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N 000	Initial Comments On 07/03/2024, Surveyor conducted an abbreviated survey and reviewed a self-report at Maple Ridge of Plover Memory Care. Additional information was gathered through 07/11/2024. As a result of the survey, two (2) new deficiencies were identified. Census: 20	N 000		
N 239	83.20(2)(a)-(d) Department-approved training courses. Standard Precautions. All employees who may be occupationally exposed to blood, body fluids or other moist body substances, including mucous membranes, non-intact skin, secretions, and excretions except sweat, whether or not they contain visible blood shall successfully complete training in standard precautions before the employee assumes any responsibilities that may expose the employee to such material. Fire safety. Within 90 days after starting employment, all employees shall successfully complete training in fire safety. First aid and choking. Within 90 days after starting employment, all employees shall successfully complete training in first aid and procedures to alleviate choking. Medication administration and management. Any employee who manages, administers or assists residents with prescribed or over-the-counter medications shall complete training in medication administration and management prior to assuming these job duties.	N 239		

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

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N 239	Continued From page 1 This Rule is not met as evidenced by: Based on record review and staff interview, the provider did not ensure Caregiver A received Department approved training courses within 90 days after starting employment and/or assuming job duties. Caregiver A did not have training in first aid and choking within 90 days after starting employment. Findings include: On 07/03/2024, Surveyor reviewed Caregiver A's employee record. Caregiver A was hired on 04/06/2022. The record for Caregiver A, hired 04/06/2022, did not contain evidence of training or evidence of meeting an exemption for first aid and choking. Upon Surveyor's request on 07/10/2024 at 2:49 PM, Executive Director B emailed a document which contained Caregiver A's training in first aid and choking completed on 03/16/2023. On 07/11/2024, at 1:30 PM, Surveyor interviewed Executive Director B, Director C, and Employee Relations D. Executive Director B and Director C confirmed Caregiver A completed first aid and choking training, but did not complete it within 90 days after starting employment and/or assuming job duties.	N 239		
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	N 389		

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N 389	Continued From page 2 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 observations, interviews, and record review, the provider did not ensure Resident 1 and Resident 2's individual service plans (ISPs) was updated with a description of the services the provider would offer to meet Resident 1's needs related to a pressure injury on his/her buttocks and Resident 2's restrictions involving use of his/her private bathroom. Findings include: Example 1 - Pressure Injury On 07/03/2024 at 12:30 PM, Executive Director B and Employee Relations D introduced Resident 1 to Surveyor while touring his/her private room. Resident 1 was seated in a slouched position in his/her recliner with the footrest raised. Resident 1's spouse was also in the room. Surveyor asked Resident 1 how s/he was doing. Resident 1 responded his/her "bottom hurts" and was observed adjusting his/her position in the recliner in what appeared to be an attempt to alleviate discomfort. Executive Director B and Employee Relations D left the room while Surveyor interviewed Resident 1 and his/spouse.	N 389		

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When asked about the pain, both Resident 1 and Spouse E said it was due to a sore on his/her bottom. Spouse E said that Resident 1 has had the sore for "a couple of years". Resident 1 described the pain as getting "worse" over time. When asked a general question about how the facility could improve, Resident 1 stated "get rid of soreness."

On 07/03/2024 at 12:50 PM, Surveyor interviewed Caregiver F and asked if Resident 1 had any wounds. Caregiver F responded "no" and was unaware of Resident 1's apparent pain originating from a sore on his/her bottom. Later in the interview, Caregiver F gave conflicting responses regarding the presence of a pressure injury of Resident 1's bottom and ultimately responded that s/he was recently hired and unsure of Resident 1's current wound status.

On 07/03/2024 at 2:38 PM, Surveyor interviewed Caregiver G and asked which residents have wounds. Caregiver G listed a different resident, but did not identify Resident 1. Surveyor asked about Resident 1's needs and whether s/he may have sore on his/her bottom. Caregiver G said s/he was unaware of Resident 1 having a sore and said s/he typically does not provide cares to Resident 1.

On 07/09/2024 at 1:34 PM, Surveyor interviewed Family Member H who said s/he visits Resident 1 at least weekly. S/he stated Resident 1 has had a "sore" on his/her "bottom" since prior to admission. Family H was unsure of the specific date that s/he observed the "wound" recently, but described it as "raw and open." S/he said Resident 1 has a history of refusing cares especially toileting cares due to pain and

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discomfort often times originating from the sore. Family Member H said "It does get agitated ...when [Resident 1] is sitting a lot."

Record Review

On 07/08/2024 at 8:00 AM, Surveyor reviewed resident records including care plans, observation notes, and Medication Administration Record (MAR).

Resident 1 was admitted to the facility on 12/29/2022. S/he was elderly with diagnoses to include type 2 diabetes mellitus and retention of urine.

On 07/08/2024 at 11:30 AM, Surveyor reviewed Resident 1's observation notes from March 2024 to July 2024 and noted the following:

-- 03/07: " ...residents buttock sore was still very much open and slightly bleeding ...applied lotions to ...encourage healing ...now ...laying down to prevent further breakdown."
-- 03/08: " ...resident was ...put into bed ...due to the sores on [his/her] bottom."
-- 03/11: " ...sore on [his/her] butt were open and the resident was wincing while being cleaned. Staff put barrier cream on."
-- 04/11: " ...bottom is raw, staff put cream on it."
-- 04/19: " ...resident has a big open sore on [his/her] buttocks and it is bleeding ...applied a barrier cream generously ..."
-- 04/21: " ...Barrier cream was liberally applied to the residents buttock area, pressure sore looks to be healing well."
-- 04/24: " ...noticed bottom sores have gotten worse, applied barrier cream ..."
-- 04/25: "The resident had open sores on [his/her] butt that staff put cream on ...the

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resident was complaining that the sores were hurting ..."
-- 04/30: "Residents bottom sores are worse than they were last week, did apply cream ..."
-- 05/15: " ...Staff told [him/her] [s/he] will get infection in [his/her] bottom sores ...[s/he] is complaining it (sores on bottom) hurts ...The resident is in [his/her] recliner on the side to stay off [his/her] sore spot ...Staff will need to check [him/her] frequently and apply cream to sore areas."
-- 05/18: " ...Resident had mucus in [his/her] brief along with [his/her] BM. [S/he] has a small open wound on [his/her] bottom. [S/he] needs more barrier cream."
--06/17: " ...[his/her] bottom still has pressure sores, but [his/her] barrier cream was applied ..."
--07/04: " ...[his/her] skin is intact besides the pressure wounds on [his/her] buttocks; barrier cream was applied ..."

During the months of March, April, May, and June 2024, observation notes documented 21 occasions where Resident 1 refused cares regarding toileting, transferring, and dressing changes.

July 2024 MAR contained a scheduled topical gel "IODODORB GEL ...2 TIMES A DAY TO PRESSURE WOUNDS/REDNESS ON BUTTOCKS." Prior to 05/24/2024, Iodosorb Gel was listed "AS NEEDED TO PRESSURE WOUNDS/REDNESS ON BUTTOCKS."

Upon Surveyors request, on 07/10/2024, Executive Director B emailed Resident 1's most current Individualized Service Plan (ISP) dated 05/02/2024. The ISP identified the need for full assistance with bathing, dressing, and toileting tasks. The ISP also identified that Resident 1 is

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incontinent of bowl, has a urine catheter, and wears depends. The ISP identified the need for partial assistance from staff while ambulating and the use of a walker or wheelchair for mobility.

The ISP:

-- Did not identify Resident 1's risk for pressure injuries due to age, diagnoses, immobility or incontinence.
-- Did not identify strategies to prevent skin break down.
-- Did not identify Resident 1's tendency to refuse cares.
-- Did not identify the presence of a pressure injury or the recent history of them.
-- Did not identify strategies to manage the existing pressure injury (e.g. frequent repositioning, frequent incontinence checks, pressure relieving devices, barrier cream or other prescription topical medications.

Note: According to Cleveland Clinic, "Bedsores are wounds that occur from prolonged pressure on your skin. People who are immobile for long periods, such are those who are bedridden or use a wheelchair, are most at risk for bedsores. These painful wounds or pressure ulcers, can grow large and lead to infections. In some instances, bedsores can be life-threatening ...

You may also hear these terms for bedsores: ...

--Pressure injuries ...

Bedsores are most likely to develop on the parts of your body where your bone sits closest to your skin, such as your: ...

-- Buttocks ...

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N 389	Continued From page 7 -- Tailbone ... Bedsores occur when pressure reduces or cuts off blood flow to your skin. This lack of blood flow can cause a pressure wound injury to develop in as little as two hours ... Who is at risk for bedsores? People who have thinner skin and people who have limited (or no) ability to move ....These include people who: ...use wheelchairs ... Adults with certain health conditions are more likely to develop bedsores. These conditions include: ... -- Dementia. -- Diabetes ... What are the stages of bedsores?... -- Stage 1: Your skin looks red or pink, but there isn't an open wound. It may be hard for people with darker skin to see a color change ...Your skin may feel tender to the touch. Or your skin might feel warmer, cooler, softer or firmer. -- Stage 2: A shallow wound with a pink or red base develops. You may see skin loss, abrasions and blisters. -- Stage 3: A noticeable wound may go into your skin's fatty layer ... -- Stage 4: The wound penetrates all three layers of skin, exposing muscles, tendons and bones ... Complications of bedsores ... You may develop sepsis or require an amputation ...Worldwide, bedsores lead to the deaths of more than 24,000 people each year ...	N 389		

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N 389	Continued From page 8 How can you prevent bedsores?... -- Change positions every 15 minutes ... -- Check your skin regularly ... -- Keep your skin clean and dry ... Source: https://my.clevelandclinic.org/health/diseases/17823-bedsores-pressure-injuries On 07/11/2024 at 1:30 PM, Surveyor interviewed Executive Director B, Director C, and Employee Relations D regarding Resident 1's pressure injury status. Director C denied the presence or a history of a pressure injury. S/he explained there was an area on Resident 1's bottom but it was "just redness" with a "very small wound opened" that was "pencil width" and impacted "just the first layer of skin." Director C was unable to provide information regarding the transition of Isosorbide Gel from as needed to scheduled on 05/24/2024, but thought it could have been due to a switch in providers. Executive Director B acknowledged the observation notes regarding staff documentation of a wound on Resident 1's buttocks. S/he acknowledged the need for staff to complete addition education to identify pressure injuries. Director C acknowledged the ISP was silent to preventing and treating pressure injuries for Resident 1 and said s/he was already making updates to address the needs. Example 2 - Bathroom Restrictions On 07/03/2024 at 12:59 PM, while touring the facility with Executive Director B, Surveyor observed a cloth drape covering the bathroom door in Resident 2's private room. Executive Director B unsuccessfully attempted to open the	N 389		

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door to the bathroom. Surveyor pointed to one screw drilled diagonally into the doorframe approximately 6 feet up from the floor inhibiting the door from opening. A second screw attached in the same manor was also found approximately one foot from the floor. Executive Director B observed the screws inhibiting the door from opening and stated, "well, that is not ok for that to be there" and that s/he would have to discuss with Director C to "see if [s/he] has the right approval."

At 1:04 PM Surveyor asked Employee Relations D about Resident 2's access to his/her bathroom. Employee Relations D thought it was due Resident 2 flushing things down the toilet, but was unsure as s/he had recently started employment at the facility this past December. Employee Relations D explained Resident 2 utilizes a public bathroom in the facility located down the hall from his/her private room. Employee Relations D was unaware of Resident 2 flushing items and clogging the public bathroom recently. Employee Relations D suggested that the public bathroom is "more monitored" and advised Surveyor to speak with Director C.

On 07/03/2024 at 2:20 PM Surveyor attempted to interview Resident 2. Surveyor asked Resident 2 a series of questions to which s/he responded with unintelligible sounds.

Record Review

On 07/09/2024 at 9:00 AM, Surveyor reviewed Resident 2's records including the individual service plan (ISP) and observation notes.

Resident 2 was admitted to the facility on 05/22/2020. S/he was elderly with diagnoses to

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include hypertension, hyperlipidemia, pre diabetes, and dementia. Resident 2 was identified as being at risk for wandering and had a legal guardian.

On 07/10/2024 at 10:00 AM, Surveyor reviewed Resident 2's observation notes from February 2022 to July 2024 and noted the following:

-- 05/14/24: "Resident ...going into other residents [sic] rooms and climbing in other residents [sic] beds ..."
-- 04/24/24: " ...[s/he] filled one of the main bathrooms [sic] toilets with garbage ..."
-- 02/26/24: " ...resident may have put all of the garbage content into the toilet ..."
-- 02/01/24: " ...going into other residents [sic] rooms. In [one room] [s/he] had a banana smashed into the sink and water running ... [another room] [s/he] had threw a whole banana peel in this residents toilette ..." [sic - all]

On 07/10/2024, Executive Director B emailed Surveyor an attached document titled, "[Resident 2] POA consent." The document was dated February 2022, authored by Director C and read in part, "Verbal consent from [Resident 2's] POA, [POA I] to lock personal restroom door and put up curtain to avoid [his/her] from using the bathroom in [his/her] room due to flushing items down the toilet and causing floods." The date of the verbal consent was not documented.

Upon Surveyors request, on 07/10/2024, Executive Director B emailed Resident 2's most current ISP dated 06/19/2024. The ISP identified the need for full assistance with bathing, dressing, and toileting every 2 hours. The ISP also identified Resident 2 as at risk for wandering, independent with ambulation, positioning, and

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N 389	Continued From page 11 transfers. The ISP: -- Did not identify Resident 2's history of flushing items down the toilet or interventions to mitigate the behavior (e.g. increased supervision.) -- Did not identify the restricted access to his/her private bathroom. -- Did not identify previous interventions in place to help mediate the behaviors prior to restricting access his/her private bathroom. -- Did not identify strategies to manage intrusive wandering behaviors. On 07/11/2024 at 1:30 PM, Surveyor interviewed Executive Director B, Director C, and Employee Relations D regarding Resident 2's restricted access to his/her private bathroom. Director C acknowledged the behaviors of flushing items down the toilets and turning on faucets which have led to flooding. Director D acknowledged that Resident 2 was restricted access to his/her bathroom due to forementioned behaviors and it was not identified in the ISP.	N 389		