STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525580	A. BUILDING _____ B. WING _____	09/30/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MEADOWBROOK AT BLOOMER	1840 PRIDDY ST BLOOMER, WI 54724

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 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility did not ensure each resident's care plan is reviewed and revised, based on the resident's needs and comprehensive assessment. This occurred for 2 of 10 residents whose care plans were reviewed (Residents (R) 8 and R7). R8's care plan was not revised to identify current nutritional status, goals and interventions or mobility status. R7's care plan was not revised to include a toileting plan. This is evidenced by: 1. R8 was admitted to the facility on [DATE], having [DIAGNOSES REDACTED]. The significant change in status Minimum (MDS) data set [DATE] documents R8 does not ambulate in the room or corridor. The 06/25/20 discharge assessment documents R8 does not ambulate in the corridor. Care plan in part, Mobility (Resident name) is on walking Nursing restorative maintenance program and participates in range of motion exercises with active assist r/t Weakness (Resident name) will maintain current level of functioning RESTORATIVE - Range of Motion (Active) - Upper extremity exercises with morning and evening cares and/or Activities ROM Group Walk with resident 1 to 2 times a day distances as tolerated. As . allows Surveyor observed R8 transfer with the use of a sit to stand lift on 09/28/20 at 12:30 p.m. Surveyor interviewed Certified Nursing Assistant (CNA) D who states R8 does not ambulate, just goes from chair to bed. CNA D stated R8 transfers with assist of 2 and the sit to stand lift. On 09/29/20 at 11:15 a.m., Surveyor interviewed CNA E asking about mobility status for R8. CNA E stated R8 transfers with a sit to stand lift. Surveyor asked if R8 ambulates. CNA E stated, Not since I started in December. Surveyor reviewed the documentation for ambulation. All entries stated the activity did not occur, or the resident refused. On 09/30/20 at 3:30 p.m., Surveyor interviewed Director of Nursing (DON) B and asked if the care plan has been revised to reflect R8's mobility status. DON B stated, No, I will update the care plan. Nutrition Care plan in part, (Resident name) has a potential nutritional problem related to [MEDICAL CONDITION] and nausea with variable intake. Goal: Will maintain weight of 195# - 205# by review date .Eating- Eats in dining room . Surveyor reviewed the weights of R8 and noted a current weight of 173.5 pounds. R8 has been within 5 pounds of this weight since 5/28/20. The care plan goal states a goal weight of 195-205 pounds. There have been no revisions to reflect R8's gradual weight loss and need for more supervision and cueing for R8. R8 has not been eating in the dining room since March 2020. This has not been revised on the care plan. Surveyor interviewed Dietary Manager (DM) C on 09/29/20 at 12:15 p.m Surveyor asked DM C who is responsible for revising the care plans. DM C stated it is her responsibility. Surveyor asked if R8's care plan accurately reflects nutritional status as it states R8 has a potential for a nutritional problem, when the medical record documents an actual nutrition problem with gradual weight loss. Surveyor asked if the goal weight for R8 was accurate. DM C stated the care plan is not accurate and has not been revised. DM C states she had not gotten to reviewing this resident's care plan. 2. R7 was admitted on [DATE] with [DIAGNOSES REDACTED]. The admission Minimum Data Set ((MDS) dated [DATE] documents R7 is frequently incontinent of bowel and always incontinent of urine. The care plan in part, The resident has a self-care performance deficit The resident will maintain current level of function in through the review. The resident will improve current level of function in ADL'S through the review date. BATHING/SHOWERING - ASSIST - TWO for transfer and dressing, ONE assist for washing DRESSING - ASSIST - ONE PERSONAL HYGIENE/ORAL CARE - ASSIST - TWO Toileting- dependent with toileting The self care deficit care plan gives no detail on the type of toileting program or frequency. Surveyor observed resident for incontinence during the complaint survey. R7 has a history of urinary and bowel incontinence per the medical record. Surveyor observed R7 having assistance with toileting. On 09/28/20 at 11:20 a.m., Surveyor asked CNA D what type of help R7 requires for toileting. CNA D indicated R7 has to be assisted quite often. On 09/29/20 at 11:15 a.m., Surveyor interviewed CNA E and asked about the toileting plan for R7. CNA E indicated R7 is dependent needing assist to toilet. CNA E indicated R7 is incontinent of bowel and bladder most of the time. Surveyor asked CNA E what the care plan instructs for a toileting schedule. CNA E reviewed the care plan and said, This has not been updated. Surveyor reviewed the toileting documentation for the past month. The documentation records R7 being toileted 2- 4 times per day. Surveyor reviewed the Continence Evaluation Assessment completed on 07/03/20 and 09/26/20. The assessment in part, Resident able to participate in a bowel and bladder program. The specific instructions are: Every 2 hour prompted toileting and changing of incontinence products. On 09/29/20 at 3:30 p.m., Surveyor interviewed DON B and asked about the care plan accuracy for R7's toileting plan. DON B stated the care plan did not contain the information.
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility did not ensure that 1 Resident (R2) of 8 reviewed for accidents had adequate assistance devices and interventions in place to prevent accidents. The facility did not thoroughly investigate and or complete a root-cause analysis to prevent future falls for R2 after R2 fell on [DATE], 02/18/2020, and 02/24/2020. Findings include: R2 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. R2's Admission MDS (Minimum Data Set) dated 12/04/2019 documents a BIMS (Brief Interview for Mental Status) score of 15, indicating that R2 was cognitively intact. Section G (Functional Status) documents that R2 required limited assistance and a one person physical assist for transfer and bed mobility needs. R2 had Fall Risk Assessments completed on 2/18/2020 and 3/4/2020; both indicated R2 was At risk for falls. Care Conference note dated 2/6/2020, stated: R2 has had 9 falls since 1/20/2020. Record review revealed R2 sustained a fall on 2/15/2020 and 2/18/2020. Surveyor did not find documentation of any other falls during the time period 1/30/2020 - 3/6/2020. On 09/28/2020 at 2:26pm, Surveyor requested to view fall investigation reports for all of R2's falls sustained during the identified time period. On 9/29/2020 at 2:16pm, Surveyor spoke to Nursing Home Administrator (NHA) A and Director of Nursing (DON) B, who stated investigations were completed for R2's falls on 02/15/2020 and 02/18/2020, but no investigation was completed for R2's fall on 2/24/2020. No explanation was provided as to why the investigation was not completed or why there was no documentation of the fall in the medical record. NHA A provided a copy of the fall investigations, which consisted of a Nurse Progress Note following R2's falls on 2/15/2020 and 2/18/2020. These notes did not contain a detailed assessment of R2 following the falls, identification of root-causes, or new interventions to be implemented to prevent future falls. R2's Care Plan related to falls was last revised 01/27/2020; no updates to the Care Plan were made following falls on 2/15/2020, 2/18/2020, or 2/24/2020.
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.**

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

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

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F 0690 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to have physician orders and follow standards of practice for the care and treatment of [REDACTED]. R4 had an indwelling foley catheter without a physician order to direct the care and treatment for [REDACTED]. was removed and unable to be replaced. R9 has an indwelling foley catheter without a physician order to direct the care and treatment for [REDACTED]. This is evidenced by: 1. R4 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Surveyor reviewed the medical record orders for the catheter use. Physician Orders dated 10/21/2019, read: Change foley catheter (Specify size in Fr. and CC's) PRN (as needed) with indication of infection, Obstruction or leakage. Document reason for change in progress notes. every 24 hours as needed. Surveyor could not locate an order for [REDACTED]. Surveyor asked how staff would know which type and size of catheter to use if R5 needed catheter changed. NHA A stated there should be orders in the medical record. Surveyor requested a copy of the order for R5. On 09/30/20, NHA emailed a scanned copy of hospital discharge paperwork stating Indwelling urinary catheter Coude 16 Fr had been placed on 12/02/2019, prior to admission to facility. 2. R5 was admitted to facility on 11/13/2019 with [DIAGNOSES REDACTED]. R5's Physician Order dated 11/13/2019 stated: Foley catheter present 16 French due to [MEDICAL CONDITION] with failed attempt to d/c. Active resistance to straight cath. Order was discontinued on 04/28/2020. Physician Communication Report dated 03/30/2020, stated: Nursing Reports/Concerns: Resident is still bypassing cath even with bigger size . Physician's response: .send me fluids input No documentation found that Physician had ordered a larger size catheter. Nursing Note dated 04/25/2020 at 1200, stated: .Attempted to flush catheter with sterile water, but unable to flush. Removed catheter and noted that catheter had white sediment in tip. Attempted to place 22 gauge catheter using sterile technique, but became agitated and attempted to move away from staff while screaming . Nursing Note dated 04/27/2020 at 0914, stated: .Resident foley not in place DON aware and provider will be updated this morning. The catheter order was discontinued 04/28/2020. Surveyor interviewed NHA A and DON B via telephone 09/29/2020 at 2:16 PM. Surveyor asked if the catheter change attempted on 04/25/2020 was unsuccessful due to the nurse using the incorrect size of catheter. Surveyor also asked why the Physician was not notified when the catheter was unable to be replaced. No answer was provided at that time. On 09/29/2020 at 3:43PM, NHA emailed Surveyor stating: Please see attached for R5's foley inquiries .As for the note on the 22 french-the RN who wrote the note I am unsure if it was a typo in size. Summarizing, the 25th the catheter came out 27th unable to reinsert due to agitation and discomfort to the resident and MD updated and the 28th it was discontinued. 3. R9 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The [DIAGNOSES REDACTED]. On 09/28/20 at 11:10 a.m., Surveyor observed R9 in his room and could see a foley catheter in place. Surveyor reviewed the medical record for orders and rationale for the catheter use. Surveyor could not locate an order for [REDACTED]. DON B indicated R9 had been on hospice for a while and hospice had a catheter order. Surveyor noted the medical record documents R9 was discharged from hospice on 09/10/20. On 09/29/20 at 4:10 p.m Surveyor interviewed NHA A about the catheter order. NHA A indicated hospice had the order. Surveyor asked how the staff working with R9 would know what to do with the catheter if they have no physician orders in the electronic medical record on when to change the catheter or what size to insert if it were to come out. NHA A indicated the orders should have been put in the electronic medical record. On 09/30/30 at 9:00 a.m., Surveyor interviewed NHA A and asked for the medical rationale for the use of the catheter. A rationale or [DIAGNOSES REDACTED].
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 record review and interviews, the facility did not ensure residents receive PRN (As Needed) orders for [MEDICAL CONDITION] drugs to be limited to 14 days for 2 (Resident (R) 9 and R5) of 4 residents reviewed with [MEDICAL CONDITION] medications. The physician or prescribing practitioner did not document their rationale in the resident's medical record, indicate the duration for the PRN order and evaluate the resident for the appropriateness of that medication for R9. R5 had a PRN (as needed) order for an anti-anxiety medication with no documented physician rationale for the PRN order extending beyond 14 days. This is evidenced by: 1. Review of R9's medical record documents current diagnoses, in part: Metabolic [MEDICAL CONDITION], chronic [MEDICAL CONDITION], heart failure, and [MEDICAL CONDITION]. Review of physician orders [REDACTED]. The Medication Administration Record [REDACTED]. Review of the physician progress notes [REDACTED]. The medical record does not include a rationale of necessary or clinically significant reasons for the continued use of the medication. Surveyor interviewed Director of Nursing (DON) B on 09/29/20 at 3:45 p.m. to ask about an end date for the [MEDICATION NAME] or physician rationale for the continued use of the medication beyond 14 days. DON B indicated that getting an end date or rationale was missed and that a message had been sent to the physician today. 2. R5 was admitted to facility on 11/13/2019, with [DIAGNOSES REDACTED]. R5 had two physician's orders [REDACTED]. [MEDICATION NAME] ([MEDICATION NAME]) 0.25 mg via gastrostomy tube PRN for anxiety before cares related to OTHER SYMPTOMS AND SIGNS INVOLVING COGNITIVE FUNCTIONS AND AWARENESS; administer 1 hour before cares. Start date: 01/31/2020; end date: 05/24/2020. 2. [MEDICATION NAME] 0.25 mg via PEG tube (percutaneous endoscopic gastrostomy tube) as needed for 1 hour prior to cares. Start date: 06/04/2020; end date: 12/04/2020. This order was initially started 04/13/2020, with end date: Indefinite. Order was revised on 06/04/2020 to include new end date: 12/04/2020. R5's Medication Administration Record [REDACTED]. R5's Pharmacy Consultation Report, dated 06/03/2020, reads: R5 has a PRN order for an anxiolytic, which has been in place for greater than 14 days without a stop date .Recommendation: If the medication cannot be discontinued at this time, current regulations require that the prescriber document the indication for use, the intended duration of therapy, and the rationale for the extended time period. Physician circled 6 months as selected duration, and placed an X next to: Physician's Response: I accept the recommendation(s) above, please implement as written. No documentation in R5's medical record indicated prescriber provided rationale for the extended duration of PRN order.