surveyor could not locate how R131 met the definition of infection for being treated for [REDACTED]. RN-O returned a few minutes later and informed Surveyor she does not have any infection control sheets for R131. On 3/4/20 at 9:13 a.m. Surveyor showed RN-O R131's urine culture collected on 12/16/19 with a handwritten notation of no new orders colonized and then the same lab faxed to a physician five days later with a handwritten notation for an antibiotic. Surveyor informed RN-O there is no documentation in R131's record as to why the antibiotic was started. RN-O then informed Surveyor that's why she didn't have a sheet for R131. RN-O informed Surveyor she was going to contact Physician-EE and will get back to Surveyor. RN-O did not provide Surveyor with any additional information. On 3/5/20 at 9:17 a.m. RN Managed Care-U informed a Surveyor R131 is a complex resident and was placed [MEDICATION NAME] to a culture with E (escherichia) coli. RN Manager Care-U indicated R131 did not meet the criteria for treating an UTI, there is no documentation in R131's medical record but the antibiotic was ordered due to R131's complexity.
F 0758 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility did not ensure that 3 (R80, R10 and R138) of 5 residents reviewed had a medication regimen free from unnecessary [MEDICAL CONDITION] medications, received gradual dose reductions unless clinically contraindicated or received a PRN (As Needed) medication order limited to 14 days. *R80 was prescribed [MEDICATION NAME] (antipsychotic) due to a [DIAGNOSES REDACTED]. *R10 was prescribed PRN [MEDICATION NAME] (antianxiety) without a stop dated provided. *R138 was prescribed PRN [MEDICATION NAME] (antianxiety) with no stop date provided. Findings include: The facility policy, entitled [MEDICAL CONDITION] Management, dated November 2017, documents: . [MEDICAL CONDITION] medications are not administered unless they are necessary to treat specific conditions as diagnosed and documented in the resident's medial record. Gradual dose reductions of [MEDICAL CONDITION] medications and behavioral or non-pharmacological interventions are attempted, unless clinically contraindicated, in an effort to discontinue the medications, if appropriate. . Administering PRN [MEDICAL CONDITION] medications: [REDACTED]. PRN orders for [MEDICAL CONDITION] medications are limited to 14 days, except as provided by Federal regulations, and cannot be renewed unless the Attending Physician or prescribing Licensed Practitioner evaluates the resident for the appropriateness of the medication. If the Attending Physician or prescribing Licensed Practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rational in the resident's medical record and indicate the duration for the PRN order. 1. R80 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. R80's Quarterly Minimum Data Set Assessment (MDS), with an Assessment Reference Date (ARD) of 1/6/2020, documents: Brief Interview of Mental Status (BIMS) score of 9, indicating R80 has moderately impaired daily decision making skills; Patient Health Questionnaire (PHQ-9) score of 0, indicating no depressive symptoms; rejection of staff assistance with care 1-3 days per week; requires supervision of one staff for dressing, toilet use and personal hygiene; received antipsychotic medication 7 of the last 7 days and antidepressant medication 7 of the last 7 days; last Gradual Dose Reduction (GDR) 1/3/19. R80's Care Plan, dated 4/25/18, documents: (R80) has a behavior problem, may be resistive to cares, may be resistive or combative to redirection related to [DIAGNOSES REDACTED]. Interventions include: Administer medications as ordered. Observe/document for side effects and effectiveness, (dated 4/25/18); Allow choices within individual's decision making abilities, (dated 4/25/18); Anticipate and meet the resident's needs, (4/25/18); Behaviors include delusions, hallucinations, placing self on the floor, striking out at other. Interventions: Redirect PRN (As Needed), call niece on phone if necessary to re-enforce reality type orientation, encouragement that this brother . needs him ASAP (As Soon As Possible) and he will reduce agitation, (dated 5/29/19, revised 5/29/19); Explain all procedures to the resident before starting and allow resident time to adjust to changes, (dated 4/25/18); If reasonable, discuss the resident's behavior, Explain/reinforce why behavior is inappropriate and/or unacceptable to the resident, (dated 4/25/18); (R80) might be resistive or combative to redirection, (dated 4/25/18, revised 6/11/19); (R80) may be resistive to cares, (dated 4/25/18, revised 6/11/19); Notify MD (Medical Doctor) as needed, (dated 4/25/18). I received antipsychotic medication because I have a psychiatric condition that causes me to act in ways that are inappropriate from my setting and situation, puts me at risk of hurting myself or others, (dated 2/15/18, revised 2/15/18). Interventions include: Observe for side effects to medication as needed, complete AIMS as directed, (dated 2/15/18); Psychology. Psychiatrist consult PRN, (dated 2/15/18); When acting ways that are inappropriate for my setting and situation, it helps if you sit quietly with me, (dated 2/15/18); When I am acting in ways that are inappropriate for my setting and situation, it helps to lie down, (dated 2/15/18). R80 was seen and evaluated by Psychological Services on 12/20/19. On 12/20/19, Psychological Services documented: . Attempted a GDR of Zyrexa on 4/23/19 and failed, restarted on 5/15/19 due to obsessive picking. . Will attempt another slower GDR and hold the dose of [MEDICATION NAME] on Sunday evenings. . Continue [MEDICATION NAME] 2.5 mg (milligram) Mon. (Monday)-Sat. (Saturday). Follow up in 1 month. Review of R80's, December 2019 Medication Administration Record [REDACTED]. R80 was seen and evaluated by Psychological Services on 1/30/2020. On 1/30/2020, Psychological Services documented: . It was recommended that his [MEDICATION NAME] be held one day a week, however, the recommendation was not followed. . Recommend to hold [MEDICATION NAME] on Sundays. Continue [MEDICATION NAME] 2.5 mg Mon.-Sat. Review of R80's, January 2020 Medication Administration Record, [REDACTED]. Review of R80's, February 2020 Medication Administration Record, [REDACTED]. Review of R80's, March 2020 Medication Administration Record, [REDACTED]. On March 3rd a new order was written for [MEDICATION NAME] 2.5 mg every evening Monday,Tuesday, Wednesday,Thursday, Friday and Saturday. On 3/05/20, at 8:36 AM, Surveyor interviewed, Director of Social Services-T, who stated: The social workers are part of the Interdisciplinary Team (IDT) and meet with the rest of the IDT to review resident behaviors and discuss the need for medication and possible reductions. The IDT will discuss the possibility of a GDR and it is the responsibility of the unit managers to follow through with the recommended GDR. On 3/5/20, at 9:02 AM, Surveyor interviewed Registered Nurse (RN), Managed Care-U, to discuss who follows through on the Psychiatric Services recommendations for medication changes and gradual dose reductions. RN Managed Care-U, stated this is his first week in taking over this task. RN Managed Care-U stated the nurse from the Psychiatric Services provides the facility with a spread sheet of all recommendations and it is placed in his mailbox. RN Managed Care-U then contacts the physicians for the residents involved and informs them they can locate the new Psychiatric Services recommendations in their facility mailbox and should respond to the recommendations as soon as possible. RN Managed Care-U stated, he is unable to answer to the facility process before he took over but the facility does have a new process in place to address Psychiatric Services recommendations as the Social Work staff were not able to call the physicians and obtain orders for any recommended changes. RN Managed-Care-U stated he was made aware of R80's recommended GDR on 3/3/20 and that was when he obtained the new order and is not sure why the recommendation was not addressed when first recommended in December. On 3/5/20, Surveyor informed Administrator-A and Corporate Consultant-C of the above concern.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525604	A. BUILDING _____ B. WING _____	03/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SOUTHPOINTE HEALTHCARE CTR	4500 W LOOMIS RD GREENFIELD, WI 53220

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0758 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 11) 2. R10 was admitted to the facility on [DATE] with a [DIAGNOSES REDACTED]. R10's Admission MDS dated [DATE] documents a BIMS (Brief Interview for Mental Status) score of 13, indicating that R10 is cognitively intact. Section G (Functional Status) documents that R10 has total dependence on staff and requires a two person physical assist for his bed mobility and transfer needs. Section G0400 (Functional Limitation in Range of Motion) documents that R10 has impairment to both sides of his upper and lower extremities. R10's [MEDICAL CONDITION] Drug Use CAA (Care Area Assessment) dated 11/29/19 documents under the Care Plan Considerations section, Transfer from another facility . Antipsychotic, antidepressant. PO (by mouth) DM (Diabetes Mellitus) meds (medication). [MEDICATION NAME] daily . Monitor for changes. Update MD (medical doctor)/hospice as needed. Monitor for drug efficacy and side effects. R10's physician order [REDACTED]. R10's February 2020 MAR (Medication Administration Record) documents that R10 received the above PRN (as needed) anti-anxiety medication on the following dates: 2/1/20, 2/2/20, 2/5/20, 2/6/20, 2/15/20, 2/16/20, 2/19/20, 2/20/20, 2/24/20 to 2/26/20 and 2/29/20. Surveyor was unable to locate any documentation in R10's medical record that documented a rationale or a physician assessment for R10's continued PRN use of the anti-anxiety medications [MEDICATION NAME] and [MEDICATION NAME] beyond 14 days. On 3/4/20 at 3:51 p.m., during the daily exit meeting, Surveyor informed Administrator-A and DON (Director of Nursing)-B of the above findings. At the time, no additional information was provided. On 3/5/20 at 9:02 a.m., RN (Registered Nurse) Managed Care-U, whom had recently taken over the pharmacy recommendation and antipsychotic medication management at the facility, informed Surveyor that he (RN Managed Care-U) could not provide any additional information as to why R10 had an order for [REDACTED]. 3. R138 was admitted to the facility on [DATE] with a [DIAGNOSES REDACTED]. R138's Significant Change MDS (Minimum Data Set) dated 2/14/20 documents a BIMS (Brief Interview for Mental Status) score of 13, indicating that R138 is cognitively intact. R138's [MEDICAL CONDITION] Drug Use CAA (Care Area Assessment) dated 2/14/20 documents under the Care Plan Considerations section, Recent d/c (discharge) from hospice services. Uses walker for mobility. [MEDICATION NAME], antidepressant .Update MD (medical doctor) as needed. R138's physician order [REDACTED]. R138's Pharmacy Consultation Report dated 1/22/20 documents, R138 has a PRN (as needed) order for any anxiolytic, which has been in place for greater than 14 days without a stop date: [MEDICATION NAME] for anxiety. Hospice patients are included in the guidance below. Please document for facility compliance. R138's Pharmacy Consultation Report dated 2/20/20 documents, R138 has a PRN (as needed) order for any anxiolytic, which has been in place for greater than 14 days without a stop date: [MEDICATION NAME] for anxiety. One dose given since 1/27/20. Surveyor could not locate any documentation that R138's physician had acted on the pharmacist documentation as documented above. R138's December 2019 MAR (Medication Administration Record) documents that R138 received the above medication on the following dates: 12/29/19 and 12/31/19. R138's January 2020 MAR indicated [REDACTED]. R138's February 2020 MAR indicated [REDACTED]. Surveyor was unable to locate any documentation in R138's medical record that documented a rationale or a physician assessment for R138's continued PRN use of the anti-anxiety medications [MEDICATION NAME] and [MEDICATION NAME] beyond 14 days. On 3/4/20 at 3:51 p.m., during the daily exit meeting, Surveyor informed Administrator-A and DON (Director of Nursing)-B of the above findings. At the time, no additional information was provided. On 3/5/20 at 9:02 a.m., RN (Registered Nurse) Managed Care-U, whom had recently taken over the pharmacy recommendation and antipsychotic medication management at the facility, informed Surveyor that he (RN Managed Care-U) had just taken over the antipsychotic medication program and could not speak to what had occurred before. RN Managed Care-U informed Surveyor that he could not provide any additional information as to why R138 had an order for [REDACTED].
F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** Based on observation, record review, and interview the facility did not ensure that food was prepared, distributed, and served in accordance with professional standards for food service safety in 1 of 1 serving kitchens. * On 3/2/20, facility staff was observed running soiled dishware through the dish machine when the dish machine was rinse water cycle was not up to disinfecting temperature. * On 3/1/20, Certified Nursing Assistant (CNA)-I was observed touching ready to eat food with bare hands and serving it to R35 to eat. This deficient practice has the potential to affect 163 of 166 residents who have their dishware washed and disinfected in the main kitchen. Findings include: 1. Dish Machine On 3/2/20 at 10:40 a.m., during the initial walk through of the main kitchen in which all of the resident dishware is washed and disinfected, Surveyor observed the dish machine to be in operation with Dietary Aide-KK pushing soiled dishware into the dish machine. Surveyor observed that on the other end of the dish machine, Dietary-Aide-JJ was picking up the washed dish ware and placing the dishware onto racks for it to dry and be reused. Surveyor observed the dish machine disinfecting rinse temperature to initially be 140 degrees Fahrenheit, well below the documented minimum disinfecting temperature of 180 degrees that was observed to be posted on the dish machine. Surveyor observed Dietary Aide-KK then push through 8 soiled food trays into the dish machine while the dish machine displayed a disinfecting rinse temperature of 120 degrees. Surveyor observed Dietary Aide-JJ await the 8 food trays to come out the dish machine and place them on a rack for the clean dishware section of the kitchen. On 3/2/20 at approximately 10:50 a.m., Surveyor informed Dietary Manager-H, of the above findings to prevent any additional dishware from being improperly disinfected in the dish machine and stored as clean for residents to use. Surveyor and Dietary Manager-H both walked over to the dish machine and observed the dish machine disinfecting temperature to be 178 degrees Fahrenheit. Dietary Manager-H then informed Surveyor that she would get maintenance to look at the dish machine, and that then proceeded to run a food grade thermometer through the dishmachine. When the food grade thermometer came out the dishmachine, after going through the disinfecting rinse cycle, Surveyor observed the thermometer read 100 degrees Fahrenheit. On 3/2/20 at 10:58 a.m., Maintenance Director-II arrived to the Kitchen and inspected the dishmachine. Maintenance Director-II informed Surveyor that the previous Maintenance employee had turned off the dishmachine's independent water heater that helped the water reach the disinfecting temperature. Maintenance Director-II informed Surveyor that he had turned on the dishmachine's independent water heater and would see if the dishmachine's disinfecting temperature would reach 180 degrees Fahrenheit. On 3/2/20 at 11:00 a.m., Surveyor observed the dishmachine's rinse cycle, which disinfects the dishware, reach only 178 degrees Fahrenheit. On 3/2/20 at 11:01 a.m., Surveyor observed Dietary Manager-H run a food grade thermometer through the dishmachine. When the food grade thermometer came out the dishmachine, after going through the disinfecting rinse cycle, Surveyor observed the thermometer to again read 100 degrees Fahrenheit. On 3/2/20 at 11:06 a.m., Surveyor asked Dietary Manager-H and Corporate Dietary Consultant-HH to see the temperature log for the dishmachine for 3/2/20. Corporate Consultant-HH showed Surveyor the dishmachine's temperature log for 3/2/20. Surveyor observed the dishmachine's temperature log to be empty and have no documented wash or rinse temperatures for the post breakfast dishmachine service for 3/2/20. On 3/2/20 at 11:06 a.m., Dietary Manager-H informed Surveyor that she took the initial temperature's for the post breakfast dishmachine service for 3/2/20 but did not document them on the temperature log. On 3/2/20 at 11:07 a.m., Surveyor observed Dietary Manager-H run a food grade thermometer through the dishmachine. Surveyor noted that the dishmachine rinse temperature reach only 170 degrees Fahrenheit. When the food grade thermometer came out the dishmachine, after going through the disinfecting rinse cycle, Surveyor observed the thermometer to again read 100 degrees Fahrenheit. On 3/2/20 at 11:10 a.m., Surveyor observed Dietary Manager-H run a T-Stick Disposable Thermometer Stick through the dishmachine. When the T-Stick Disposable Thermometer Stick came out of the dishmachine, after going through the disinfecting rinse cycle, Surveyor observed the T-Stick Disposable Thermometer Stick not turn black, which would indicate that that the temperature at the core of the dishmachine was not reaching 160 degrees Fahrenheit. Dietary Manager-H informed Surveyor that she would call for a commercial contractor to come service the dishmachine. On 3/2/20 at 3:35 p.m., Dietary Manager-H provided Surveyor with a copy of the service call log from ECOLAB, the commercial contractor whom serviced the dishmachine. The service call log documents, Kitchen: Comments- Booster heater leak needs to be fixed by maintenance. This is a separate heater from the wash tank on the dish machine. This supplies the rinse water temp (temperature) for the machine. There was no issue until today with the wash tank heater. Under the Comments section it documents, Temperature issue on the wash tank. I replaced the contact, thermostat and high limit switch. The booster heater is a separate issue. This does not control the wash tank temperature. The booster controls the final rinse temperature. If there is an issue with the booster heater, connect the bucket of Ultra San for chemical sanitation. This needs to test between 50-100 PPM (parts per millions) when in use. On 3/3/20 at 4:18 p.m., Surveyor informed Dietary Manager- H of the above findings. No additional information was provided as to why the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525604	A. BUILDING _____ B. WING _____	03/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SOUTHPOINTE HEALTHCARE CTR	4500 W LOOMIS RD GREENFIELD, WI 53220

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 12) facility did not ensure that food dishware was cleaned and disinfected in accordance with professional standards for food service safety. 2. On 3/1/20 at 1:23 p.m. Surveyor observed in the large dining room CNA (Certified Nursing Assistant)-I hold onto R35's roll with her bare hand, place a piece of turkey on the roll to make a sandwich and then CNA-I with her bare hand handed R35 the roll with turkey. Surveyor observed CNA-I was not wearing any gloves. On 3/1/20 at 1:38 p.m. Surveyor observed CNA-I open a packet of crackers and then with her bare hand handed a resident the cracker. On 3/4/20 at 6:55 a.m. Surveyor asked DAM (Dietary Account Manager)-H if staff should touch food with their bare hands. DAM-H replied no, should have gloves on. Surveyor informed DAM-H of the observations on 3/1/20 of bare hand food contact. On 3/4/20 at 3:31 p.m. Administrator-A and DON (Director of Nursing)-B were informed of the above.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the Facility did not have an effective infection control program to help prevent the transmission of infections. * The Facility's December 2019 infection line listing log was not completed. * Baseline rates of infections were not calculated for December 2019 and January 2020. * The facility did not complete mandatory monthly CRE (Carbapenem-Resustant [MEDICATION NAME]) surveillance reporting to NHSN (National Healthcare Safety Network). * R25 was observed was observed to not have appropriate hand hygiene during care observations and the incontinence product was placed directly on the floor. * R47 was observed was observed to not have appropriate hand hygiene during care observations and the incontinence product was placed directly on the floor. * R96 was observed was observed to not have appropriate hand hygiene during care observations and the incontinence product was placed at the end of R96's bed. * R99's urinary collection bag and Foley tubing was observed directly on the floor. This deficient practice has the potential to affect all 166 Residents residing in the Facility at the time of the survey. Findings include: 1. On 3/3/20 at 1:20 p.m. Surveyor met with ADON (Assistant Director of Nursing)-F who became the Facility's infection preventionist effective January 20, 2020 and RN (Registered Nurse)-O who was the Facility's infection preventionist until January 20, 2020. RN-O explained to Surveyor the Facility's surveillance program including completing criteria sheets to ensure definition of infections are being met, monthly tracking and trending log, mapping, and baseline rates of infections for their prevalent infections. During this conversation Surveyor asked if the Facility has a SAMS card and if the facility was reporting their Carbapenem-Resistant [MEDICATION NAME] (CRE) rates to NHSN (National Healthcare Safety Network). RN-O informed Surveyor they don't have a SAMS card and when prior DON (Director of Nursing)-FF was here they were going to start the process to get a SAMS card. Surveyor asked when prior DON-FF left the Facility. RN-O informed Surveyor prior DON-FF left in November. Surveyor asked if the Facility has ever reported to NHSN. RN-O replied no I don't think so. Surveyor noted the requirement to report CRE to the NHSN began June 1, 2017. At 1:54 p.m. Surveyor started to review the Facility's baseline rates of infection, infection log and surveillance worksheets for September 2019 to present. RN-O informed Surveyor December's infection log for tracking and trending is not completed as this is when they were switching and ADON-F became responsible. RN-O informed Surveyor she will work on the log this afternoon. On 3/3/20 at 3:36 p.m. Surveyor informed RN-O when Surveyor was reviewing the Facility's infection control information Surveyor did not note baseline rates of infections for January 2020. RN-O informed Surveyor they have not been calculated as of today as she needs to show ADON-F how to do the baseline rates of infections. The Lippincott Procedures - Hand hygiene revised June 14, 2019 under introduction documents Hand hygiene is a general term used by the Centers for Disease Control and Prevention (CDC) and the World Health Organization (WHO) to refer to handwashing, antiseptic hand washing, antiseptic hand rubbing and surgical hand asepsis. The hands are the conduits for almost every transfer of potential pathogens from one patient to another, from a contaminated object to a patient, and from a staff member to a patient. Hand hygiene, therefore, is the single most important procedure in preventing infection. To protect a patient from health care-associated infection, hand hygiene must be performed routinely and thoroughly. In effect, clean and healthy hands with intact skin, short fingernails, and no rings minimizes the risk of contamination. Artificial nails and rings can serve as reservoirs for microorganisms, as can rough or chapped hands. Washing with soap and water is appropriate when the hands are visibly soiled or contaminated with blood or other body fluids, when exposure to potential spore-forming pathogens (such as [MEDICAL CONDITION] and Bacillus anthracis) is strongly suspected or proven, and after using the restroom. Using an alcohol-based hand rub is appropriate for decontaminating the hands before direct patient contact; before putting on gloves; before inserting an invasive device; after contact with a patient; when moving from a contaminated body site to a clean body site during patient care; after contact with body fluids, excretions, mucous membranes, nonintact skin, or wound dressings (if hands aren't visibly soiled); after removing gloves; and after contact with inanimate objects in the patient's environment. 2. R25's quarterly MDS (minimum data set) with an assessment reference date of 12/11/19 documents a BIMS (brief interview mental status) score of 8 which indicates moderately impaired. R25 requires extensive assistance with two plus person physical assist for bed mobility, doesn't ambulate, requires extensive assistance with one person physical assist for toilet use, is frequently incontinent of urine and always incontinent of bowel. On 3/2/20 at 8:39 a.m. Surveyor observed CNA (Certified Nursing Assistant)-J enter R25's room and then leave. Surveyor asked CNA-J what she was going to do. CNA-J informed Surveyor she's going to check to see if R25 is soiled. At 8:40 a.m. Surveyor entered R25's room with CNA-J and CNA-M. CNA-J & CNA-M placed gloves on, CNA-M lowered the head of the bed, removed the bedding off R25 and raised the height of the bed. CNA-J unfastened R25's incontinence product, washed R25's inner thighs & frontal area and dried the area. R25 was positioned on his left side. Surveyor observed stool in R25's rectal area. CNA-J rolled the draw sheet & incontinence product under R25, inform R25 she was going to wash him, and washed R25's rectal area to remove the stool and buttocks. CNA-J removed the incontinence product, handed CNA-M the soiled incontinence product which CNA-M threw on the floor. Surveyor observed CNA-J did not remove her gloves and did not wash or cleanse her hands. CNA-J stated to CNA-M that she threw the product on the floor and product needs to go in the garbage. CNA-M then picked up the incontinence product off the floor and placed the product in a garbage container. CNA-J and CNA-M placed a new draw sheet and incontinence product under R25. CNA-J informed R25 his gown was wet, they would pull him up and get R25 out of the gown. CNA-J and CNA-M positioned R25 up in bed and CNA-J placed a gown on R25. CNA-M removed her gloves and left R25's room without washing or cleansing her hands. CNA-J covered R25 with bedding, lowered the height of the bed, removed her gloves and washed her hands. On 3/3/20 at 1:09 p.m. Surveyor asked ADON (Assistant Director of Nursing)-F when staff are doing personal cares for a resident is it okay for staff to throw an incontinence product on the floor or place the product at the end of a bed. ADON-F replied no and explained staff shouldn't be doing this as it's an infection control issue. Surveyor informed ADON-F of the observation. At 1:10 p.m. Surveyor asked ADON-F when staff is providing personal cares when should staff perform hand hygiene. ADON-F explained if staff wash a resident's face first they should get a new wash cloth, remove their gloves and wash their hands. If staff are doing peri care they should have new gloves on, clean front to back with wash cloth, rinse off, dry, remove their gloves and wash their hands as they don't want to come in contact with dirty stuff. Surveyor asked if staff removes their gloves should they wash or cleanse their hands. ADON-F replied definitely, any time should wash and put new gloves on. ADON-F informed Surveyor she tells staff to think about anything they could bring home to their family. Surveyor informed ADON-F of Surveyor's observations. ADON-F informed Surveyor she will be doing inservice and checking. 3. R47's admission MDS (minimum data set) with an assessment reference date of 1/3/20 documents a BIMS (brief interview mental status score of 9 which indicates moderately impaired. R47 requires extensive assistance with one person physical assist with bed mobility & toilet use, extensive assistance with two plus person physical assist for transfer, and is frequently incontinent of urine and bowel. On 3/2/20 at 8:21 a.m. Surveyor observed CNA (Certified Nursing Assistant)-M in R47's room wearing gloves. CNA-M handed R47 a wash cloth for R47 to wash his face, and placed tubi grips and gripper socks on R47 while R47 was washing his own face. CNA-M informed R47 she was going to check and change him. Surveyor inquired if the product was wet which CNA-M replied yes. CNA-M wet the end of a towel and then washed & dried R47's frontal area. CNA-M positioned R47 on his left side and washed R47's rectal area & buttocks. CNA-M removed the soiled incontinence product and placed the product directly on the floor. CNA-M did not remove her gloves and did not wash or cleanse her hands. CNA-M placed an incontinence product under R47 and fastened the product. CNA-M picked the incontinence product off the floor and placed this product in a garbage bag. CNA-M opened R47's closet doors, asked R47 about wearing short, and removed a pair of shorts. CNA-M placed shorts on R47, lowered the bed, brought a wheelchair over by the bed, placed shoes on R47 and transferred R47 into the wheelchair. CNA-M removed R47's gown, placed a sweatshirt & hat on R47, removed her gloves and wheeled R47 out of his room. During this observation, Surveyor did not observe CNA-M wash or cleanse her hands. On 3/3/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525604	A. BUILDING _____ B. WING _____	03/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SOUTHPOINTE HEALTHCARE CTR	4500 W LOOMIS RD GREENFIELD, WI 53220

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 13) at 1:09 p.m. Surveyor asked ADON (Assistant Director of Nursing)-F when staff are doing personal cares for a resident is it okay for staff to throw an incontinence product on the floor or place the product at the end of a bed. ADON-F replied no and explained staff shouldn't be doing this as it's an infection control issue. Surveyor informed ADON-F of the observation. At 1:10 p.m. Surveyor asked ADON-F when staff is providing personal cares when should staff perform hand hygiene. ADON-F explained if staff wash a resident's face first they should get a new wash cloth, remove their gloves and wash their hands. If staff are doing peri care they should have new gloves on, clean front to back with wash cloth, rinse off, dry, remove their gloves and wash their hands as they don't want to come in contact with dirty stuff. Surveyor asked if staff removes their gloves should they wash or cleanse their hands. ADON-F replied definitely, any time should wash and put new gloves on. ADON-F informed Surveyor she tells staff to think about anything they could bring home to their family. Surveyor informed ADON-F of Surveyor's observations. ADON-F informed Surveyor she will be doing inservice and checking. 4. R96's quarterly MDS (minimum data set) has a BIMS (brief interview mental status) score of 00 which indicates severe impairment. R96 is dependent with one person physical assist for bed mobility & toilet use, does not ambulate and is always incontinent of urine & bowel. On 3/3/20 at 10:17 a.m. Surveyor observed CNA (Certified Nursing Assistant)-J wheel R96's broda chair into her room. PT (Physical Therapist)-N entered R96's room. Surveyor observed staff are wearing gloves. CNA-J & PT-N attached the sling under R96 to the hoyer lift and R96 was transferred onto her bed. R96's sling was unhooked from the hoyer lift, PT-N removed her gloves, washed her hands and left R96's room. CNA-J removed her gloves, cleansed her hands, and placed gloves on. CNA-J informed R96 she was going to check her brief to see if she was wet. CNA-J wet a towel, removed an incontinence product from the closet and lowered R96's pants. CNA-J checked R96's incontinence product stating has a little poop. CNA-J unfastened the incontinence product, positioned R96 on her side and washed R96's rectal area to remove the stool. CNA-J did not remove her gloves and wash or cleanse her hands. CNA-J placed an incontinence product under R96, applied barrier cream on R96's buttocks, removed her right glove and placed another glove on her right hand. CNA-J did not wash or cleanse her hands. R96 was positioned on her other side, CNA-J removed the soiled incontinence product placing the product at the end of the bed. Surveyor noted the incontinence product was not placed in a bag prior to be placed at the end of R96's bed. CNA-J fastened R96's incontinence product, removed the soiled incontinence product from the end of the bed and placed the product in a garbage container. CNA-J removed her gloves but did not wash or cleanse her hands. CNA-J placed a body pillow along the right side and R96 was positioned on her left side. CNA-J lowered R96's bed down low, placed the mat on the floor, and raised the head of R96's bed. CNA-J went into the bathroom and washed her hands. On 3/3/20 at 1:09 p.m. Surveyor asked ADON (Assistant Director of Nursing)-F when staff are doing personal cares for a resident is it okay for staff to throw an incontinence product on the floor or place the product at the end of a bed. ADON-F replied no and explained staff shouldn't be doing this as it's an infection control issue. Surveyor informed ADON-F of the observation. At 1:10 p.m. Surveyor asked ADON-F when staff is providing personal cares when should staff perform hand hygiene. ADON-F explained if staff wash a resident's face first they should get a new wash cloth, remove their gloves and wash their hands. If staff are doing peri care they should have new gloves on, clean front to back with wash cloth, rinse off, dry, remove their gloves and wash their hands as they don't want to come in contact with dirty stuff. Surveyor asked if staff removes their gloves should they wash or cleanse their hands. ADON-F replied definitely, any time should wash and put new gloves on. ADON-F informed Surveyor she tells staff to think about anything they could bring home to their family. Surveyor informed ADON-F of Surveyor's observations. ADON-F informed Surveyor she will be doing inservice and checking. 5.) R99's quarterly MDS (minimum data set) with an assessment reference date of 1/29/20 documents R99 requires extensive assistance with one person physical assist for bed mobility, transfer, & toilet use and does not ambulate. R99 is coded as having an indwelling catheter. On 3/1/20 at 11:32 a.m. Surveyor observed R99 sitting in a wheelchair in his room. Surveyor observed R99's urinary collection bag is resting directly on the floor under R99's wheelchair. On 3/1/20 at 12:38 p.m. Surveyor observed R99 sitting in a wheelchair in the dining room. Surveyor observed there is a blue bag covering the collection bag but the collection bag is coming out of the bottom of the bag and is resting directly on the floor. On 3/2/20 at 7:55 a.m. Surveyor observed R99 sitting in a wheelchair in the doorway of his room. Surveyor observed the urinary collection bag and Foley catheter tubing are resting directly on the floor under R99's wheelchair. On 3/2/20 at 10:04 a.m. Surveyor observed R99 sitting in a wheelchair along side his bed. Surveyor observed the urinary collection bag and Foley catheter tubing are resting directly on the floor under R99's wheelchair. On 3/2/20 at 2:20 p.m. Surveyor observed R99 sitting in a wheelchair in his room. Surveyor observed the urinary collection bag and Foley catheter tubing are resting directly on the floor under R99's wheelchair. On 3/3/20 at 10:52 a.m. Surveyor asked RN (Registered Nurse) Manager-L if R99's urinary collection bag and Foley catheter tubing should be resting directly on the floor. RN Manager-L replied no, shouldn't be on the floor. Surveyor informed RN Manager-L of Surveyor's observations.