STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017768	A. BUILDING: _____ B. WING _____	C 02/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACY OF DEFOREST (THE)	6639 PEDERSON CROSSING BLVD DE FOREST, WI 53532

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N 000	Initial Comments On 02/05/2024, with information gathered through 02/12/2024, Surveyor conducted a complaint investigation at The Legacy of DeForest. Two deficiencies were identified. Complaint was substantiated. One of the 2 deficiencies were repeat violations (see Statement of Deficiency (SOD) 085D11). Census: 21	N 000		
N 353	83.32(3)(i) Rights of Residents: Adequate treatment In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Prompt and adequate treatment. Receive prompt and adequate treatment that is appropriate to the resident ' s needs. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 1 resident received adequate treatment. Resident 1's fall risk intervention was not utilized to ensure his/her safety. Findings include: On 01/22/2024, the Department received a concern that residents who were a fall risk were not monitored. On 02/05/2024, Surveyor reviewed Resident 1's record. Resident 1 admitted to the memory care section	N 353		

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

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of the facility on 10/17/2023, after living in the independent section of the facility.

Resident 1's Incident Reports documented:
12/13/2023 - Fall unwitnessed - Dining Room. "Was eating dinner when [s/he] fell asleep while eating [s/he] then fell from [his/her] chair. Was at the desk doing meds when a resident pointed at [Resident 1]. Then I notice [s/he] was on the floor. [S/he] wasn't speaking when we first talk to [him/her]. [S/he] had [his/her] eyes closed and not responding to me calling [his/her] name. We got [him/her] in [his/her] wheelchair and [s/he] woke up." Prepared by Caregiver E.
12/14/2023 - Fall unwitnessed - Bedroom. "By 8:30 AM I walk to [his/her] room to do [his/her] medication and I saw [him/her] right next to [his/her] bed on the floor." Prepared by Lead Caregiver C.
12/15/2023 - Fall unwitnessed - Bedroom. "I went into resident's room to check on [him/her] that's when I saw [him/her] on the floor. [S/he] was face down with [his/her] chin on the floor and [his/her] forehead resting on the wall." Prepared by Caregiver B.
01/08/2024 - Fall unwitnessed - Bedroom. "As staff was walking past resident's apartment, staff saw that resident was laying on the floor. [S/he] was laying on [his/her] right side with [his/her] head almost in the doorway." Prepared by Caregiver D.
01/28/2024 - Fall unwitnessed - Bedroom. "Staff went to check on resident after they stated they were not feeling well. When staff entered [his/her] apartment they could see that the resident was on the floor crawling on [his/her] hands and knees." Prepared by Caregiver B.

On 02/06/2024, at approximately 12:30 PM, Surveyor interviewed Caregiver B while observing

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Resident 1 sleeping in his/her bed. Caregiver B stated Resident 1 had a chair alarm and a bed alarm. Caregiver B demonstrated the chair alarm that was placed in Resident 1's Broda chair. Caregiver B showed Surveyor where the bed alarm was placed under Resident 1 in his/her bed. Surveyor stated Resident 1 had sustained numerous falls and asked if the bed alarm ever malfunctioned; therefore, not alerting staff. Caregiver B stated that s/he was not aware of the bed alarm malfunctioning but had experienced finding Resident 1 on the floor with the bed alarm not alarming but that was due to the bed alarm being disengaged. Surveyor asked if Caregiver B had reported those findings. Caregiver B stated s/he had informed his/her supervisor and the hospice staff.

On 02/06/2024, at approximately 12:40 PM, Surveyor interviewed Resident 1's Family Member F. Family Member F stated, "I do not understand how my [mom/dad] can sustain these many falls and staff cannot tell me how it happened."

On 02/06/2024, at approximately 4:00 PM, Surveyor interviewed Executive Director A. Executive Director A stated s/he did not believe there was a system in place that staff are to check the status of bed/chair alarms during shift changes. Executive Director A stated s/he would be discussing the concern where Caregiver B stated that staff were disengaging the bed/chair alarms; "This is unacceptable." Executive Director A and Surveyor reviewed Resident 1's incident reports and Executive Director A stated, "The reports read that each fall was unwitnessed, and the staff were not responding because the chair/bed alarm was sounding."

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N 353	Continued From page 3 On 02/09/2024, Surveyor reviewed Resident 1's hospice notes which documented: "11/03/2023 - Unsteady on feet chair alarm placed and chairs [sic] and instructed staff on use. Instructed staff to assist patient with all transfers." "01/08/2024 - was reported that patient had a fall this morning out of bed. Patient's alarms were not sounding. ... Staff were educated on alarm use. How to note when alarms are on, how to check and change batteries. Writer replaced one alarm box and did provide batteries." "01/17/2024 - Bruising noted to buttocks, scattered bruising to lower extremities and right forearm. Reinforce and reeducated staff on importance of alarms on patient at all times in bed and/or in chair." "01/28/2024 - a bruise noted over [his/her] left eye. ... Reinforced with staff to ensure bed is in low position, fall mat is in place and alarms are on and operating."	N 353		
N 381	83.35(1)(a) Pre-admission and ongoing assessments. Scope. The CBRF shall assess each resident ' s needs, abilities, and physical and mental condition before admitting the person to the CBRF, when there is a change in needs, abilities or condition, and at least annually. The assessment shall include all areas listed under par. (c). This requirement includes individuals receiving respite care in the CBRF. For emergency admissions the CBRF shall conduct the assessment within 5 days after admission.	N 381		

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N 381	Continued From page 4 This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not ensure an assessment of Resident 1's physical and mental condition was completed when there was a change in needs. Resident 1 sustained 6 falls between 10/17/2023 and 02/07/2024 and a fall assessment was not completed. Resident 1 utilized bed rails and an assessment had not been completed. This is a repeat deficiency. See Statement of Deficiency (SOD) 085D11, dated 01/19/2023. Findings include: On 01/22/2024, the Department received a concern alleging that residents were not monitored for fall risks. The provider is licensed to care for a maximum of 25 residents from client group Advanced Aged and Irreversible Dementia/Alzheimer's. On 02/05/2024, at approximately 3:00 PM, and on 02/06/2024, at approximately 12:30 PM, Surveyor observed Resident 1 in his/her room and noted that s/he utilized side bedrails. On 02/05/2024, Surveyor reviewed Resident 1's record. Resident 1 admitted to the memory care section of the facility, on 10/17/2023, after living in the independent section of the facility. Resident 1's current ISP documented: "Transferring: Transferring status to remain stable r/t (related to) HTN (hypertension) and chronic pain. No concerns at this time. Continue to	N 381		

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monitor and update RN (registered nurse) / MD (medical doctor) / hospice / family of any transferring concerns. Date Initiated: 10/17/2023."
"Behaviors: Behaviors to stay stable. DX (diagnosis) - major depressive disorder recurrent. Date Initiated: 10/17/2023."
"Health Monitoring: V/S (vitals/signs/symptoms) and health will remain stable."
"Mobility: Mobility to remain stable. DX - osteoarthritis, chronic pain, spinal stenosis. No concerns at this time. Continue to monitor and update RN / MD / hospice / family of any mobility concerns. Date Initiated: 10/17/2023. Revision on: 01/24/2024."
"Safety: To remain safe. Call light within reach at all times while in room. CBRF door alarmed, delayed egress doors on facility exits. Keep apartment clean and tidy. Nonskid footwear to be worn for all transfers. Date Initiated: 10/17/2023. Revision on: 01/24/2024."
"Falls: To remain free from falls. Bed and Chair alarms on at all times. High Fall Risk. DON (Director of Nursing) to complete Fall Risk Assessment on admission, annually, and with COC (change of condition). Date Initiated: 10/17/2023. Revision on 01/24/2024. Date Initiated: 01/24/2024." (Surveyor was unable to determine what revisions had been initiated on 01/24/2024.)
The ISP did not document any guidelines regarding sleep or assistive devices.

Resident 1's Incident Reports documented:
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[him/her]. [S/he] had [his/her] eyes closed and not responding to me calling [his/her] name. We got [him/her] in [his/her] wheelchair and [s/he] woke up." Prepared by Caregiver E.
12/14/2023 - Fall unwitnessed - Bedroom. "By 8:30 AM I walk to [his/her] room to do [his/her] medication and I saw [him/her] right next to [his/her] bed on the floor." Prepared by Lead Caregiver C.
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01/28/2024 - Fall unwitnessed - Bedroom. "Staff went to check on resident after they stated they were not feeling well. When staff entered [his/her] apartment they could see that the resident was on the floor crawling on [his/her] hands and knees." Prepared by Caregiver B.

Resident 1's fall risk assessment, dated 10/16/2023, day before admission, documented: "What ambulatory aids if any, does the resident use? None/bedrest/wheelchair/nurse assist" "Gait - Impaired - Difficulty rising from chair, uses chair arms to get up, bounces to rise; Keeps head down when walking, watches the ground; grasps furniture, person or aid when ambulating. Cannot walk unassisted."
"Mental Status - Overestimates or forgets limits."

On 02/06/2024, at approximately 12:30 PM,

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N 381	Continued From page 7 Surveyor interviewed Caregiver B and Caregiver D. Caregiver B and Caregiver D stated that Resident 1 did not have any strength in his/her legs, so when s/he attempted to stand/ambulate on his/her own, s/he would fall. On 02/06/2024, at approximately 12:40 PM, Surveyor interviewed Resident 1's Family Member F. Family Member F stated Resident 1 did not have any muscle strength in his/her legs which is why s/he was a fall risk. On 02/06/2024, at approximately 4:00 PM, Surveyor interviewed Executive Director A. Executive Director A stated s/he was unable to locate a bed rail assessment. Executive Director A reviewed hospice documentation as they ordered Resident 1's hospital bed to determine if hospice had completed a bed rail assessment; documentation could not be located. Executive Director A and Surveyor reviewed Resident 1's ISP which documented that a fall assessment had been completed upon admission, 10/17/2023, but had not been updated after Resident 1 experienced six falls since admission. Executive Director A stated s/he was unable to locate additional fall risk assessments and would review the request with the nurse when s/he was back in the office. On 02/12/2024 at 12:01 PM, Executive Director A emailed Surveyor the 10/16/2023 fall risk assessment; there were no additional assessments. According to the U.S. Food & Drug Administration's Hospital Bed Safety Workgroup, "...Strangling, suffocating, bodily injury, or death can occur when patients or parts of their bodies are caught between rails or between the bed rails	N 381		

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N 381	Continued From page 8 and mattresses...Regardless of the purpose for which bed rails are being used or considered, a decision to utilize or remove those in current use should occur within the framework of an individual patient assessment...3. Use of bed rails should be based on patients' assessed medical needs and should be documented clearly...Bed rail effectiveness should be reviewed on a regular basis...The patient's chart should include a risk-benefit assessment that identifies why other care interventions are not appropriate or not effective if they were previously attempted and determined not to be the treatment of choice for the patient. 4. Bed rail use for treatment of a medical symptom or condition should be accompanied by a care plan (treatment program) designed for that symptom or condition. The plan should present clear directions for further investigation of less restrictive care interventions. The documentation should describe the attempts to use less restrictive care interventions and, if indicated, their failure to meet patients' assessed needs...The care plan should: include educating the patient about possible bed rail danger to enable the patient to make an informed decision; and address options for reducing the risks of the rail use..." (Source: "Clinical Guidance For the Assessment and Implementation of Bed Rails In Hospitals, Long Term Care Facilities, and Home Care Settings" https://www.fda.gov/media/88765/download (retrieval date 02/10/2024).)	N 381		