

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0017021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 10/17/2024
NAME OF PROVIDER OR SUPPLIER PNUMA 3		STREET ADDRESS, CITY, STATE, ZIP CODE 1955 COUNTY TRUNK A NEENAH, WI 54956		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	Initial Comments From 10/14/2024 to 10/17/2024, Surveyor conducted a complaint investigation and abbreviated survey at Pnuma 3, a CBRF in Neenah. One deficiency was identified. The complaint was substantiated. Census: 5	N 000		
N 327	83.31(4)(b) Allowable reasons for involuntary discharge. Discharge or transfer initiated by CBRF. Reasons for involuntary discharge. The CBRF may not involuntarily discharge a resident except for any of the following reasons: 1. Nonpayment of charges, following reasonable opportunity to pay. 2. Care is required that is beyond the CBRF 's license classification. 3. Care is required that is inconsistent with the CBRF 's program statement and beyond that which the CBRF is required to provide under the terms of the admission agreement and this chapter. 4. Medical care is required that the CBRF cannot provide. 5. There is imminent risk of serious harm to the health or safety of the resident, other residents or employees, as documented in the resident 's record. 6. As provided under s. 50.03 (5m), Stats. 7. As otherwise permitted by law. This Rule is not met as evidenced by: Based on record review and interview, the provider issued a 30-day involuntary discharge	N 327		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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N 327	Continued From page 1 notice for reasons other than nonpayment of charges, care required outside of the CBRF's license classification, care required that was inconsistent with the CBRF's program statement and beyond that which the CBRF is required to provide, medical care was required that the CBRF could not provide, an imminent risk of serious harm, as provided under s. 50.03(5m), Stats. or otherwise permitted by law. The provider issued a 30-day involuntary discharge notice to Resident 1 stating his/her functioning levels were outside the provider's scope of care; however, documentation indicated Resident 1's level care could be met by a CBRF. Findings include: On 10/14/2024, Surveyor conducted a complaint investigation alleging the provider was attempting to discharge a resident due to his/her need for assistance with "simple tasks." On 10/14/2024 at approximately 9:00 a.m., Surveyor asked Regional Manager A if any residents had recently been issued a 30-day notice. Regional Manager A replied, "Yes, [Resident 1]." Regional Manager A explained that the provider had been struggling with Resident 1 wanting staff to do more than they should. Regional Manager A gave an example that Resident 1 wanted staff to reach down to get string cheese from the bottom of the refrigerator which s/he was capable of doing him/herself. Regional Manager A then went on to explain that Resident 1 had a catheter placed in July, which the provider was unable to care for and was worried Resident 1 would end up with severe infections due to his/her poor hygiene. On 10/14/2024 at approximately 9:30 a.m.,	N 327		

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N 327	Continued From page 2 Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider's facility on 08/02/2007 with diagnoses of schizophrenia and history of alcohol abuse. Resident 1's individual service plan (ISP), dated 02/01/2024, stated, "Personal Care: While [Resident 1] has many abilities to perform [his/her] own personal care, [s/he] is asking for more assistance from staff. Staff will continue to encourage [him/her] to do as much as [s/he] can on [his/her] own so [his/her] abilities do not further diminish ... Staff will provide 'non-hands on' assistance with bathing like monitoring, assisting with in and out and rinsing of hair. [Resident 1] should perform the actual tasks of self-care." Resident 1's ISP did not include catheter care. Resident 1's record included the following progress notes and medical notes: - 07/08/2024: Emergency Room (ER) Visit with urinary retention resulting in Resident 1 discharging with a catheter in place. - 07/12/2024: Reported painful private area and has not changed his/her brief since ER visit. Taken back to ER - Physician informed Resident 1 to shower and keep peri-area clean. - 07/17/2024: Urology visit with failed attempt to remove catheter. - 08/19/2024: Urology visit for catheter change. Went to ER later that day for a urinary tract infection and catheter obstruction. - 09/12/2024: Urology visit with successful discontinuation of his/her catheter. *Surveyor noted progress notes from 07/08/2024 to 09/12/2024, documented caregivers occasionally assisting Resident 1 with emptying the catheter bag and Resident 1's difficulty to complete catheter cares independently due to his/her long fingernails and poor eyesight. Documentation did not document any offering to	N 327		

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N 327	Continued From page 3 assist with or completion of peri-cares. On 10/14/2024 at approximately 10:00 a.m., Surveyor interviewed Regional Manager A and Administrator B. Surveyor once again asked why Resident 1 was issued an involuntary discharge notice. Regional Manager A stated the primary reason for the discharge notice was Resident 1's catheter placement and the provider's concern that s/he would suffer a serious infection due to his/her poor hygiene while having a catheter. Surveyor asked why the provider was unable to care for Resident 1's catheter. Both Regional Manager A and Administrator B stated the facility was ambulatory and did not provide hands-on care for residents. Surveyor reviewed the provider's program statement, which stated, "Personal Care: Each individual is expected to maintain a regular pattern of personal hygiene and grooming. Staff provides necessary support, with strong encouragement in directing tenants to maintain an independent lifestyle, with minimal assistance and reminders." Surveyor also explained that though residents may be ambulatory, Chapter 83 required facilities to assist with personal care needs. Regional Manager A stated s/he was unaware that peri-care for residents with a catheter was not a skilled nursing need. Both Regional Manager A and Administrator B stated the facility historically had not provided hands on care. Administrator B further explained that Resident 1's discharge was a result of a multitude of reasons including Resident 1 aging, having increased backpain and then most recently a catheter placed which the facility was unable to care for. Administrator B stated s/he had tried to work with Resident 1's managed care organization (MCO) on alternate placement as s/he could see Resident 1's needs changing; however, the MCO stated a 30-day	N 327		

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N 327	Continued From page 4 discharge would need to be issued in order to seek alternate placement. Administrator B acknowledged Resident 1's needs had not justified a 30-day notice at the time of issuance, but that s/he was following the directive of Resident 1's MCO. Cross Reference: N0425 DHS 83.38(1)(a) Personal Care	N 327		