STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525276	A. BUILDING _____ B. WING _____	C 12/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SSM HEALTH ST MARY'S CARE CENTER	3401 MAPLE GROVE DR MADISON, WI 53719

(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) COMPLETION DATE
F 000	INITIAL COMMENTS This was a complaint and partial extended survey conducted at SSM Health St. Mary's Care Center from 11/20/23 through 12/4/23. This survey identified substandard quality of care at F689. Federal citations issued: 3 The most serious citation is F689 cited at a severity/scope level of J (Immediate Jeopardy/Isolated). Census: 115 Sample size: 8	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.	F 609		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525276	A. BUILDING _____ B. WING _____	C 12/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SSM HEALTH ST MARY'S CARE CENTER	3401 MAPLE GROVE DR MADISON, WI 53719

(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) COMPLETION DATE
F 609	Continued From page 1 §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility did not ensure all allegations of abuse were reported timely to the state survey agency (SSA) for 1 resident (R3) of 8 sampled residents. The facility failed to timely report to the SSA when an allegation of abuse was reported to administration. Evidenced by: The facility policy titled, "Abuse, Neglect, and Exploitation," revision date 1-23, states, in part: ...It is also the policy of this community to take appropriate steps to ensure that all alleged violations of federal or state laws which involve mistreatment, neglect, abuse, injuries of unknown source, and misappropriation of resident property are reported immediately to the administrator of the community. If the events that caused the allegation involve abuse or serious bodily injury, it must be reported to the State agency immediately but no later than two hours after forming the suspicion per State and Federal regulation. Events that do not involve abuse and/or do not result in serious bodily injury must be reported to the State agency no later than 24 hours as per State and Federal regulations...	F 609		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525276	A. BUILDING _____ B. WING _____	C 12/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SSM HEALTH ST MARY'S CARE CENTER	3401 MAPLE GROVE DR MADISON, WI 53719

(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) COMPLETION DATE
F 609	Continued From page 2 R3 was admitted to the facility on 6/13/22. R3's most recent Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 9/27/23, indicates R3 has a Brief Interview for Mental Status (BIMS) score of 15 indicating R3 is cognitively intact. R3's most recent MDS GG functional abilities indicates R3 requires toileting hygiene: the ability to maintain perineal hygiene, adjust clothes before and after using the toilet, commode, bedpan, or urinal ....02, substantial/maximal assistance - helper does more than half the effort. Facility self report to state agency, states, in part ...Date occurred 10/14/23 Time occurred 10:36AM Date discovered 10/18/23. Briefly describe the incident ...Management received an email on 10/16/23 from C.N.A. outlining a long call light time resulting in needs not being met. Management discussed at morning meeting and reviewed the call light report. The call light report did not show an extensive call light time, and R3 is alert and oriented x3. R3 and daughter have a very good relationship with management and SW. Upon investigation, management discovered that R3 sat in feces for a total of 3 hours with two C.N.A.s knowing this, ultimately neglecting her care. Management immediately suspended the two staff members pending the results of the investigation ... Describe the effect ...A full body assessment was completed 10/18/23 and 10/20/23, with no skin issues noted. Additionally R3 did not have any psycho-social signs of distress, no change in mood, behavior, food/fluid intake, activity attendance, no decline in ADLs (activities of daily living). The SW will continue to check in daily ....Explain what steps ...Termination of both employees. The care plan	F 609		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525276	A. BUILDING _____ B. WING _____	C 12/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SSM HEALTH ST MARY'S CARE CENTER	3401 MAPLE GROVE DR MADISON, WI 53719

(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) COMPLETION DATE
F 609	Continued From page 3	F 609		

was reviewed by the IDT (interdisciplinary team) and modified accordingly.

Surveyor reviewed facility investigation regarding incident on 10/14/23. Incident was reported to administration through an email from a nursing staff. The email, states, in part; sent: Sunday, October 15, 2023 10:03PM Hello, When I came in for my Saturday pm shift, Room [#'s] call light was going off. I got report went to answer it and the resident was very upset saying she had been sitting in her BM since 10:45am. I immediately went to grab [staff name] the CNA that had [room #] in her group. She told me [room #] had to poop but the other aide was on break at the time and she couldn't do her alone. Then I asked why she wasn't changed when the aide came back. She said because they had to get ready to serve lunch. I reminded her lunch was at 11:30. [room #] sat from 10:45 until 2:00 that's over 3 hours. She got upset and really rude saying it wasn't her fault and that she was busy. I went to get the AM nurse [staff name] worked with and she said she wasn't aware that [room #] had been waiting so long sitting in her BM, but could have assisted if [staff name] needed help. I asked if [staff name] could please change [room #] and she kept coming up with excuses and blaming others on why [room #] didn't get changed. The nurse literally had to get stern with [staff name] to get her to get [room #] cleaned up before she left. When she left [room #] called and told me [staff name] was kind of rude and told [room #], she had 10 mins to get her changed so they had to be quick. [room #] said she was really itchy and wanted to be washed thoroughly with wash cloths and [staff name] told her she only had 10 minutes and couldn't do all of that. This is totally

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525276	A. BUILDING _____ B. WING _____	C 12/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SSM HEALTH ST MARY'S CARE CENTER	**3401 MAPLE GROVE DR MADISON, WI 53719**

(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) COMPLETION DATE
F 609	Continued From page 4	F 609		

unacceptable! [staff name] could have grabbed a nurse. If the nurse wasn't available she could have called charge. When the other aide came back from lunch, they could have done her together while the nurse served. There are so many things that could have been differently. There is absolutely no excuse why this happened. I feel like someone during this shift should have done something. This means that for over three hours no one checked on [room #]. Nurse or aide! I was so shocked at the behavior from [staff name] when this unfolded. She took no responsibility, showed no remorse at all and was very rude. Please follow up on this. This is one of the saddest cases of neglect I've ever witnessed here!...

DON B (Director of Nursing) replied back to email on Monday, October 16, 2023, 4:57 PM, ...I did just look at the report. [room #'s] light was on 48 minutes total, but still way too long ...the nursing staff that reported allegation replied back on Monday, October 16, 2023, 6:14 PM, ...[resident name] knows how to turn her own call light off. She turned it off after she told [staff name] she had to have a bm. The call light was not on the whole time she was waiting. But I'm glad you all are looking into it! Have a good evening...

It is important to note the incident occurred on 10/14/23 and the investigation did not start, nor was it reported to the SSA until 10/18/23.

On 11/20/23 at 11:48 AM, Surveyor interviewed R3. R3 indicated staff are usually quick to respond to her call light; however, there was one time recently that she had a bowel movement and sat for three hours. R3 indicated it did not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525276	A. BUILDING _____ B. WING _____	C 12/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SSM HEALTH ST MARY'S CARE CENTER	3401 MAPLE GROVE DR MADISON, WI 53719

(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) COMPLETION DATE
F 609	Continued From page 5	F 609		

feel good sitting on a bowel movement for three hours and that she didn't want to make a mess for the staff. R3 indicated she feels the facility has now followed up on this concern, but that it took a few days for them to investigate it. R3 indicated R3 will turn off and on her call light if needed. R3 indicated if staff come in and turn off her call light, and they didn't assist her, R3 will wait 10 minutes or so and turn on her call light again.

On 11/20/23 at 3:10 PM, DON B indicated she was the management staff that followed up on the incident from 10/14/23 with R3. DON B indicated a nurse reported the incident on 10/15/23 by sending an email to administration. DON B indicated the facility practice is that staff should immediately call administration or the on call staff to report an allegation of possible abuse. DON B indicated it is not acceptable to send an email and that the nursing staff and all staff were educated on the importance of reporting. DON B provided Surveyor the memo and staff signature sheet regarding education provided after 10/14/23 incident. DON B indicated DON B did not start an investigation immediately because when she first read the email she felt it didn't seem urgent and was merely a call light concern. DON B indicated the next day (Tuesday, 10/17/23) or the following (Wednesday, 10/18/23) she was thinking about the incident, and something felt off. DON B indicated she cannot remember what felt off, but she then started an investigation at that point. Surveyor questioned, was the investigation started on 10/18/23, and reported to state agency at that time? DON B indicated yes.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525276	A. BUILDING _____ B. WING _____	C 12/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SSM HEALTH ST MARY'S CARE CENTER	3401 MAPLE GROVE DR MADISON, WI 53719

(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) COMPLETION DATE
F 609	Continued From page 6 On 11/21/23 at 8:15 AM, DON B indicated an investigation should have been started immediately after the incident on 10/14/23 with R3. DON B indicated she was new to her position at that time and looking back she should have started the investigation and reported it to state agency prior to 10/18/23.	F 609		
F 610 SS=E	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility did not have evidence that all alleged violations are thoroughly investigated for 4 of 7 sampled residents (R2, R3, R5, R7). R2's self report, dated 10/22/23, was not thoroughly investigated.	F 610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525276	A. BUILDING _____ B. WING _____	C 12/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SSM HEALTH ST MARY'S CARE CENTER	3401 MAPLE GROVE DR MADISON, WI 53719

(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) COMPLETION DATE
F 610	Continued From page 7 The facility did not ensure residents were protected when an allegation of abuse was reported for R3. R5 did not have thorough follow-up after responding to interview questions. R7 did not have thorough follow-up after responding to interview questions. Evidenced by: The facility policy, "Abuse, Neglect, and Exploitation", dated 1-2023, states, in part; ...c. Allegations of abuse, neglect, or exploitation will be thoroughly investigated. The investigation will be initiated upon receipt of the allegation. The administrator, or designee, will complete the investigation process. d. The investigation can include, but is not limited to: i. The name(s) of the resident(s) involved ii. The date and time the incident occurred iii. The circumstances surrounding the incident iv. Where the incident took place v. The names of any witnesses vi. The name of the person(s) alleged with committing the act 6. Resident Protection: Residents are protected from harm during an investigation Example 1 R2 is a long-term resident of the facility. R2's most recent Minimum Data Set (MDS), dated 10/27/23, documents a score of 15 on the Brief Interview of Mental Status (BIMS) which indicates R2 is cognitively intact. The facility submitted a self-report, dated 10/22/23, regarding R2 feeling unsafe and neglected. Based off the documentation	F 610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525276	A. BUILDING _____ B. WING _____	C 12/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SSM HEALTH ST MARY'S CARE CENTER	3401 MAPLE GROVE DR MADISON, WI 53719

(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) COMPLETION DATE
F 610	Continued From page 8	F 610		

provided, the facility was able to conclude that there was no intent for R2 to have been neglected; however, throughout this investigation there were other concerns that arose that required follow up.

For this investigation, it is noted that the staff that were working on the date of this incident (10/22/23) were not interviewed except for the Certified Nursing Assistant (CNA) that reported the incident and the CNA that the incident was reported about.

On 11/20/23 at 1:49 PM, Surveyor interviewed CNA C. Surveyor asked CNA C if he recalled the incident 10/22/23 with R2, CNA C said yes. Surveyor asked CNA C to explain what happened, CNA C explained that he was scheduled to come in at 7 AM; however, he had overslept because he had been working doubles prior to this date, he actually was woke up by a co-worker at his door; CNA C went on to explain that he got to the facility at 10 AM and at that time, he was not scheduled on R2's unit but that was his regular assignment and he did note that her call light was on so he answered it. CNA C stated that when he entered R2's room she began to yell at him about why no one had been in by her yet, that she hadn't had breakfast, and that she hadn't been changed. Surveyor asked CNA C if normally those tasks would have been completed, CNA C said yes, and he noted that she was still in the position that she is in for bed at night. Surveyor asked CNA C to continue; CNA C then stated he made R2 breakfast and served it to her and told her he would be back in a while to get her out of bed, changed, and dressed. Surveyor asked CNA C if there were

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525276	A. BUILDING _____ B. WING _____	C 12/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SSM HEALTH ST MARY'S CARE CENTER	3401 MAPLE GROVE DR MADISON, WI 53719

(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) COMPLETION DATE
F 610	Continued From page 9	F 610		

any issues after that, CNA C said no. Surveyor asked CNA C what he thought might have happened, CNA C said there were call ins and I'm guessing the staff that was here didn't plan and she was overlooked.

On 11/20/23 at 3:12 PM, Surveyor interviewed RN D (Registered Nurse). Surveyor asked RN D to explain what occurs as far as assignments when call ins happen, RN D explained that the charge nurse is responsible for making new assignments, that is relayed to the floor nurse, and the floor nurse to the CNA's. Surveyor asked RN D if she recalled this specific date 10/22/23, RN D said she couldn't remember everything but what she could recall was that she was to be the charge nurse but then a nurse called in, so she filled in on a unit, a CNA had also called in, and CNA C came in at 10 AM, late. Surveyor asked RN D if she recalled speaking with the floor nurse that day about the plan, RN D said yes as she stated that she was assisting with answering call lights as well, and that CNA C was moved to a different unit that had less residents on it so they figured the 1 CNA down there until he arrived would be okay.

It is important to note that Surveyor attempted to interview the other CNA and LPN (Licensed Practical Nurse) that were scheduled that date without success; however, based off these 2 interviews it is indicative that the call ins and re-assignment of residents didn't go well and R2 was inadvertently missed.

The facility then provided education on neglect reporting regarding this incident. There were no specifics of this incident with R2 in the education.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525276	A. BUILDING _____ B. WING _____	C 12/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SSM HEALTH ST MARY'S CARE CENTER	3401 MAPLE GROVE DR MADISON, WI 53719

(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) COMPLETION DATE
F 610	Continued From page 10	F 610		

While R2 did indicate that she felt neglected, the root cause of this incident seemed to be the call in and re-assignment procedure, which was not educated on.

Staff interviews regarding education noted the following:

On 11/20/23 at 11:53 AM, Surveyor interviewed MA E (Medication Aide). Surveyor asked MA E if she recalled receiving education in late October regarding R2, MA E described some medication specific education. Surveyor asked MA E if she recalled any education about neglect or call in/re-assignment procedure, MA E said no. CNA F was present at this time and said they (herself and MA E) are regulars on R2's hall.

On 11/20/23 at 11:56 AM, Surveyor asked CNA F if she recalled receiving education in late October regarding R2, CNA F said she heard about the incident but didn't work that day. Surveyor asked CNA F if she recalled any education about neglect or call in/re-assignment procedure, CNA F said no.

On 11/20/23 at 12:00 PM, Surveyor interviewed CNA G. Surveyor asked CNA G if she recalled receiving education in late October regarding R2, CNA G said yes that R2's call light should not exceed 10 minutes before being answered. Surveyor asked CNA G if she recalled any education about neglect or call in/re-assignment procedure, CNA G said no.

It is important to note, 1) CNA F who is a consistent CNA on R2's unit was not listed as receiving the education and 2) MA E and CNA G

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525276	A. BUILDING _____ B. WING _____	C 12/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SSM HEALTH ST MARY'S CARE CENTER	3401 MAPLE GROVE DR MADISON, WI 53719

(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) COMPLETION DATE
F 610	Continued From page 11	F 610		

were listed on the neglect education but did not recall that it was in relation to R2.

The two resident interviews that were part of this investigation responded to interview questions in a manner that required follow up and that follow up was not done until 11/20/23 when Surveyor asked about it.

On 11/20/23 at 3:43 PM, Surveyor interviewed NHA A (Nursing Home Administrator). Surveyor asked NHA A if she could explain what transpired on 10/22/23 with R2; NHA A explained that CNA C was scheduled to be in at 7 AM, CNA C had texted her that R2 said she had been neglected all morning, but he was there now, and would take care of R2. NHA A went on to say she spoke with R2 and her husband over the phone and interviewed R2 again the next morning. NHA A said she contacted the Police, that she was told R2 had been check and changed around 5:30 AM; NHA A said R2 told her she awoke to someone saying the time loudly in the hall, R2 said she could tell someone had been there, in her room because her pills were at bedside. NHA A said R2 told her she felt unsafe like they had forgotten her but didn't believe it to be intentional. Surveyor asked NHA A how she determined which staff to interview, NHA A stated she chose the staff based on consistency of work assignment on R2's hallway. Surveyor asked NHA A if she considered speaking with the staff that was working on that date to see if they could get to the root cause of the issue, NHA A said that was partly why R2 hadn't been checked on. NHA A stated there was a lot going on that day with other matters as well. Surveyor asked NHA A if it is possible that the communication about

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525276	A. BUILDING _____ B. WING _____	C 12/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SSM HEALTH ST MARY'S CARE CENTER	3401 MAPLE GROVE DR MADISON, WI 53719

(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) COMPLETION DATE
F 610	Continued From page 12	F 610		

re-assignments from call ins contributed, NHA A said yes. Surveyor asked NHA A if she had any follow up for R5 or R7 after their responses to the interview questions, NHA A said she would have to look. Surveyor asked NHA A if she feels like neglect reporting was the appropriate education for this incident with R2, NHA A replied that R2 indicated she felt neglected, so she started there and she feels that she over educates on abuse/neglect but sees that the staffing situation caused confusion and potentially miscommunication.

Example 2
R5 is a long-term resident of the facility. Her most recent MDS dated 10/13/23 documents a score of 15 on her BIMS, which indicates that she is cognitively intact.

R5 was interviewed as part of the self-report investigation for R2 on 10/22/23. The questions asked and her responses were as follows:
"1) Overall, do you feel safe in the community?" R5's documented response was "sometimes."
"2) Do you feel that staff treat you with respect/dignity?" R5's documented response was "sometimes."

R5's Nurse's Notes from 10/22/23-10/31/23 were reviewed, there was no documentation present in relation to follow-up from interview questions.

R5 had a grievance on 10/25/23 regarding call lights.

On 11/20/23 at 3:43 PM, Surveyor interviewed NHA A. Surveyor asked NHA A if she had any

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525276	A. BUILDING _____ B. WING _____	C 12/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SSM HEALTH ST MARY'S CARE CENTER	3401 MAPLE GROVE DR MADISON, WI 53719

(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) COMPLETION DATE
F 610	Continued From page 13	F 610		

follow up for R5 or R7 after their responses to the interview questions, NHA A said she would have to look.

On 11/21/23 at 7:40 AM, Surveyor was provided via email from NHA A with a screenshot of a Nurse's Note dated 10/31/23 that documents call light response from a recent grievance. There was a note from NHA A documenting the following: "Here is a screenshot after my follow-up with R5. She did not feel neglect or abuse, and felt safe..." Surveyor emailed NHA A back and requested a full copy of R5's Nurse's Note so that the name of resident could be identified and asked if there was specific documentation for R5 and R7 in relation to the interview questions asked. It is important to note that this additional email documentation reads like it is follow up to the grievance.

On 11/21/23 at 11:40 AM, Surveyor was provided with additional documentation via email from NHA A. This handwritten documentation included: "R5 (written out first name only) #1 follow up: Sometimes I worry when there isn't enough staff, but nothing has happened specifically. #2 follow up: If they are rude, I address it right away and tell staff."
It is important to note that this document is not thorough; the residents' full name is not present, date or time, questions asked nor the name of the interviewer.

On 11/21/23 at 1:45PM, R5 indicated no one ever followed back up with her after she voiced that she doesn't always feel safe and doesn't always feel she is treated with respect and dignity. R5 indicated NHA came and talked to her yesterday,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525276	A. BUILDING _____ B. WING _____	C 12/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SSM HEALTH ST MARY'S CARE CENTER	3401 MAPLE GROVE DR MADISON, WI 53719

(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) COMPLETION DATE
F 610	Continued From page 14 11/20/23, but never before that. On 11/21/23 at 12:55PM, Surveyor asked NHA A, if a resident is asked "Overall, do you feel safe in the community?" And their response is "sometimes," what should happen next? NHA A indicated the staff asking this question should ask more questions to determine next steps. Surveyor asked NHA A, if a resident is asked "Do you feel that staff treat you with respect/dignity?" And their response is "sometimes", what should happen next? NHA A indicated that NHA A would ask more questions and try to better understand the resident and his/her concerns. NHA A indicated when she interviews residents during investigations it is more of a conversation between her and the resident, and it can be difficult documenting the questions and conversations while it is happening. NHA A indicated she realizes NHA A documentation needs to be more detailed and include follow up, resident full names, date, time, and who interviewer is. Example 3 R7 is a long-term resident of the facility. R7 was interviewed as part of the self-report investigation for R2 on 10/22/23. The questions asked and her responses were as follows: "2) Do you feel that staff treat you with respect/dignity?" R5's documented response was "sometimes, don't know how to do their job" R7's Nurse's Notes from 10/22/23-10/31/23 were reviewed, there was no documentation present in relation to follow-up from interview questions.	F 610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525276	A. BUILDING _____ B. WING _____	C 12/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SSM HEALTH ST MARY'S CARE CENTER	3401 MAPLE GROVE DR MADISON, WI 53719

(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) COMPLETION DATE
F 610	Continued From page 15 On 11/20/23 at 3:43 PM, Surveyor interviewed NHA A. Surveyor asked NHA A if she had any follow up for R5 or R7 after their responses to the interview questions, NHA A said she would have to look. On 11/21/23 at 7:40 AM, Surveyor was provided via email from NHA A with a screenshot of Nurse's Notes that document call light response from a recent grievance. There was a note from NHA A documenting the following: "Here is a screenshot after my follow-up with R5. She did not feel neglect or abuse and felt safe...My follow-up with R7 was similar. She went on to explain that sometimes she gets a caregiver that doesn't know her routine, so she thinks they don't know her job. She did not feel neglect or abuse and felt safe." Surveyor emailed NHA A back and asked if there was specific documentation for R5 and R7 in relation to the interview questions asked. On 11/21/23 at 11:40 AM, Surveyor was provided with additional documentation via email from NHA A. This handwritten documentation included: "R7 (Written out first name and first letter of last name only) #2 follow-up: Some staff aren't as personable and don't know the routine, so they don't know their job." It is important to note that this document is not thorough; the residents' full name is not present, date or time, questions asked nor the name of the interviewer. of the facility. R2's most recent Minimum Data Set (MDS) dated 10/27/23 documents a score of 15 on the Brief Interview of Mental Status (BIMS) which indicates R2 is	F 610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525276	A. BUILDING _____ B. WING _____	C 12/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SSM HEALTH ST MARY'S CARE CENTER	3401 MAPLE GROVE DR MADISON, WI 53719

(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) COMPLETION DATE
F 610	Continued From page 16 cognitively intact. The facility submitted a self-report dated 10/22/23 regarding R2 feeling unsafe and neglected. Based off of the documentation provided, the facility was able to conclude that there was no intent for R2 to have been neglected however throughout this investigation there were other concerns that arose that required follow up. For this investigation it is noted that the staff that were working on the date of this incident (10/22/23) were not interviewed except for the CNA that reported the incident and the CNA that the incident was reported about. Example 4 R3 was admitted to the facility on 6/13/22. R3's most recent Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 9/27/23, indicates R3 has a Brief Interview for Mental Status (BIMS) score of 15 indicating R3 is cognitively intact. R3's most recent MDS GG functional abilities indicates R3 requires toileting hygiene: the ability to maintain perineal hygiene, adjust clothes before and after using the toilet, commode, bedpan, or urinal ....02, substantial/maximal assistance- helper does more than half the effort. Facility self report to state agency, states, in part ...Date occurred 10/14/23 Time occurred 10:36AM Date discovered 10/18/23. Briefly describe the incident ...Management received an email on 10/16/23 from C.N.A. outlining a long call light time resulting in needs not being met. Management discussed at morning meeting and	F 610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525276	A. BUILDING _____ B. WING _____	C 12/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SSM HEALTH ST MARY'S CARE CENTER	3401 MAPLE GROVE DR MADISON, WI 53719

(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) COMPLETION DATE
F 610	Continued From page 17	F 610		

reviewed the call light report. The call light report did not show an extensive call light time, and R3 is alert and oriented x3. R3 and daughter have a very good relationship with management and SW. Upon investigation, management discovered that R3 sat in feces for a total of 3 hours with two C.N.A.s knowing this, ultimately neglecting her care. Management immediately suspended the two staff members pending the results of the investigation ... Describe the effect ...A full body assessment was completed 10/18/23 and 10/20/23, with no skin issues noted. Additionally R3 did not have any psycho-social signs of distress, no change in mood, behavior, food/fluid intake, activity attendance, no decline in ADLs. The SW will continue to check in daily ....Explain what steps ...Termination of both employees. The care plan was reviewed by the IDT and modified accordingly.

Surveyor reviewed facility investigation regarding incident on 10/14/23. Incident was reported to administration through an email from a nursing staff. The email, states, in part; sent: Sunday, October 15, 2023, 10:03 PM Hello, When I came in for my Saturday pm shift, (R3's Room#)call light was going off. I got report went to answer it and the resident was very upset saying she had been sitting in her BM since 10:45am. I immediately went to grab the CNA (Certified Nursing Assistant) that had resident in her group. She told me the resident had to poop but the other aide was on break at the time and she couldn't do her alone. Then I asked why she wasn't changed when the aide came back. She said because they had to get ready to serve lunch. I reminded her lunch was at 11:30. The resident sat from 10:45 until 2:00 that's over 3

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525276	A. BUILDING _____ B. WING _____	C 12/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SSM HEALTH ST MARY'S CARE CENTER	3401 MAPLE GROVE DR MADISON, WI 53719

(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) COMPLETION DATE
F 610	Continued From page 18	F 610		

hours. She got upset and really rude saying it wasn't her fault and that she was busy. I went to get the AM nurse the CNA worked with and she said she wasn't aware that the resident had been waiting so long sitting in her BM, but could have assisted if the CNA needed help. I asked if CNA could please change (R3) and she kept coming up with excuses and blaming others on why (R3) didn't get changed. The nurse literally had to get stern with the CNA J to get her to get R3 cleaned up before she left. When she left R3 called and told me CNA J was kind of rude and told R3, she had 10 mins to get her changed so they had to be quick. R3 said she was really itchy and wanted to be washed thoroughly with wash cloths and CNA J told her she only had 10 minutes and couldn't do all of that. This is totally unacceptable! CNA J could have grabbed a nurse. If the nurse wasn't available she could have called charge. When the other aide came back from lunch, they could have done her together while the nurse served. There are so many things that could have been differently. There is absolutely no excuse why this happened. I feel like someone during this shift should have done something. This means that for over three hours no one checked on R3. Nurse or aide! I was so shocked at the behavior from CNA J when this unfolded. She took no responsibility, showed no remorse at all and was very rude. Please follow up on this. This is one of the saddest cases of neglect I've ever witnessed here!...

DON B (Director of Nursing) replied back to email on Monday, October 16, 2023, 4:57 PM, ...I did just look at the report. R3's light was on 48 minutes total, but still way too long ...the nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525276	A. BUILDING _____ B. WING _____	C 12/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SSM HEALTH ST MARY'S CARE CENTER	3401 MAPLE GROVE DR MADISON, WI 53719

(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) COMPLETION DATE
F 610	Continued From page 19	F 610		

staff that reported allegation replied back on Monday, October 16, 2023, 6:14 PM, ...R3 knows how to turn her own call light off. She turned it off after she told CNA J she had to have a bm. The call light was not on the whole time she was waiting. But I'm glad you all are looking into it! Have a good evening.

It is important to note the incident occurred on 10/14/23 and the investigation was not started until 10/18/23.

On 11/20/23 at 11:48 AM, R3 indicated staff are usually quick to respond to her call light; however, there was one time recently that she had a bowel movement and sat for three hours. R3 indicated it did not feel good sitting on a bowel movement for three hours and that she didn't want to make a mess for the staff. R3 indicated she feels the facility has now followed up on this concern, but that it took a few days for them to investigate it. R3 indicated R3 will turn off and on her call light if needed. R3 indicated if staff come in and turn off her call light, and they didn't assist her, R3 will wait 10 minutes or so and turn on her call light again.

Surveyor reviewed time sheets for the two accused CNA's. One of the accused CNA's worked 10/15/23 and 10/16/23.

On 11/20/23 at 3:10 PM, DON B indicated she was the management staff that followed up on the incident from 10/14/23 with R3. DON B indicated a nurse reported the incident on 10/15/23 by sending an email to administration. DON B indicated the facility practice is that staff should immediately call administration or the on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525276	A. BUILDING _____ B. WING _____	C 12/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SSM HEALTH ST MARY'S CARE CENTER	3401 MAPLE GROVE DR MADISON, WI 53719

(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) COMPLETION DATE
F 610	Continued From page 20 call staff to report an allegation of possible abuse. DON B indicated it is not acceptable to send an email and that the nursing staff and all staff were education on the importance of reporting. DON B provided Surveyor the memo and staff signature sheet regarding education provided after 10/14/23 incident. DON B indicated DON B did not start an investigation immediately because when she first read the email she felt it didn't seem urgent and was a call light concern. DON B indicated the next day (Tuesday, 10/17/23) or the following (Wednesday, 10/18/23) she was thinking about the incident, and something felt off. DON B indicated she can not remember what felt off, but she then started an investigation at that point. Surveyor questioned, was the investigation started on 10/18/23? DON B indicated yes. Surveyor asked when were the two accused CNA's put on administrative leave? DON B and NHA A (Nursing Home Administrator) reviewed CNA's time punches. DON B and NHA A indicated they were put on leave once the investigation was started on 10/18/23. Surveyor asked did one of the accused CNA's work 10/15/23 and 10/16/23? DON B indicated yes. On 11/21/23 at 8:15AM, DON B indicated an investigation should have been started immediately after the incident on 10/14/23 with R3. DON B indicated she was new to her position at that time and looking back she should have started the investigation and put accused CNA's on administrative leave immediately.	F 610		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that -	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525276	A. BUILDING _____ B. WING _____	C 12/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SSM HEALTH ST MARY'S CARE CENTER	3401 MAPLE GROVE DR MADISON, WI 53719

(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) COMPLETION DATE
F 689	Continued From page 21 §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility did not ensure that each staff implemented proper safety interventions as directed by a resident's plan of care and did not ensure residents were free from accidents and hazards for 1 of 3 residents (R1) reviewed for falls. On 10/29/23, a Certified Nursing Assistant (CNA) attempted to provide care to R1 without maintaining the proper safety interventions as directed in R1's care plan. R1 rolled off the bed and fell approximately 2 feet to the floor, hitting her head. R1 suffered multiple fractures and a subarachnoid hemorrhage (bleeding in the space surrounding the brain), resulting in death. This created a finding of immediate jeopardy that began on 10/29/23. The facility's failure to to ensure all staff follow proper safety interventions to prevent accidents created a finding of Immediate Jeopardy that began on 10/29/23. Surveyor notified the NHA A (Interim Nursing Home Administrator) of the Immediate Jeopardy on 11/21/23 at 1:30 PM. The Immediate Jeopardy was removed on 11/20/23, however the deficient practice continues at a scope/severity of a D (potential for more than minimal harm/isolated) as the facility continues to implement its action plan.	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525276	A. BUILDING _____ B. WING _____	C 12/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SSM HEALTH ST MARY'S CARE CENTER	3401 MAPLE GROVE DR MADISON, WI 53719

(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) COMPLETION DATE
F 689	Continued From page 22	F 689		

This is evidenced by:
According to the Center for Disease Control (CDC,) "Twenty to thirty percent of people who fall suffer moderate to severe injuries such as lacerations, hip fractures, or head traumas." According to the CDC, falls are the most common cause of traumatic brain injuries; traumatic brain injury accounts for 46% of fatal falls among older adults (those 65 or older). Among older adults, falls are the leading cause of injury death and are the most common cause of nonfatal injuries and hospital admissions for trauma. The CDC notes that in 2008, over 19,700 older adults died from unintentional fall injuries. (http://www.cdc.gov/homeandrecreationalsafety/falls/adultfalls.html)

The facility's mechanical lift policy states the following:
*Type of lift will be included on resident care plan as well as CNA care sheet.
*Staff of 1-2 person will depend on individual resident's need as indicated on residents care plan and CNA care sheet.
*Full body lifts (Hoyer) require 2 staff members at all times.

R1 was a 106-year-old resident who was admitted to the facility on 4/19/18 and had diagnoses that included Alzheimer's disease. Her Minimum Data Set (MDS) dated 10/25/23 shows a Brief Interview for Mental Status (BIMS) was not conducted, indicating her low cognition level renders her as rarely or never understood. R1's 2/28/23, 4/28/23, and 7/25/23 MDS indicate she is a 1 person assist for bed mobility and a 2 person assist for transfers. Her 10/25/23 MDS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525276	A. BUILDING _____ B. WING _____	C 12/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SSM HEALTH ST MARY'S CARE CENTER	3401 MAPLE GROVE DR MADISON, WI 53719

(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) COMPLETION DATE
F 689	Continued From page 23	F 689		

shows that R1 requires a helper due to all the effort in transferring her from bed to her wheelchair.

R1's care plan stated, "Mood/Behavior: ...resident is physically abusive, other residents or staff were hit, shoved, scratched ...resident resists care ...Safety/Falls: bed in low position with floor mat ...Ambulation: non-ambulatory ...Bed mobility: 1 assist ...Transfers: 2 assist mechanical lift."

The facility submitted a self-report on 11/2/23 describing an incident that occurred on the morning of 10/29/23 at approximately 6:45 AM in which R1 fell from her bed. In the incident, CNA H was performing cares on R1 while R1 was in bed. CNA H removed R1's fall mat from near the bed and turned her back from R1, at which time R1 rolled out of bed and onto the floor. CNA H alerted her floor nurse who then alerted the charge nurse. Upon assessment by the charge nurse, R1 was lying on her right side on the floor with blood around her head. The facility got orders from R1's physician to send her to the hospital. Emergency Medical Service (EMS) records show R1 arrived at the hospital at 7:24 AM. The hospital conducted x-rays and a CT scan (medical imaging) with results showing a pelvis fracture, femoral neck fracture, and a subarachnoid hemorrhage (bleeding in the space between the brain and the surrounding membrane.) R1 expired at the hospital at 12:10 PM.

On 11/21/23 at 10:27 AM, Surveyor interviewed CNA H, who stated that she had worked third shift the night before, on 10/28/23, and had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525276	A. BUILDING _____ B. WING _____	C 12/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SSM HEALTH ST MARY'S CARE CENTER	3401 MAPLE GROVE DR MADISON, WI 53719

(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) COMPLETION DATE
F 689	Continued From page 24 stayed into the first shift of 10/29/23 to help get residents up and out of bed. CNA H stated that she had gotten R1 dressed and was walking around the room back and forth getting toiletries and other items to prepare R1 for the day and she kept tripping on R1's fall mat, so she (CNA H) picked it up to move it to the other side of the room and when she got to the other side of the room, she heard R1 fall to the floor. CNA H stated R1 was on her left side in her bed before she fell and when she (CNA H) turned around to see R1 on the floor, R1 was lying on the floor on her right side. Before turning her back to R1, CNA H stated the bed was at "about knee height." CNA H stated that she was not sure how close to the edge of the bed she left R1 but did not think she was close enough to fall. Additionally, CNA H stated that R1 had been somewhat restless the night before, asking all sorts of questions in the middle of the night like, "Is it time to get up?" CNA H also stated that R1 could be fidgety and would kick her legs and stated she thinks R1 kicked her legs in a way that rolled her off the bed. CNA H stated that she had not received any education from the time the incident occurred until yesterday (11/20/23) before she started her evening shift. CNA H stated that at that time (11/20/23), she was educated on proper positioning in bed before transfers, not turning her back to residents, not moving fall mats until the time of transfer and making sure a resident's bed is in its lowest position before leaving a resident to get a lift. Surveyor again asked CNA H if she had received any of this education or any similar education the morning of the incident or any time while she was off work pending the investigation, to which she replied, "No."	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525276	A. BUILDING _____ B. WING _____	C 12/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SSM HEALTH ST MARY'S CARE CENTER	3401 MAPLE GROVE DR MADISON, WI 53719

(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) COMPLETION DATE
F 689	Continued From page 25 On 11/20/23 at 9:49 AM, Surveyor interviewed LD I (Lead Detective,) who headed the local police department's investigation into the incident. LD I stated that when the police arrived on 10/29/23 after 7:00 PM they measured the height of R1's bed to be 25" off the ground. LD I did not have any additional information for Surveyors that the facility did not already have in their internal investigation, nor was the local police department able to find any criminal misconduct. On 11/20/23, RN P (at 11:12 AM) and CNA K (at 11:18 AM) demonstrated for Surveyors what "low bed" meant. In both demonstrations, these staff employed a current resident's bed and lowered the bed to its lowest point via the bed remote until the bed stopped moving. On 11/21/23 at 11:21 AM, CNA L demonstrated "low bed" in R1's room, which is now vacant. CNA L lowered the bed until it would not lower any further. In each demonstration, staff stated the bed was approximately 10-12" off the ground. Additionally, on 11/20/23 Surveyors interviewed CNA G at 10:05 AM and LPN N at 11:28 AM and CNA M on 11/21/23 at 10:20 AM. All 3 stated that "low bed" means the bed is lowered to the ground until it cannot go any further. Surveyor gathered the following additional interviews: *11/20/23 at 3:00 PM, RN O stated that CNA H should not have turned her back to R1 when providing cares without the fall mat or bed in the low position. RN O was the charge nurse on the	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525276	A. BUILDING _____ B. WING _____	C 12/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SSM HEALTH ST MARY'S CARE CENTER	3401 MAPLE GROVE DR MADISON, WI 53719

(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) COMPLETION DATE
F 689	Continued From page 26	F 689		

night of the incident.
*11/20/23 at 3:55 PM, RN Q stated the bed in R1's room at the time of the incident was about 2 feet off the ground and was not at its lowest position. RN Q was the floor nurse who responded to CNA H's request for help on the morning of 10/29/23.
*11/20/23 at 4:38 PM, DON B (Director of Nursing) stated that "low bed" is different depending on the resident. DON B provided Surveyor with documentation the next morning,
*11/21/23 at 11:21 AM, CNA L stated she regularly worked with R1 and that R1 would grab out at times and could move her legs. CNA L also stated that R1 could "absolutely" have rolled out of bed if she were lying on her side if she kicked her legs the way she (CNA L) had seen her do in the past.

Not following R1's care plan by removing her fall mat, leaving her bed at a height greater than lowest position without supervision resulted in R1 falling, resulting in death. The facility removed the jeopardy on 11/20/23 when it had completed the following:

The facility conducted an investigation following the event and did the following:
*Immediately suspended CNA H
*Contacted local law enforcement
*Interviewed residents and staff
*Educated staff

The education included a review of the facility's mechanical lift policy with the following additional information:
*Before leaving room, ensure bed is in low position and resident has call light.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525276	A. BUILDING _____ B. WING _____	C 12/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SSM HEALTH ST MARY'S CARE CENTER	3401 MAPLE GROVE DR MADISON, WI 53719

(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) COMPLETION DATE
F 689	Continued From page 27 *Hoyer lifts always require two people. *Do not move fall mat until Hoyer lift is in room and ready to be put in place. *If you need to walk away from a resident to go get a lift, you must ensure the resident is positioned safely in their bed or recliner. The facility educated CNAs, Licensed Practical Nurses (LPN,) and Registered Nurses (RN.) Staff signatures were captured on a number of sign-in sheets to indicate staff had received the training. CNA H's signature was not found on any of the education forms or sign-ins. On 11/20/23 at 4:31 PM, Surveyor interviewed NHA A (Nursing Home Administrator) regarding CNA H's education after the incident. NHA A stated that she did talk with CNA H after the incident, but did not have anything documented or written down. NHA A then brought an undated, handwritten note to Surveyor that stated she had talked with a CNA (name was not that of CNA H) stating, "...educated on not removing fall mat prior to transfer and not leaving resident with back turned on edge of bed." The facility provided the following documentation to Surveyors on 11/21/23 showing CNA H had received education on 11/20/23. The education included the following: *Position resident in center of bed prior to beginning and after transfers. *Do not ever turn back on a resident if they are not positioned completely centered. *Residents with fall mats cannot have the mat removed until ready to complete transfer. *If going to get a lift, ensure bed is in lowest possible position. *Hoyer sling should not be placed under resident	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525276	A. BUILDING _____ B. WING _____	C 12/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SSM HEALTH ST MARY'S CARE CENTER	3401 MAPLE GROVE DR MADISON, WI 53719

(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) COMPLETION DATE
F 689	Continued From page 28 until transfer is ready to begin. According to facility records and timesheets, between 10/29/23 when the incident occurred and 11/20/23 when Surveyors identified the absence of CNA H's education, CNA H worked 15 shifts on 14 days. The facility's removal plan indicated it had or would be completing the following: *Follow-up was done by NHA on the incident on 11/20/2023 to ensure completeness. Staff assigned to R1 were interviewed by NHA on 10/29/2023-10/30/2023. Local law enforcement was notified 10/29/2023 by NHA. *NHA/ DON will review all falls with injury on 11/21/2023 to ensure no other education requirements are identified. Any negative findings will be properly investigated and reported as required. Negative findings will be reported to the QAPI team. *Education began on team members on Hoyer lift procedures, removing fall mats, resident positioning safety and the turning back on resident by nurse manager on 10/29/2023. *Education began on team members on bed in low position and breaks locked by DON on 11/20/2023. *Education from (RDO) Regional Director of Operations and Regional Director of Clinical Operations to Administrator on investigation requirements, what to do when completing and making corrections during investigations and educational requirements, was completed on 11/20/2023. Education with CNA H was completed by NHA and RN House Supervisor on 11/20/2023 with direct how to with repeat back and in person	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525276	A. BUILDING _____ B. WING _____	C 12/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SSM HEALTH ST MARY'S CARE CENTER	3401 MAPLE GROVE DR MADISON, WI 53719

(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) COMPLETION DATE
F 689	Continued From page 29 training with positioning, fall mat use, low bed to be in low position when resident in bed. *Education continues with team members on low bed, mechanical lifts, removing fall mats, resident positioning safety in bed and the turning back on resident, and Resident Abuse/Reporting by NHA/DON on 11/21/2023. Clinical staff will be educated prior to working. *Incident Reports to be reviewed for thoroughness prior to final submission by RDO or RDQCS to ensure staff discipline, witness statements, staff interviews, resident interviews have been completed and followed up on. 5x a week x 3 months. *All falls with major injury will be followed up on, investigated and reported as required by regulations daily ongoing by NHA/DON. Any negative findings will be properly investigated and reported as required. Negative findings will be reported to the QAPI team. Audits to include: 1) Beds in lowest position when in bed 5x a week x 2 weeks, 3 x a week x 2 weeks and 1 x week x 2 months and 2) Fall mats in place until time of transfer 5x a week x 2 weeks, 3 x a week x 2 weeks and weekly x 2 months. Results of Audits will be reported to QAPI.	F 689		