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	0012461	A. BUILDING: _____ B. WING _____	C 07/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR GROVE GARDENS II	626 VAN ALTENA AVE CEDAR GROVE, WI 53013

(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 On 07/19/2024-07/22/2024, Surveyor conducted a complaint investigation and standard survey at Cedar Grove Gardens II. Three deficiencies were identified. The complaint was unsubstantiated. Census: 18	N 000		
N 389	83.35(3)(d) Service plans updated annually or on changes Individual service plan review. Annually or when there is a change in a resident ' s needs, abilities or physical or mental condition, the individual service plan shall be reviewed and revised based on the assessment under sub. (1). All reviews of the individual service plan shall include input from the resident or legal representative, case manager, resident care staff, and other service providers as appropriate. The resident or resident ' s legal representative shall sign the individual service plan, acknowledging their involvement in, understanding of and agreement with the individual service plan. This Rule is not met as evidenced by: Based on observation, record review, and interview, the individual service plan (ISP) was not updated for 3 of 3 resident records reviewed when there was a change in resident needs and abilities. Resident 5's ISP was not updated to include interventions for verbal aggression.	N 389		

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

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N 389	Continued From page 1 Resident 2's ISP was not updated to include the use of adaptive equipment to aid in transferring in and out of bed. Resident 7's ISP was not updated to include the use of adaptive equipment to aid in transferring in and out of bed. Findings include: On 07/19/2024, Surveyor reviewed resident records and identified the following: Example 1: Resident 5 Resident 5 was admitted to the facility on 03/23/2021. Resident 5 is their own decision maker. Resident 5's ISP dated 04/22/2024 documented: "Emotionally/Attitude: "yell out/can be resistive at times", was underlined. Monitor resident and address any concerns as they arise. Socialization: Interacts independently without conflicts. Verbally abusive at times-MD aware. Encourage conversation and interaction with peers and staff daily." Resident 5's progress notes documented: "04/17/24-Yearly: Resident remains A+O x4. Able to make needs know. Ambulated with wheelchair. [Husband/wife] remains involved with care and medical needs. See charting regarding behavior and agreement. Resident will see anger management. Any increased behavior or outbursts resident will receive a 30-day notice. 03/18/24 12:45: On 3/14/24 approx 1715 caregiver asked all residents if anyone would like more soup at dinner. Resident stated, "if they want ore, they can ask themselves." Another	N 389		

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N 389	Continued From page 2	N 389		

resident replied, "we want won't ask you." [Resident 5] turned around saying to [Resident 6], "if you come at me once more, I'm knocking you on your [expletive]. [Resident 6] replied "you will not, be quiet." [Resident 5] wheeled over to [Resident 6] knocking over all walkers out of the way until [s/he] was bumping into [Resident 6's] chair and yelled in [his/her] face 'hit me so I can knock you on your [expletive]. I will break your jaw." [Resident 6] told [him/her] 'to get away." Staff got in between the two residents and [Resident 5] continued to try and get at [Resident 6]. Staff then got [Resident 6] up from chair and headed [him/her] towards the living room to sit in the recliner. [Resident 5] then road ahead of [Resident 6] to sit in the recliner [Resident 6] usually uses stating "and I'm going to sit in your [expletive] chair all night." [Resident 6] asked [him/her] for [his/her] blanket, [Resident 5] said "I don't want your piss blanket." [Resident 6] sat on the couch and asked to be left alone. [Resident 5] began saying "my pants are wet now from sitting in your piss chair." [Resident 5] tried to get up and [Resident 6] asked "do you need help?" [Resident 5] then said, "if you say one more word, I'll break your jaw." Caregiver entered living room and told [Resident 5] it was enough and to stop it. [Resident 5] said "[s/he] doesn't need to stop anything." [Resident 5] said "[s/he] doesn't need to babysit [him/her]. [Resident 5] then lunged forwarded towards [him/her] with [his/her] fist. [S/he] took [Resident 6] to [his/her] room. [Resident 6] began to cry and remained in [his/her] room for over an hour afraid to come out."

Resident 5's 30-day notice dated 03/15/2024 documented:
" ...Your involuntary discharge from the provider is taking place because there is imminent risk of

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serious arm to the health, safety, and well-being of other residents and employees because of your documented behaviors of witnessed threatening, swearing, and screaming at other vulnerable residents and/or employees, along with resident's family member complaints regarding your behaviors."

On 07/19/2024 at 10:50 AM, Surveyor interviewed Caregiver C. Caregiver C stated Resident 5 had ongoing behaviors of verbal aggression and being affectionate towards female staff. Caregiver C stated the provider issued a 30-day notice to Resident 5 due to an incident in March 2024 between resident 5 and Resident 6. Caregiver C stated Resident 5 was allowed to stay at the facility as long as s/he took weekly anger management classes. Surveyor asked if Resident 5's care plan had any strategies for staff to utilize Resident 5's behaviors. Caregiver C stated "no", but staff will try to prompt Resident 5 or call his/her husband/wife.

The ISP did not identify updated interventions or approaches for staff to utilize in managing Resident 5's verbal aggression.

Example 2: Resident 2

According to the U.S. Food & Drug Administration's Hospital Bed Safety Workgroup, "...Strangling, suffocating, bodily injury, or death can occur when patients or parts of their bodies are caught between rails or between the bed rails and mattresses...Regardless of the purpose for which bed rails are being used or considered, a decision to utilize or remove those in current use should occur within the framework of an individual patient assessment.

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N 389	Continued From page 4 2. Because individuals may differ in their sleeping and nighttime habits, creation of a safe bed environment that takes into account patients ' medical needs, comfort, and freedom of movement should be based on individualized patient assessment by an interdisciplinary team...3. Use of bed rails should be based on patients ' assessed medical needs and should be documented clearly...Bed rail effectiveness should be reviewed on a regular basis...The patient's chart should include a risk-benefit assessment that identifies why other care interventions are not appropriate or not effective if they were previously attempted and determined not to be the treatment of choice for the patient. 4. Bed rail use for treatment of a medical symptom or condition should be accompanied by a care plan (treatment program) designed for that symptom or condition. The plan should present clear directions for further investigation of less restrictive care interventions. The documentation should describe the attempts to use less restrictive care interventions and, if indicated, their failure to meet patients ' assessed needs. 5. Bed rail use for patient's mobility and/or transferring, for example turning and positioning within the bed and providing a hand-hold for getting into or out of bed, should be accompanied by a care plan...The care plan should: include educating the patient about possible bed rail danger to enable the patient to make an informed decision; and address options for reducing the risks of the rail use. 6. The process of reducing and/or eliminating existing use of bed rails should be undertaken incrementally using an individualized, systematic, and documented approach..." (Source: "Clinical Guidance For the Assessment and Implementation of Bed Rails In Hospitals, Long Term Care Facilities, and Home Care Settings"	N 389		

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N 389	Continued From page 5 https://www.fda.gov/media/88765/download (retrieval date 07/20/2024)). On 07/19/2024 at 10:39 AM, Surveyor toured Resident 2's bedroom and observed half rails on both sides of his/her bed. Surveyor reviewed Resident 2's record. Resident 2 was admitted to the facility on 01/13/2023. Surveyor reviewed Resident 2's ISP dated 02/06/2024. The ISP did not address the use of half rails. Example 3: Resident 7 On 07/19/2024 at 1:40 PM, Surveyor observed Resident 7's bedroom and observed a quarter rail on the left side of Resident 7's bed. Surveyor reviewed Resident 7's record. Resident 7 admitted to the facility on 07/10/2024. Surveyor reviewed Resident 7's ISP dated 07/10/2024. The ISP did not address the use of a quarter rail. On 07/19/2024 at 2:00 PM, Surveyor conducted an exit conference and shared findings with Supervisor A and Nurse B. Nurse B acknowledged s/he did not update Resident 5's ISP to address verbal aggression. Surveyor noted if the provider went to the extent of issuing a 30-day notice due to Resident 5's verbal aggression and a plan was agreed on for him/her to stay, then his/her ISP should have been updated with interventions or approaches for staff to utilize in managing Resident 5's verbal aggression. Nurse B agreed and stated staff already prompt Resident 5 to calm down or will call his/her husband/wife in hope to calm Resident 5. Nurse B stated s/he did not know adaptive devices had to be added to the care	N 389		

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N 389	Continued From page 6 plan. Nurse B stated s/he will update ISP's to be in compliance.	N 389		
N 441	83.39(3) Hand washing. Employees shall follow hand washing procedures according to centers for disease control and prevention standards. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure employees followed hand washing procedures according to Centers for Disease Control and Prevention (CDC) standards. Caregiver C did not wash or sanitize hands between each resident during medication administration. Findings include: In October 2002, the CDC published the "Guideline for Hand Hygiene in Healthcare Settings." This guideline sets the standard for caregivers regarding glove use and hand washing to prevent the spread of infections. The CDC has recommended that caregivers wash their hands before having direct contact with residents, after contact with a resident's intact skin, after contact with body fluids or excretions, if moving from a contaminated-body site to a clean-body site during cares, after contact with inanimate objects and after removing gloves. On 07/19/2024 at 11:40 AM to 12:00 PM, Surveyor observed Caregiver C administer resident medications. The medication cart was stationed in the dining room and Caregiver C unlocked the medication cart using a set of keys	N 441		

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N 441	Continued From page 7 s/he had on their person. Surveyor did not observe any hand sanitizer on the medication cart. At 11:40 AM, Caregiver C prepped Resident 1's medications and then administered medication to Resident 1 in his/her bedroom. Caregiver C returned to the medication cart and prepped to test Resident 1's blood sugar. Resident 1 refused the finger prick test and asked staff to use his/her Dexcom result. Caregiver C stated Resident 1's blood sugar was 68, which required a call to the physician. Surveyor observed Caregiver C provide an update to Nurse B. Caregiver C signed out Resident 1's medication on the laptop. At 11:45 AM, Caregiver C prepped Resident 2's medications. Caregiver C administered Resident 2's medication to him/her in the dining room. Caregiver C returned to the medication cart and signed out Resident 2's medication. At 11:47 AM, Caregiver C prepped Resident 3's medications. Caregiver C administered Resident 3's medications in his/her bedroom (touching Resident 3's doorknob), including eye drops without wearing gloves. Caregiver C returned to the medication cart and signed our Resident 3's medications on the laptop. Between 11:40 AM to 11:47 AM, Caregiver C was not observed to conduct hand hygiene. At 11:48 AM, Surveyor interviewed Caregiver C and expressed concern s/he had not conducted hand hygiene between residents. Caregiver C stated s/he had forgot and went over to a wall station of hand sanitizer and conducted hand hygiene. Caregiver C stated s/he had training on hand hygiene when getting hired but had forgot it was required between residents.	N 441		

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N 441	Continued From page 8 At 11:52 AM, Caregiver C prepped Resident 4's medication. Caregiver C administered Resident 4's medication to him/her in the dining room. Caregiver C returned to the medication cart and signed out Resident 4's medication. At 11:57 AM, Caregiver C prepped Resident 5's medication. Caregiver C went to Resident 5's bedroom to test his/her blood sugar. Caregiver C donned gloves, tested blood sugar, and gave Resident 5 6 units of insulin. At 12:00 PM, upon returning to the medication cart, Caregiver C doffed gloves and signed out Resident 5's medication. Between 11:52 AM to 12:00 PM, Caregiver C was not observed to conduct hand hygiene. On 07/19/2024 at 2:00 PM, Surveyor conducted an exit conference and shared findings with Supervisor A and Nurse B. Surveyor expressed concern Caregiver C continued to not conduct hand hygiene between resident medication pass even after Surveyor interviewed him/her. Supervisor A acknowledged an understanding of the concern and stated hand hygiene is part of orientation and yearly training. Supervisor A noted s/he would follow up with Manager D when s/he returns from vacation and come up with a plan of correction.	N 441		
N 488	83.44(1)(c) Clothes dryers enclosed and vented Clothes dryers. The CBRF shall enclose any clothes dryer having a rated capacity of more than 37,000 Btu/hour in a one-hour fire resistive rated enclosure. If the clothes dryer requires a vent, the CBRF shall use dryer vent tubing that is	N 488		

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N 488	Continued From page 9 of rigid material with a fire rating that exceeds the temperature rating of the dryer. The dryer vent tubing shall be clean and maintained. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure 1 of 2 clothes dryers utilized a vent that was made of rigid vent tubing. Findings include: On 07/19/2024 at 10:35 AM, Surveyor observed the laundry room. Surveyor observed 1 of 2 clothes dryer vent was made of semi-rigid material for approximately 1 foot. On 07/19/2024 at 10:45 AM, Surveyor showed Supervisor B the clothes dryer duct made of semi-rigid material. Supervisor B acknowledged an understanding of the concern. On 07/19/2024 at 2:00 PM, Surveyor conducted an exit conference and shared findings with Supervisor A and Nurse B. Supervisor A stated s/he did not know why 1 of 2 clothes dryer vents was not in compliance. Supervisor A stated s/he would follow up with Manager D when s/he returned from vacation.	N 488		