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 _____	R-C 06/05/2024

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

(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
{N 000}	Initial Comments On 05/29/2024, with information gathered through 06/05/2024, Surveyor conducted a verification visit and a complaint investigation at The Legacy of Deforest. Two deficiencies were identified. Complaint was substantiated. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census: 21	{N 000}		
N 169	83.12(5)(a) Notification: incident, injury, changes. The CBRF shall immediately notify the resident's legal representative and the resident's physician when there is an incident or injury to the resident or a significant change in the resident's physical or mental condition. This Rule is not met as evidenced by: Based on record review and interview, the provider did not immediately notify 1 of 1 resident (Resident 1's) resident representative when s/he suffered an unwitnessed fall which resulted in a fractured rib, clavicle, and hip. Findings include: On 04/25/2024, the Department received a concern that resident representative was not contacted when resident sustained a fall requiring transport to a hospital.	N 169		

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
	0017768	A. BUILDING: _____ B. WING _____	R-C 06/05/2024

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

(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
N 169	Continued From page 1 On 05/29/2024, Surveyor reviewed Resident 2's record. Resident 2 was admitted to the facility, 05/25/2021, with diagnoses including dementia, psychotic disturbance, mood disturbance, anxiety, and osteoporosis. Resident 2's "Progress Notes" documented: "03/26/2024 - On 03/21 at 6:45 AM staff heard a grunting noise and thud come from across the hallway. Staff found [Resident 2] on the floor lying on [his/her] right side between [his/her] chair and [his/her] bed facing the window. Staff went and got another staff member, who immediately called 911. [Resident 2] had c/o (complaints of) pain to [his/her] head, left shoulder, and upper left leg, [Resident 2] was not moved by staff. After calling 911 staff noted that [Resident 2] is enrolled in hospice. EMS (emergency medical service) assisted [Resident 2] up off the floor and assisted [him/her] to [his/her] recliner. At 9 AM hospice RN (registered nurse) arrived at the facility for [his/her] evaluation following the fall. At 11:00 AM after speaking with [Resident 2's] activated POA (power of attorney), Hospice RN decided that [s/he] should be sent to the ER (emergency room) for evaluation. ... was admitted to the [hospital] for left intertrochanteric hip fx (fracture), left distal clavicle fx, and fx at left fist costochondral junction." Resident 2's Guardian G was not informed that Resident 2 had suffered a significant fall for approximately 4 hours. On 05/29/2024, Surveyor reviewed supporting documentation that was submitted with the Department concern which documented:	N 169		

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 _____	R-C 06/05/2024

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

(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
N 169	Continued From page 2 Email on 03/28/2024 from Guardian G to Executive Director A, Hospice Nurse H, Hospice Social Worker I, managed care organization (MCO) Care Manager (CM) J, and provider's Vice President of Healthcare K: "My only concern at this point is the lack of communication through appropriate channels. [Resident 2] fell and broke [his/her] clavicle, a rib and suffered an intertrochanteric hip fracture. I received calls from two nurses from [Hospice] last Thursday. I notified [CM J]. [CM J] reached out to provider. [Healthcare Coordinator L] responded to [CM J] request for information with the attached email. At no point did anyone from [provider] call or email me about what happened. Was my notification supposed to be the [Hospice] phone call?" Vice President of Healthcare K responded, "I apologize for this. Staff should have called you immediately to update you. We have already addressed this with staff. When [Hospice] got to the facility that day, the RN (registered nurse) told staff that they were going to contact you, so they didn't at that time. We will continue to educate staff on proper notification." The attached email documented referenced in above statement documented: Healthcare Coordinator L emailed CM J and MCO RN M on 03/21/2024 at 4:41 PM - Update on [Resident 2], [s/he] had an unwitnessed fall this morning around 7AM. Staff stated it looked like [Resident 2] tried to stand up from sitting in [his/her] recliner and lost [his/her] balance and fell. [S/he] was admitted to the [hospital]. I just received an update from the Nurse I and [s/he] has a fractured rib, fractured clavicle and fractured hip." On 05/29/2024, Surveyor reviewed Resident 2's MCO documentation that had been requested by the organization prior to the start of survey. The documentation stated:	N 169		

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 _____	R-C 06/05/2024

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

(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
N 169	Continued From page 3 "03/21/2024 at 1:00 PM: Social Services Progress Note: Discussion with [Guardian G] stating member fell this morning while transferring from [his/her] chair. [S/he] stated [s/he] was notified by [hospice]. [S/he] stated member went to the [hospital] due to fractured rib, clavical [sic] and hip. ... Discussion with [Executive Director A] stating member did in fact fall. [S/he] stated [s/he] has been in meetings all day and will get further details from [Healthcare Coordinator L] about what occurred. ... Discussion with hospice [SW I]. [SW I] confirmed member had a fall and ended up going to the [hospital]." On 06/05/2024, at approximately 9:25 AM, Surveyor interviewed Chief Operating Officer N. Chief Operating Officer N stated s/he would follow up with staff on when a resident's care team should be contacted.	N 169		
N 431	83.38(1)(g) Health monitoring. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident ' s highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Health monitoring. 1. The CBRF shall monitor the health of residents and make arrangements for physical health, oral health or mental health services unless otherwise arranged for by the resident. Each resident shall have an annual physical health examination completed by a physician or an advanced practice nurse as defined in s. N 8.02(1), unless seen by a physician or an advanced practice nurse as defined in s. N	N 431		

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 _____	R-C 06/05/2024

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

(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
N 431	Continued From page 4 8.02(1) more frequently. 2. When indicated, a CBRF shall observe residents ' food and fluid intake and acceptance of diet. The CBRF shall report significant deviations from normal food and fluid intake patterns to the resident ' s physician or dietician. 3. The CBRF shall document communication with the resident ' s physician and other health care providers, and shall record any changes in the resident ' s health or mental health status in the resident ' s record. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure changes in 1 of 1 resident's (Resident 2) health was communicated to the nursing staff when s/he was experiencing black bowel movements which could be a symptom of internal bleeding. Findings include: On 04/25/2024, the Department received a concern alleging resident's were not being monitored after returning from hospitalization. On 05/29/2024, Surveyor reviewed Resident 2's record. Resident 2 was admitted to the facility, 05/25/2021, with diagnoses including dementia, psychotic disturbance, mood disturbance, anxiety, and osteoporosis.	N 431		

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 _____	R-C 06/05/2024

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

(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
N 431	Continued From page 5 Resident 2's "Progress Notes" documented: "03/26/2024 - On 03/21 at 6:45 AM staff heard a grunting noise and thud come from across the hallway. Staff found [Resident 2] on the floor lying on [his/her] right side between [his/her] chair and [his/her] bed facing the window. Staff went and got another staff member, who immediately called 911. [Resident 2] had c/o (complaints of) pain to [his/her] head, left shoulder, and upper left leg, [Resident 2] was not moved by staff. After calling 911 staff noted that [Resident 2] is enrolled in hospice. EMS (emergency medical service) assisted [Resident 2] up off the floor and assisted [him/her] to [his/her] recliner. At 9 AM hospice RN (registered nurse) arrived at the facility for [his/her] evaluation following the fall. At 11:00 AM after speaking with [Resident 2's] activated POA (power of attorney), Hospice RN decided that [s/he] should be sent to the ER (emergency room) for evaluation. ... was admitted to the [hospital] for left intertrochanteric hip fx (fracture), left distal clavicle fx, and fx at left first costochondral junction." Resident 2's Individual Service Plan (ISP), dated and signed 04/04/2024 by Vice President of Healthcare, documented: "Bowel: Assist with incontinent care. 2 assist for incontinence care every 2 hours. No concerns at this time. Will continue to monitor and update RN/hospice/family with any bowel concerns. Document all bowel movements." Resident 2's Bowel Movement (BM) chart, was placed in his/her room by hospice for staff to track his/her BM's documented: 03/28/2024 (date s/he returned from the hospital after hip surgery) - Large, soft 2x's (times) with the word 'Black' written on with a different colored	N 431		

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 _____	R-C 06/05/2024

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

(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
N 431	Continued From page 6	N 431		

pen.
04/07/2024 - Large, loose - 9 days of no documented BMs
04/08/2024 - Med (medium)
04/09/2024 - Small
04/10/2024 - Small, soft with the word 'Black' written on with a different colored pen.
04/16/2024 - Medium, loose - 5 days of no documented BMs
04/20/2024 - Medium, soft x 2 and small, runny, black - 3 days of no documented BMs
04/21/2024 - Small, runny
04/22/2204 - Black soft
No additional tracking until his/her discharge on 04/26/2024.

Resident 2's "Progress Notes," dated 03/29/2024 to 04/29/2024, did not document any observations of BMs.

On 05/29/2024, Surveyor reviewed the provider's internal documentation regarding Resident 2's black bowel movements which documented: "04/25/2024 - On Tuesday April 23 [Hospice Nurse H] for [Resident 2] stated in a update to [Guardian G] that our staff had just reported to [Hospice Nurse H] that since [Resident 2] had been back from the hospital [s/he] was having black stool. ... I spoke to several caregivers ... I asked staff if they had reported anything to [Vice President of Healthcare K] or Health Care Coordinator [Healthcare Coordinator L] and they said no because they thought that [Hospice Nurse H] would have reported it to our nurse and Health Care Coordinator. ... Verbal warnings were given ..."

On 06/03/2024, Surveyor reviewed Resident 2's hospice documentation that had been requested by the organization prior to the start of survey.

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 _____	R-C 06/05/2024

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

(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
N 431	Continued From page 7	N 431		

The documentation stated:
04/23/2024 - Comprehensive assessment and plan of care review performed. ... Writer reviewed patient's LBM (log of bowel movement) and staff wrote down on 04/22 patient had a black soft stool. Writer asked [Caregiver O] if stool was really black and [s/he] stated that it was black and states it has been tarry ever since patient had returned back from the hospital. Staff had not updated writer about this.

On 06/03/2024, Surveyor reviewed supporting documentation that had been submitted with the Department concern. The documentation stated: Email from Hospice Nurse H to Guardian G, managed care organization (MCO) Care Manager J, Executive Director A, and Hospice Social Worker I on 04/23/2024 stated: " ... Staff also reported to me that ever since [Resident 2] got back to the [provider] after the hospital [s/he] has been having black stools, which is concerning that [s/he] may be bleeding somewhere in [his/her] abdomen. I have not been able to see [his/her] stool since [s/he] got back from the hospital. I will contact the [hospital administration] right away tomorrow morning to update them on [Resident 2] and see what [doctor name] thoughts are.

On 06/05/2024, at approximately 9:25 AM, Surveyor interviewed Chief Operating Officer (COO) N. COO N stated that s/he would have expected staff to inform the provider's nursing staff if they observed a resident having black stools; not just report it to a hospice staff member. COO N asked to review possible electronic documentation where staff may have recorded notes about Resident 2's bowel movements.

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 _____	R-C 06/05/2024

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

(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
N 431	Continued From page 8 On 06/05/2024 at 12:01 PM, COO N emailed Surveyor and stated, "I was able to pull the caregiver alert listing I was talking about that is available in PCC (electronic software); staff did not utilize this method to chart any details related to [Resident 2]. They were only utilizing the bowel charting in the ADL/Task sheet to document [his/her] bowels as well as the BM sheet which both you already have."	N 431		