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	0016280	A. BUILDING: _____ B. WING _____	C 04/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGE POINTE COMMONS THE CRESTE	101 WALNUT DR GRAFTON, WI 53024

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N 000	Initial Comments From 04/16/2024 to 04/19/2024, Surveyor conducted a complaint investigation and standard survey at Village Pointe Commons The Creste, a CBRF in Grafton. Seven deficiencies were identified. Two deficiencies were repeat deficiencies - See Statement of Deficiency (SOD) 03U011, dated 01/22/2021 and SOD 03U012, dated 04/28/2021. The complaint was unsubstantiated. Census: 22	N 000		
N 172	83.12(6) Documentation requirements for written report All written reports required under this section shall include, at a minimum, the time, date, place, individuals involved, details of the occurrence, and the action taken by the provider to ensure residents ' health, safety and well-being. This Rule is not met as evidenced by: Based on record review and interview, the provider did not maintain documentation, that included time, date, place, individuals involved, details of the occurrence and action taken by the provider to ensure resident's health, safety and well-being was maintained when a resident was found with an injury of an unknown source. The provider did not maintain documentation of their investigation related to Resident 3's femur fracture. This is a repeat deficiency - See Statement of Deficiency (SOD) 03U011, dated 01/22/2021. Findings include:	N 172		

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

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N 172	Continued From page 1	N 172		

From 04/16/2024 to 04/19/2024, Surveyor conducted a complaint investigation regarding the cause of a resident's fracture.

On 04/17/2024 at approximately 12:30 p.m., Surveyor reviewed Resident 3's record. Resident 3 was admitted to the provider's facility on 12/12/2018. Resident 3's progress notes, dated 12/01/2024 to 12/13/2024 documented the following:

- 12/12/2024: Resident had swelling to left knee and tenderness upon range of motion.
- 12/13/2024: Resident has a fracture to back of knee.

On 04/17/2024 at approximately 1:00 p.m., Surveyor reviewed Resident 3's hospice records, obtained by Surveyor. The record included the following:

- 12/10/2024: PRN visit due to left knee swelling and uncontrolled pain.
- 12/11/2024: Moaning and grimacing when pulling on pant leg. Bruising to left shin purplish in color. Swelling and warmth to left knee. No reported falls. X-ray ordered.
- 12/13/2024: Nonverbal signs of extreme pain. X-ray revealed femur fracture - A CT scan was advised for full assessment as fracture may be represent of a pathologic fracture.
- 12/14/2024: Shows signs of pain and discomfort. Facility reports no incidents. Further imaging would need to be completed to determine pathological cause.

On 04/16/2024 at approximately 2:45 p.m., Surveyor interviewed Administrator A regarding Resident 1's fracture. Administrator A stated the

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N 172	Continued From page 2 facility had ruled out any concerns related to an incident or trauma that would have caused Resident 1's fracture. Surveyor requested documentation to confirm how the facility ruled out an incident or trauma. Administrator A stated s/he would follow up with his/her team regarding documentation. Administrator A was given until 04/17/2024 to provide follow up documentation. Documentation related to Resident 3's fracture was not obtained. On 04/18/2024 at approximately 9:30 a.m., Administrator A followed up and stated all staff were asked if there had been an incident of any kind that could have caused Resident 3's fracture, but no one was aware of anything happening and s/he did not have documentation to provide. Administrator A did not have documentation to indicate the time, date, place, individuals involved, details of the occurrence and action taken by the provider to ensure resident's health, safety and well-being was maintained when the fracture with an unknown cause, was found.	N 172		
N 195	83.14(1)(b) Licensee: caregiver background requirements. A licensee shall meet the caregiver background requirements under s. 50.065, Stats., and ch. DHS 12. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure a caregiver background check following the procedures in s. 50.065 and	N 195		

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N 195	Continued From page 3 ch. DHS 12 was completed for 1 of 3 caregivers reviewed. Caregiver D did not have background checks completed upon hire following the procedures in s. 50.065 and ch. DHS 12. Findings include: On 04/16/2024 at approximately 12:30 p.m., Surveyor reviewed employee records. Records indicated Caregiver D was hired on 02/01/2023. Caregiver D's background information disclosure (BID) indicated s/he resided in Mississippi within 3 years of his/her employment date. Caregiver D's record did not include a background check completed with the State of Mississippi. On 04/16/2024 at approximately 2:45 p.m., Surveyor interviewed Administrator A. Surveyor asked if the provider completed an out-of-state background check for Caregiver D upon hire. Administrator A replied, "I know for a fact we didn't."	N 195		
N 277	83.25 Continuing education The administrator and resident care staff shall receive at least 15 hours per calendar year of continuing education beginning with the first full calendar year of employment. Continuing education shall be relevant to the job responsibilities and shall include, at a minimum, all of the following: (1) Standard precautions; (2) Client group related training; (3) Medications; (4) Resident rights; (5) Prevention and reporting of abuse, neglect and misappropriation; (6) Fire safety and emergency procedures, including first aid.	N 277		

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N 277	Continued From page 4 This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 1 caregivers reviewed completed at least 15 hours of continuing education beginning with the first full calendar year of employment. Caregiver B did not receive 15 hours of continuing education in 2022 or 2023. This is a repeat deficiency. See Statement of Deficiency (SOD) 03U012, dated 04/28/2021. Findings include: On 04/16/2024 at approximately 12:30 p.m., Surveyor reviewed employee records provided by Administrator A. Caregiver B's record indicated s/he was hired on 06/01/2021. Caregiver B's record did not include documentation of any continuing education in 2022. Caregiver B's record indicated s/he completed 7.25 hours of continuing education in 2023. On 04/16/2024 at approximately 1:00 p.m., Surveyor reviewed concern with Administrator A and Regional Staff C that Caregiver B did not complete 15 hours of continuing education annually. Regional Staff C stated the provider had already identified the concern on their own and was addressing the concern.	N 277		
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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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 record review and interview, the provider did not ensure 2 of 3 individual service plans (ISP) reviewed were updated when there was a change in the resident's needs and/or that the ISP was signed by all involved parties to acknowledge involvement, understanding and agreement of the ISP.

Resident 2's ISP was not updated to include his/her interventions for fall prevention.

Resident 1's ISP was not signed by his/her activated Health Care Power of Attorney (HCPOA).

Findings include:

On 04/16/2024 at approximately 12:30 p.m., Surveyor reviewed resident records and identified the following concerns:

Example 1 - Resident 2:

Resident 2 admitted to the provider's facility on 04/12/2021. Resident 2's progress notes, dated 01/01/2024 to 04/16/2024, documented the

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following:

- 01/21/2024: Resident found on floor next to bed.
- 02/13/2024: Resident slid to floor while staff were providing peri-care. Resident was unable to stand long. Intervention = Gripper socks and EZ stand use for lengthy cares.
- 02/23/2024: Resident had a fall in the bathroom. Intervention = Do not leave alone in bathroom.
- 04/03/2024: Resident found on his/her bottom. Appears to have fallen while transferring from wheelchair. Intervention = Encourage to ask for help with transfers.
- 04/06/2024: Resident slid out of wheelchair. Intervention = Make sure resident is seated all the way back in wheelchair.

Resident 2's ISP was dated 09/21/2023. The ISP did not include the fall interventions listed above.

On 04/16/2024 at approximately 2:45 p.m., Surveyor reviewed Resident 2's fall interventions and the observation that Resident 2's ISP did not include the fall interventions with Administrator A. Surveyor asked Administrator A if the fall interventions were added to the ISP or any sort of extension of the ISP once they were put into place. Administrator A stated s/he would need to follow up on documentation.

Administrator A was given until 04/17/2024 to provide follow up documentation. Documentation to indicate Resident 2's ISP was updated to include his/her fall interventions was not received.

Example 2 - Resident 1:

Resident 1 was admitted to the provider's facility on 01/24/2024. Resident 1 had an activated Health Care Power of Attorney. Resident 1's ISP

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N 389	Continued From page 7 was dated 01/24/2024 and signed by the facility's RN. Resident 1's ISP did not include a signature from Resident 1's HCPOA. On 04/16/2024 at approximately 2:45 p.m., Surveyor interviewed Administrator A and shared observation that Resident 1's ISP was not signed by his/her HCPOA. Administrator A stated s/he would look through further documentation to see if s/he had a signed copy. Administrator A was given until 04/17/2024 to provide follow up documentation. Documentation related to ISPs was not received.	N 389		
N 393	83.35(5)(a) Initial evaluation of evacuation limitations. Initial evaluation. The CBRF shall evaluate each resident within 3 days of the resident ' s admission to determine whether the resident is able to evacuate the CBRF within 2 minutes in an unsprinklered CBRF and 4 minutes in a sprinklered CBRF without any help or verbal or physical prompting, and what type of limitations that resident may have that prevent the resident from evacuating the CBRF within the applicable period of time. A form provided by the department shall be used for the evaluation. The resident ' s evaluation shall be retained in the resident ' s record. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 3 residents was evaluated within 3 days of his/her admission to determine his/her ability to evacuate. Resident 1 was not evaluated for his/her ability to evacuate	N 393		

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N 393	Continued From page 8 the facility until greater than 2 months after his/her admission. Findings include: On 04/16/2024 at approximately 12:30 p.m., Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider's facility on 01/24/2024. Resident 1's evacuation assessment was dated 03/21/2024. On 04/16/2024 at approximately 2:45 p.m., Surveyor interviewed Administrator A. Surveyor reviewed the timespan between Resident 1's admission and completion of his/her evacuation assessment. Administrator A was unsure why there was a delayed. Administrator A was given until 04/17/2024 to provide follow up documentation. Documentation related to evacuation assessments was not received.	N 393		
N 408	83.37(1)(i) PRN psychotropic medication. As needed (PRN) psychotropic medication. When a psychotropic medication is prescribed on an as needed basis for a resident, the CBRF shall do all of the following: 1. The resident ' s individual service plan shall include the rationale for use and a detailed description of the behaviors which indicate the need for administration of PRN psychotropic medication. 2. The administrator or qualified designee shall monitor at least monthly for the inappropriate use of PRN psychotropic medication, including but not limited to, use contrary to the individual service plan, presence of significant adverse side effects, use for discipline or staff convenience, or contrary	N 408		

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N 408	Continued From page 9 to the intended use. 3. Documentation in the resident ' s record shall include the rationale for use, description of behaviors requiring the PRN psychotropic medication, the effectiveness of the medication, the presence of any side effects, and monitoring for inappropriate use for each PRN psychotropic medication given. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure resident individual service plans (ISP) included the rationale for use and a detailed description of behaviors which indicated the need for administration of PRN psychotropic medications for 2 of 2 residents reviewed that received PRN psychotropic medications. Resident 1 and Resident 3's ISPs did not include the use of their psychotropic medications. Findings include: Example 1 - Resident 1: Resident 1 was admitted to the provider's facility on 01/24/2024 with diagnosis of vascular dementia. Resident 1's physician orders included Lorazepam .5 mg (Start Date: 01/19/2024) every 4 hours as needed for anxiety and Seroquel 25 mg (Start Date: 01/19/2024) 2x/day as needed for agitation. Resident 1's ISP documented that Resident 1's behaviors included pacing, crying, wringing hands, calling out, exit seeking, verbal or physical reluctance to cares and refusal of medications or treatments. The ISP did not include the use of the PRN psychotropic medications. Example 2 - Resident 3:	N 408		

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N 408	Continued From page 10 Resident 3 was admitted to the provider's facility on 12/12/2018 with diagnoses of Alzheimer's disease and anxiety. Resident 3's physician orders included Haloperidol 2 mg/ml (Start Date: 06/01/2023) .5 ml every 2 hours as needed for agitation/restlessness and Lorazepam .5 mg (Start Date: 06/01/2023) every 2 hours as needed for anxiety. Resident 3's ISP, dated 11/03/2023, did not include the use of PRN psychotropic medications. On 04/16/2024 at approximately 2:45 p.m., Surveyor interviewed Administrator A. Surveyor asked Administrator A if the provider included the PRN psychotropic medications in resident ISPs. Administrator A stated s/he would need to follow up with his/her team. Administrator A was given until 04/17/2024 to provide follow up information. Information related to PRN psychotropic medications in ISPs was not received.	N 408		
N 452	83.41(3)(b) Food safety. Food safety. Whether food is prepared at the CBRF or off-site, the CBRF shall store, prepare, distribute and serve food under sanitary conditions for the prevention of food borne illnesses, including food prepared off-site, according to all of the following: 1. The CBRF shall refrigerate all foods requiring refrigeration at or below 40°F. Food shall be covered and stored in a sanitary manner. 2. The CBRF shall maintain freezing units at 0°F or below. Frozen foods shall be packaged, labeled and dated. 3. The CBRF shall hold hot foods at 140°F or above and shall hold cold foods at 40°F or below until serving.	N 452		

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This Rule is not met as evidenced by:
Based on observation and interview, the provider did not ensure food was stored under sanitary conditions for the prevention of food borne illnesses. The facility had juice, fruit, salad and hard boiled eggs that were not dated in the refrigerator.

Findings include:

"Date marking is a way to control the growth of a bacteria called Listeria, which grows under refrigeration and is the third leading cause of death from foodborne illness in the United States." (Source: Wisconsin Food Code Fact Sheet, Date Marking of Ready-to-Eat Time-Temperature Control for Safety Foods, April 2022)

On 04/16/2024 at approximately 1:00 p.m.., Surveyor toured the facility's kitchen and observed the following in the provider's refrigerator:

- Two containers of juice that were not dated. Care Coordinator E stated the juice was made earlier that day.
- A container of strawberries that was not dated. Care Coordinator E stated the fruit was from the day prior.
- A container of watermelon that was not dated. Care Coordinator E stated the fruit was from the day prior.

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N 452	Continued From page 12 - A to-go container that contained a salad. Care Coordinator E stated the salad was from the day prior. - 2 bags of hard-boiled eggs that were not dated. On 04/16/2024 at approximately 2:45 p.m., Surveyor reviewed concern with Administrator A that the facility's refrigerator contained open food with no date. Administrator A made note of Surveyor's concern.	N 452		