STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013469	A. BUILDING: _____ B. WING _____	C 02/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE AT DEER CREEK	3585 S 147TH ST NEW BERLIN, WI 53151

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
U 000	INITIAL COMMENTS From 02/06/2024 to 02/13/2024, Surveyor conducted a complaint investigation at Heritage at Deer Creek, a RCAC in New Berlin. One deficiency was identified. The complaint was substantiated. Census: 36	U 000		
U 122	89.23(2)(c) SERVICES SUFFICIENT SERVICES. Emergency assistance. A residential care apartment complex shall ensure that tenant health and safety are protected in the event of an emergency and shall have the capacity to provide emergency assistance 24 hours a day. A residential care apartment complex shall have a written emergency plan which describes staff responsibilities and procedures to be followed in the event of fire, sudden serious illness, accident, severe weather or other emergency and is developed in cooperation with local fire and emergency services. This Rule is not met as evidenced by: Based on interview and record review, the provider did not ensure tenant health and safety was protected in the event of an emergency, including a sudden serious incident. The provider	U 122		

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

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U 122	Continued From page 1	U 122		

did not respond to Tenant 1's call for help for approximately 1 hour. Tenant 1 was found deceased.

Findings include:

On 02/06/2024, Surveyor conducted a complaint investigation alleging the provider did not provide prompt care when a tenant called for help.

On 02/06/2024 at approximately 11:45 a.m., Surveyor reviewed Tenant 1's record. Tenant 1 was admitted to the provider's complex on 05/13/2022. Tenant 1's record included a progress note, dated 01/17/2024 at 8:00 a.m., that stated, "Unexpected death on 01/17/2024 between 6:45 a.m. and 7:20 a.m. 911 called to the [scene] and police and internal investigation underway." Tenant 1's record did not include "Do Not Resuscitate" paperwork.

On 02/06/2024 at approximately 12:30 p.m., Surveyor interviewed Director of Nursing A. Director of Nursing A stated Tenant 1 called for assistance sometime between 6:45 a.m. and 7:15 a.m., but that s/he did not have the exact time Tenant 1 called for assistance.

On 02/06/2024 at approximately 2:00 p.m., Surveyor reviewed the paramedic report, dated 01/17/2024, which stated 911 was called at 7:54 a.m. and arrived at 8:04 a.m. to find Tenant 1 unresponsive, pulseless and not breathing. The report documented Tenant 1 was found with a mottled blue face, rigor to his/her jaw and lividity starting to form in both arms. The report stated resuscitation was not attempted because it was deemed futile.

On 02/08/2024 at approximately 3:00 p.m.,

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U 122	Continued From page 2 Surveyor received documentation from the provider that indicated Tenant 1 pushed his/her call light for assistance on 01/17/2024 at 6:45 a.m. Surveyor questioned why EMS was not called for assistance until 7:54 a.m. Director of Nursing A stated, "Care staff found resident pulseless, not moving, 'blue' and not breathing. The care staff found the supervisor, who then called 911 and the Director of Nursing, who directed staff to call 911 as this was potentially an unexpected death and no other clinically trained staff were on-site." Director of Nursing A did not provide a reason for the delay in seeking assistance from EMS. Director of Nursing A confirmed Tenant 1 was "Full Code." On 02/09/2024 at approximately 9:00 a.m., Surveyor reviewed a police report, dated 01/22/2024, that stated law enforcement was dispatched to report of a deceased person at 7:55 a.m. on 01/17/2024. The report stated Tenant 1 was determined to be beyond life saving measures. The report stated that Tenant 1's family member was found yelling outside their apartment for help at 7:50 a.m., at which time Supervisor B responded to the room and found Tenant 1 bent over his/her wheelchair and called for assistance. The report documented Housekeeper C contacted 911. The report documented that Caregiver D reported to law enforcement that Tenant 1 pushed his/her call button at 6:45 a.m.; however, the night shift did not respond. On 02/13/2024 at approximately 8:45 a.m., Surveyor interviewed Caregiver D. Caregiver D stated s/he worked on 01/17/2024. Caregiver D stated s/he arrived to work at approximately 7:00 a.m. and audited the medication cart with the "traveler" caregiver that had worked 3rd shift.	U 122		

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U 122	Continued From page 3 Caregiver D stated the phone the "traveler" caregiver had been using, which would notify the caregiver of a resident calling for assistance, was dead. Caregiver D stated after auditing the medication cart, s/he went to the CBRF to obtain a new phone linked with the call system. Caregiver D stated it wasn't until approximately 7:50 a.m. that s/he had gotten a charged phone and realized Tenant 1 had called for assistance at approximately 6:45 a.m. Caregiver D stated at that time, Tenant 1's family member was out in the hallway calling for assistance and Supervisor B responded to the room. Caregiver D shared concern that supervisors typically watch call times and if a call light isn't responded to in approximately 3 minutes, they communicate to caregivers to find out the reason for the delay and ensure someone is responding, but Caregiver D wasn't sure why that did not occur that day. On 02/13/2024 at approximately 2:00 p.m., Surveyor interviewed Supervisor B. Supervisor B stated s/he worked 01/17/2024 and recalled seeing Tenant 1's call for assistance on his/her phone, but thought 3rd shift would have responded since the call came in at approximately 6:45 a.m. Supervisor B stated s/he did not respond to Tenant 1's room until approximately 7:50 a.m. when Tenant 1's family member was outside the room calling for help. On 02/13/2024 at approximately 2:00 p.m., Surveyor reviewed concern that the facility did not promptly respond to Tenant 1's call for assistance in the event of a medical emergency with Director of Nursing A, Regional Director E and Regional Director F. Director of Nursing A stated s/he was unaware of the timeline Surveyor shared.	U 122		