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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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N 000	Initial Comments On 12/07/2023, with information gathered through 01/16/2024, the Bureau of Assisted Living, Southern Regional Office conducted 3 complaint investigations at Oak Hill Terrace located at 1805 Kensington Drive in Waukesha, WI. One citation of noncompliance was issued. Two complaints were substantiated, 1 complaint was unsubstantiated. Census: 100	N 000		
N 358	83.32(3)(n) Rights of Residents: Safe environment In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Safe environment. Live in a safe environment. The CBRF shall safeguard residents from environmental hazards to which it is likely the residents will be exposed, including both conditions that are hazardous to anyone and conditions that are hazardous to the resident because of the residents ' conditions or disabilities. This Rule is not met as evidenced by: Based on observation, interview, and record review, the provider did not safeguard Resident 1 from an environmental hazard resulting in significant injury. Resident 1 sustained significant burns, including third degree burns, to Resident 1's lower extremities following an incident involving a wall heater located within close proximity of Resident 1's bed. Resident 1 had diagnoses including dementia, sleep disorders, and osteoarthritis and resided within the facility's designated memory care unit.	N 358		

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

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N 358	Continued From page 1 Resident 1 experienced increased confusion, an increase in falls, including falls from Resident 1's bed, an increased need for physical assistance with transfers, and assistance with incontinence care prior to the night of 11/24/2023 leading into the early morning hours of 11/25/2023. One caregiver, Caregiver G, was on duty on the memory care unit during the night of 11/24/2023 and the early morning hours of 11/25/2023. On 11/25/2023 at 4:15 A.M., during Caregiver G's night shift care rounds, Caregiver G observed Resident 1's lower body positioned off the side of Resident 1's bed nearest Resident 1's rooms wall heater. Caregiver G left Resident 1's room to seek assistance from Lead Caregiver H without repositioning Resident 1's body or fully observing the position of Resident 1's lower body. Caregiver G did not receive response to his/her calls for help utilizing the walkie-talkie provided to Caregiver G at the beginning of his/her shift. Caregiver G left the memory care unit to find Lead Caregiver H on the first floor of the facility before both caregivers returned to Resident 1's room. Caregiver G and Lead Caregiver H repositioned Resident 1's lower body on to the bed and Caregiver G observed a significant burn to Resident 1's right lower extremity. Lead Caregiver H allegedly left the room to contact 911 and the facility's on-call nurse while Caregiver G assisted Resident 1 to get dressed in bed. A call from the facility to 911 was documented on 11/25/2023 at 4:41 A.M. with a non-emergent ambulance arriving at the facility at 4:56 A.M. During the EMTs [emergency medical technician's] response to the facility, no staff were available to provide report on Resident 1's condition nor report on an incident to explain Resident 1's injuries. No caregivers were available in Resident 1's room during the EMTs assessment and mobile transfer of Resident 1.	N 358		

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The non-emergent ambulance EMT M called for an emergent ambulance crew to respond to the facility to transport Resident 1 to a local hospital burn center related to the significance of Resident 1's burn injuries and pain management. Resident 1 was hospitalized at a local hospital burn center's intensive care unit from 11/25/2023 through 12/06/2023 receiving intravenous fluids and medications, x-rays, pain medication administration and management, laboratory tests, enteral nutrition [tube feeding], and wound dressings in treatment of significant burns to Resident 1's lower extremities and an acute urinary tract infection. On 12/06/2023, Resident 1 was admitted to a long-term acute care hospital and continued to receive treatment to burn wounds and nutrition via tube feeding. On 12/14/2023, Resident 1 was admitted to an inpatient hospice facility until Resident 1's death on 12/16/2023.

The findings are:

On 11/28/2023 and 12/04/2023, the department received complaints alleging Resident 1 sustained significant burns to Resident 1's lower extremities at the facility.

On 11/28/2023 at 3:45 P.M., Administrator A sent a fax including a self-report dated 11/27/2023 to the department. The documentation included date of incident "11/25/2023 [Saturday]" and time of incident "4:15 A.M." Documentation of the "incident description" included, "Upon rounding [Caregiver G] observed [Resident 1] laying on [his/her] side. [Resident 1's] torso was on the bed with one of [his/her] legs hanging off to one side of bed. [Caregiver G] called lead med [medication] passer [Lead Caregiver H] for assistance. Both staff members assisted

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N 358	Continued From page 3 [Resident 1] to a more comfortable position in bed. Upon evaluation, [Resident 1] sustained burn to right lower extremity from the baseboard [wall] heater. 911 called for transport to hospital." Documentation of the "incident outcome" included, "[Resident 1] was admitted to hospital for burn to right leg." Documentation of the "action taken to ensure resident's health, safety, and well being" included, "911 was called for transport to hospital. PCP [primary care physician] notified. AHCPOA [activated healthcare power of attorney/[Resident 1's Legal Representative F] notified. MCO [managed care organization] case manager notified. ED [executive director/Administrator A] and HSD [Health Services Director/Registered Nurse (RN) B] notified. Room audit completed for compliance of bed arrangement. ISP [individual service plan] will be updated when [Resident 1] returns." Documentation of "additional information" included, "[Resident 1] resides in memory care. [Resident 1] is independent with bed mobility. [Resident 1] uses call pendant appropriately. Pendant was not activated at time of incident." On 12/07/2023 at 9:30 A.M., Resident Care Coordinator C and Surveyor toured the facility, including observation of two distinct sections of the facility. Resident Care Coordinator C told Surveyor floors 1 through 3 of the facility were considered the "general" care section of the facility, and the floor 1-A was considered the memory care specific unit of the facility called "Spring House." Resident Care Coordinator C and Surveyor utilized an elevator down to floor 1-A, located on a lower level of the facility. Resident Care Coordinator C told Surveyor the elevator opened to the memory care unit without key access, but a key was required to access the	N 358		

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elevator from the memory care unit.

On 12/07/2023 at 10:15 A.M., Surveyor reviewed a copy of the "room assignments report" received from Administrator B. The report included documentation of 24 current memory care unit residents, all of which were admitted prior to 11/25/2023.

On 12/07/2023 at 10:42 A.M., Surveyor conducted an interview with Caregiver E about Resident 1's needs and services including observations of Resident 1's bedroom. Caregiver E told Surveyor Resident 1 resided within the memory care unit located in the lower level of the facility. Caregiver E told Surveyor Resident 1 shared a room with Resident 2. Caregiver E told Surveyor Resident 1 was hospitalized approximately two weeks ago following a fall between Resident 1's bed and the heat register attached to the wall in Resident 1's bedroom. Caregiver E said Resident 1 sustained second to third degree burns to Resident 1's legs and had not returned to the facility.
Caregiver E told Surveyor Resident 1 required the assistance of two caregivers with pivot transfers related to recent weakness within the last few months. Caregiver E said Resident 1 experienced mild confusion and would attempt to get up without caregiver assistance and had experienced increased incidents of falls.
Surveyor observed Resident 1's bed located parallel in its entirety and approximately 2 feet from the wall including an electric heat register. Caregiver E told Surveyor Resident 1's bed had been located closer to the wall heater prior to Resident 1's incident. Caregiver E told Surveyor s/he thought Resident 1's bed had been located approximately 7 inches from the wall heater, but s/he could not be sure. Surveyor observed a

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thermostat on the opposite wall. Caregiver E told Surveyor the thermostat controlled the electric wall heater parallel to Resident 1's bed and was controlled by facility staff, including caregivers. (See photos #1, #2, #3, #4, and #5.)
Caregiver E told Surveyor Maintenance Director D checked all resident rooms in the facility to make sure none of the resident's beds were located near the wall heaters after Resident 1's incident.

On 12/07/2023 at 11:07 A.M., Surveyor conducted an interview with Caregiver I. Caregiver I told Surveyor Resident 1 did not fall out of bed or Resident 1's wheelchair "much" and required the assistance of 1 or 2 caregivers with pivot transfers. Caregiver I told Surveyor s/he thought the wall heaters located in resident rooms were part of the air conditioning system and did not realize they were heaters until after Resident 1 sustained burn injuries.

On 12/07/2023 at 1:30 P.M., Surveyor conducted an interview with Health Service Director/Registered Nurse (RN) B and Resident Care Coordinator C regarding Resident 1. Resident Care Coordinator C told Surveyor Resident 1 required the use of a wheelchair for mobility, required standby assistance from caregivers with transfers, and was able to reposition self while in bed. Resident Care Coordinator C said Resident 1 would attempt to transfer independently to do something or some task and was encouraged to ask caregivers for assistance. Resident Care Coordinator C told Surveyor Resident 1 did not use his/her call pendant frequently but knew how to use it to call for caregiver assistance. Resident Care Coordinator C said Resident 1 experienced an increase in confusion prior to the incident on

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N 358	Continued From page 6 11/25/2023 exhibited by beginning to ask for his/her parent. Resident Care Coordinator C told Surveyor Resident 1 experienced increased falls related to self-transfer attempts during the last 6 months prior to the incident on 11/25/2023. Resident Care Coordinator C told Surveyor staff, including caregivers, Resident 1, or Resident 2 could control the shared bedroom's wall heater by using the thermostat located on the room's wall. Resident Care Coordinator C said the caregivers working night shift start their shift with a care "round" to check on each resident and then conduct rounds every 2 to 3 hours thereafter during their shift. Resident Care Coordinator C told Surveyor the memory care unit, Spring House, would normally have 2 caregivers on duty during usual sleeping hours, or night shift, with a lead caregiver to float throughout the entire facility. RN B told Surveyor Lead Caregiver H should have been on the Spring House memory care unit to meet the emergency medical technicians on 11/25/2023 to provide them with a report, Resident 1's face sheet, including demographic information and contact information, practitioner's orders, and insurance information. RN B told Surveyor Lead Caregiver H called RN B on 11/25/2023 between 4:15 A.M. and 4:30 A.M. and reported a burn observed to Resident 1's leg and a called placed to 911. RN B told Surveyor Lead Caregiver H reported an observation of Resident 1's right leg hanging off the bed, but did not report Resident 1's leg was observed on the heater. RN B told Surveyor s/he did not document his/her phone conversation with Lead Caregiver H. RN B said s/he did not know exactly how close Resident 1's bed was to the wall heater, but said it was close enough for Resident 1's leg to make contact with the wall heater. RN B told Surveyor Resident 1's bed was closer to the wall heater on	N 358		

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11/25/2023 than it was on 12/07/2023.
Resident Care Coordinator C told Surveyor some time lapsed between making Resident 1 comfortable after observing Resident 1's leg burn and Lead Caregiver H calling 911 and RN B, but s/he did not know the amount of time that had lapsed.

On 12/07/2023, Surveyor reviewed Resident 1's facility record, as provided by Administrator A.
Resident 1 was admitted to the facility's memory care unit on 11/14/2022 with diagnoses including dementia, anxiety, central nervous system degenerative disease, generalized osteoarthritis, and sleep disorders including insomnia, sleep apnea, and narcolepsy.
Resident 1's ISP dated 09/28/2023 included, "[Resident 1] required stand by assistance when transferring through next review." Resident 1's ISP included Resident 1 was incontinent.
Resident 1's ISP included, "Staff to ensure room is tidy and clutter free through the next review" and "staff to make bed daily and PRN [as needed] through next review. Staff also to ensure mattress pad is on bed daily as well."
Resident 1's ISP did not address the distance of Resident 1's bed, chairs, or any furniture from his/her bedroom's wall heater.
Resident 1's caregiver documentation dated 10/08/2023 included an unwitnessed fall incident at 11:17 A.M. The documentation included, "[Charge Nurse J] was notified that [Resident 1] was on the floor. [Charge Nurse J] observed [Resident 1] sitting on the floor along side [his/her] bed @ [at] 10:30 A.M. [Resident 1] was soiled in urine/stool. [Resident 1] was bare foot [sic]."
Resident 1's caregiver documentation dated 10/17/2023 by Resident Care Coordinator C included an unwitnessed fall incident at 9:00 A.M.

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The documentation included, "[Resident 1] was observed on the floor next to [his/her] bed. [Resident 1] states [s/he] does not remember what [s/he] was doing prior to falling. [Resident 1's] bed was in disarray with sheets pulled off. [Resident 1] was barefoot as well."
Resident 1's caregiver documentation dated 11/03/2023 by Resident Care Coordinator C included an unwitnessed fall incident at 7:04 A.M. The documentation included, "[Resident 1] was observed on the floor next to [his/her] bed."
Resident 1's caregiver documentation dated 11/15/2023 by Resident Care Coordinator K included an unwitnessed fall incident at 7:05 P.M. The documentation included, "[Resident Care Coordinator K] was notified that [Resident 1] was on floor. When [Resident Care Coordinator K went to [his/her] room...upon asking [Resident 1] said [s/he] fell while reaching out to the bed."
Resident 1's caregiver documentation dated 11/25/2023 by RN B included, "Incident type: Injury. [Resident 1] observed between bed and wall, sustained a burn to [his/her] right lower extremity from heater. Incident location: [Resident 1's] bedroom. Day & Time of incident: 11/25/2023 4:15 A.M."
Resident 1's "care plan" utilized by caregivers included, "[Resident 1] is at moderate risk for falls...[06/21/2023] fall intervention: Night staff to complete toileting rounds on [Resident 1] to ensure [s/he] is safely returning back to bed after toileting. [07/14/2023] fall intervention: Final toileting rounds on NOC [night shift] for [Resident 1] should be close to 4 [A.M.]. [08/18/2023] fall, intervention: Assist [Resident 1] with transfers in and out of bed. [08/23/2023] fall, intervention, offer oral care after meals for [Resident 1]. [10/08/2023] fall, interventions: Staff to assist [Resident 1] for am [morning] care. [10/17/2023] fall intervention PT/OT [physical

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therapy/occupational therapy] to eval [evaluate] and treat. [11/03/2023] fall intervention: [Resident 1] to have a 'call don't fall' sign placed in room to remind [him/her] to use [his/her] pendant for assistance with transfers. Fall [11/15/2023] intervention staff to offer a snack before returning to [his/her] room." Resident 1's care plan included an intervention dated on day of Resident 1's incident, "[11/25/2023] ensure [Resident 1's] bed and any furniture is [sic] 18 inches away from heating element."

On 12/07/2023 at 2:30 P.M., Surveyor conducted an interview with Maintenance Director D. Maintenance Director D told Surveyor s/he was called in to the facility on 11/25/2023 by Administrator A regarding the incident involving Resident 1. Maintenance Director A told Surveyor s/he observed on 11/25/2023 Resident 1's bed had been moved closer to the wall heater than it should have been. Maintenance Director D said s/he did not know when Resident 1's bed was moved closer to the heater prior to the incident. Maintenance Director D said it had been a policy of the facility for many years to ensure all resident beds are checked to ensure they are at least 18 inches away from the wall heaters before the heat was turned on for the heating season. Maintenance Director B said s/he was certain Resident 1's bed had been checked for appropriate location away from the heater but Maintenance Director D did not have documentation of when this check was completed. Maintenance Director D said s/he did not check the temperature of the heater when s/he observed Resident 1's bed on 11/25/2023, s/he did not know the maximum temperature of the heater, and s/he was unaware of any issues with Resident 1's wall heater, including any manufacturer recalls of the heater.

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Maintenance Director D told Surveyor in response to this incident all resident rooms, including bed locations, were checked throughout the entire facility, all checks will be documented in the future, staff/caregiver education will include resident bed location and resident safety will be ensured, and educate family members not to move resident beds.

On 12/07/2023 at 4:15 P.M., Administrator A told Surveyor s/he was not aware of Resident 1's bed being moved closer to the wall heater prior to Resident 1 sustaining burn injuries to lower extremities. Administrator A told Surveyor s/he checked the on-call phone for calls received on 11/25/2023 by RN B. Administrator A said a call was received on the on-call phone from Lead Caregiver H at 4:47 A.M. Administrator A said s/he did not know why the documented time of 4:15 A.M. on 11/25/2023 was used as the time of the incident regarding Resident 1's burn injuries, but thought it was probably an approximate time.

On 12/07/2023 at 4:35 P.M., Administrator A gave Surveyor a documented note including "1/2 [halfway] between low and high" regarding the setting of Resident 1's and Resident 2's shared room heat thermostat at the time Resident 1's injuries were observed on 11/25/2023.

On 12/13/2023 at 8:33 A.M., Surveyor conducted an interview with Caregiver G about Resident 1's incident on 11/25/2023. Caregiver G told Surveyor there were normally 2 caregivers on duty during the night shift on the facility's memory care unit, Spring House, but s/he was the only caregiver working on the memory care unit during the entire night shift between 10:15 P.M. on 11/24/2023 and 6:15 A.M. on 11/25/2023. Caregiver G told Surveyor that was the first time

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s/he had worked alone during the night shift on the memory care unit. Caregiver G told Surveyor there was a lot to do during the shift with checking on residents with fall risks, making sure they were safe in addition to their cares.
Caregiver G said the night shift routine was to check on each resident and assist, if needed, every two hours. Caregiver G said s/he started these care rounds after s/he arrived on duty at 10:15 P.M. on 11/24/2023 and then repeated the rounds approximately every two hours. Caregiver G said it took him/her longer to complete the care rounds during that night shift because s/he was the only caregiver on duty on the unit. Caregiver G said Resident 1 required a check and change of his/her incontinent brief during night shift rounds related to incontinence. Caregiver G said s/he never saw Resident 1 attempt to exit his/her bed without assistance before 11/25/2023, but assumed all residents on the memory care unit were at risk for falls.
Caregiver G told Surveyor s/he started care rounds at 4:00 A.M. on 11/25/2023 and entered Resident 1's room at approximately 4:15 A.M. Caregiver G said Resident 1 was in his/her bed without any issues all night until 4:15 A.M. Caregiver G said s/he observed Resident 1's upper half of body on his/her bed and lower half of body was off his/her bed on the heater side of Resident 1's bed when Caregiver G walked into the room. Caregiver G said s/he just saw half of Resident 1's body off the bed and knew Caregiver G needed help so s/he left Resident 1's room to call for assistance using the walkie-talkie Lead Caregiver H had given Caregiver G at the beginning of Caregiver G's shift. Caregiver G said s/he did not attempt to reposition Resident 1 back on the bed at that time and s/he did not know or see Resident 1's legs on the wall heater. Caregiver G told Surveyor s/he did not think

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about the wall heater at that time or that Resident 1's legs could be touching the heater. Caregiver G said no one responded to his/her initial walkie-talkie call and s/he used the walkie-talkie to call for assistance a few more times without a response. Caregiver G told Surveyor s/he was not told and did not know until after Resident 1's incident on 11/25/2023 s/he could have called zero on the kitchen phone to contact Lead Caregiver H at the front desk (located on the first floor of the facility). Caregiver G told Surveyor s/he was told after the incident Lead Caregiver H did not have a walkie-talkie available that night. Caregiver G said s/he assumed s/he was supposed to use the walkie-talkie since Lead Caregiver H gave it to Caregiver G at the beginning of the night shift. Caregiver G said s/he left the memory care unit to look for Lead Caregiver H when no one responded to his/her walkie-talkie calls and found Lead Caregiver H on the first floor in the facility's main office. Caregiver G told Surveyor s/he went back to the memory care unit right away with Lead Caregiver H. Caregiver G said she did not know how much time lapsed between his/her first walkie-talkie call before finding Lead Caregiver H and returning to Resident 1, but believed it was 5 minutes. Caregiver G said Resident 1 remained half on and off the bed on the side near the heater when s/he returned to Resident 1 with Lead Caregiver H. Caregiver G told Surveyor s/he and Lead Caregiver H repositioned Resident 1 fully on to the bed and Caregiver G noticed Resident 1 had a burn on the lower part of Resident 1's leg between the knee and the ankle. Caregiver G said s/he believed s/he observed Resident 1's leg on the heater before s/he and Lead Caregiver H repositioned him/her on the bed, it all happened so fast. Caregiver G said Resident 1 had a look of surprise on his/her face when Lead Caregiver

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N 358	Continued From page 13 H and Caregiver G repositioned Resident 1 on to the bed. Caregiver G told Surveyor Resident 1's room did not feel hot but s/he could feel heat coming out of the wall heater near Resident 1's bed. Caregiver G said s/he did not check the thermostat in Resident 1's bedroom. Caregiver G said Lead Caregiver H told Caregiver G s/he was going to call 911 and the on-call nurse. Caregiver G told Surveyor s/he did not make any calls related to Resident 1's incident and injuries. Caregiver G told Surveyor s/he assisted Resident 1 with getting dressed in bed before the EMTs [emergency medical technicians] arrived. Caregiver G told Surveyor s/he was not in Resident 1's room when the EMTs arrived and did not know when the EMTs arrived. Caregiver G told Surveyor s/he was located in the television area near the elevator when s/he saw the EMTs and accessed the elevator for the EMTs to leave. Caregiver G told Surveyor the only communication s/he had with the EMTs was the EMTs asking him/her to let facility management know Resident 1's room would need to be rearranged and Resident 1's bed should be moved away from the wall heater. Caregiver G told Surveyor s/he thought Lead Caregiver H spoke with the EMTs and provided the EMTs with Resident 1's information, but s/he did not know for sure. Caregiver G told Surveyor s/he did not complete any documentation about Resident 1's incident. Between 12/13/2023 and 01/16/2024, Surveyor attempted to contact Lead Caregiver H, including leaving a voicemail with Lead Caregiver H to contact Surveyor and contacting Administrator A with requests to encourage Lead Caregiver H to contact Surveyor without a response from Lead Caregiver H.	N 358		

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N 358	Continued From page 14 On 12/04/2023, Surveyor received Resident 1's ambulance documentation dated 11/25/2023 from EMS [emergency medical services] Compliance Coordinator L. Resident 1's ambulance documentation included ambulance #422 was dispatched to the facility on 11/25/2023 at 4:43 A.M. following a call received on 11/25/2023 at 4:41 A.M. The documented "nature of call" included, "Burns." The documentation included ambulance #422 arrived at the facility at 4:56 A.M. The documentation included, "[Ambulance] #422 arrived to scene w/o [without] delay or incident...crew [including EMT M] proceeded into memory care unit [Resident 1's room], crew was not greeted by overseeing staff..." The documentation included, "[Resident 1's] bed layout was horizontal and parallel to baseboard heater in room with a 6 inch pocket the length of bed for [Resident 1] to be wedged between bed and baseboard heater. [Resident 1] was found lying supine in bed, pants pulled down and bunched at left leg, one sock on. [Resident 1] was trembling and shivering and presented with right leg, 4.5 %, partial thickness burn including reddening, charring, blistering and skin peeling, crew requested ALS [advanced life support (a second ambulance #481)] to respond lights and sirens for pain management and establish I.V. [intravenous] and fluids. Crew obtained baseline vitals and recorded. [Resident 1] was soiled...extricated [Resident 1] to cot..." The documentation included, "Crew was greeted by ALS [second ambulance #481 crew] on main floor, gave report to crew. ALS agreed to continue call by ALS, move [Resident 1] to ALS cot and transfer [Resident 1] to [hospital/burn facility]." Resident 1's ambulance documentation included ambulance #481 arrived at the facility on 11/25/2023 at 5:11 A.M. related to Resident 1's	N 358		

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N 358	Continued From page 15 "Burns." The documentation included, "[Ambulance #481 crew] walks to elevator and find [ambulance #422 crew] with [Resident 1] on cot exiting [elevator]. #481 [crew] obtains report from #422 [crew]. #422 reports [Resident 1] was found laying in bed, no staff present. [EMT M] reports [Resident 1] AOX3 [alert and oriented times three (oriented to person, place, and time)] and has burns to lower right leg. [EMT M] then request (sic) ALS assistance." The documentation included, "[EMT M] reports staff did not give a report on events or injury or [Resident 1's] condition. [EMT M] located a baseboard heater directly next to [Resident 1's] bed. [EMT M] reports #422 [crew] ensured all clothes were away from [Resident 1's] burn..." The documentation included, "#481 did not get report from staff members. No staff member involved in [Resident 1's] care present upstairs entrance or that #481 could find to give report #481 report." The documentation included, "[Resident 1] reports 8/10 [8 out of 10 rating on pain scale, 10 indicating highest level] right leg pain. [Resident 1] reports feeling cold." The documentation included, "#481 visualized wound. #481 estimates approx [approximately] 5 % surface body area burns located on right shin [lower extremity], partial thickness burns with two areas of full thickness burns. The partial thickness burns were red in color, blistered with peeled skin. Full thickness burns were deep red in color [with] no blisters." The documentation included, "[Resident 1] is found tachycardic [elevated heart rate] and hypertensive [elevated blood pressure]...IV established with in right AC [antecubital, medial aspect of elbow, or crook of elbow]." The documentation included, "Once in ambulance [#481], [Resident 1] administered 50 mcg [micrograms] IV fentanyl [potent opioid pain medication]...(intravenous fluids administered)...	N 358		

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[Resident 1] reports decrease in pain to 7/10." The documentation included Resident 1 was transported to local hospital burn unit and received a second dose of fentanyl for "additional pain management" enroute.

On 12/14/2022 at 10:10 A.M., Surveyor conducted an interview with EMT M. EMT M told Surveyor s/he was part of ambulance #422 crew that responded to the facility on 11/25/2023 related to Resident 1's reported burn injury. Surveyor reviewed Resident 1's ambulance documentation dated 11/25/2023 with EMT M and EMT M verbally confirmed the document was accurate. EMT M told Surveyor ambulance #422 responded to a non-emergent call to the facility. EMT M told Surveyor no staff were observed on the memory care unit or communicated with EMTS, including in Resident 1's room, until the EMT crew needed access to the elevator to leave the unit with Resident 1. EMT M told Surveyor s/he entered Resident 1's room and observed Resident 1 laying on back with his/her face upward on bed, dressed as described in the ambulance documentation, and incontinent of urine. EMT M said Resident 1's body was shaking, s/he was tossing and turning, s/he was making groaning sounds, and Resident 1's facial expression was changing constantly, including grimacing. EMT M said s/he called for the second, advanced life support ambulance for transport to hospital burn center after observing Resident 1's burns. EMT M said a caregiver sitting in a chair near the memory care elevator "unlocked" the elevator so the EMTs could leave the memory care unit with Resident 1 on the cot. EMT M said that caregiver did not provide any documentation or report regarding Resident 1 to the EMT crew. EMT M said s/he told that caregiver Resident 1 was being transported to the

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hospital burn center and asked that caregiver to contact the facility's management about Resident 1's injuries as soon as possible. EMT M said nothing about Resident 1's room arrangement was discussed with any caregiver, including Caregiver G, at the facility. EMT M told Surveyor s/he had interactions with Lead Caregiver H at the facility during previous ambulance visits to the facility, but did not see nor interact with Lead Caregiver H during this visit to the facility on 11/25/2023. EMT M told Surveyor the ambulance crew did not receive any report regarding Resident 1 during their time in the facility, including how Resident 1 may have received lower extremity burns. EMT M said s/he could only describe what s/he observed in Resident 1's room and thought Resident 1 probably burned lower extremity on base board heater on wall approximately 6 inches away from Resident 1's bed. EMT M said s/he did not know and was not told how Resident 1 got into bed nor how s/he got dressed that morning. EMT M said ambulance #422 crew met ambulance #481 crew on the first floor of the facility immediately upon exiting the elevator and transferred Resident 1 to ambulance #481's cot for ambulance transport to the hospital burn center.

On 01/02/2024, Surveyor received Resident 1's hospital record. Resident 1's emergency department documentation dated 11/25/2023 included, "Arrival mode: Ambulance. Chief complaint: Burn ([Resident 1] arrived via ambulance from the memory care unit at [provider facility] for a burn to the R [right] lower extremity and L [left] lower ankle. Per [provider] facility report [Resident 1] fell asleep against a heater next to the bed. [Resident 1] received 50 mcg [micrograms] of fentanyl [an opioid medication to treat severe pain] prior to arrival

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from EMS [emergency medical services]). History of present illness: [Resident 1] with a history of depression, hypertension [elevated blood pressure], and dementia presents to ER [emergency room] from local nursing facility. Was reportedly found down next to a heater near [his/her] bed at the nursing facility. Unclear of the circumstances as to how [Resident 1] got there. [Resident 1] is unable to communicate this currently but complains of pain to [his/her] right lower extremity. Was giving 50 [mcgs] of fentanyl in route. Still complaining of pain. [Resident 1 knows that [s/he] is at the hospital, however is unclear as to how [s/he] sustained the burns to [his/her] lower legs. Report primarily gotten from nursing staff and EMS." The documentation included, "[Resident 1] appears anxious and shaky." and "1. Degloving [separation, or peeling away of skin layers] of skin noted to right lower extremity. [Resident 1] has evidence of dark eschar [dead skin tissue] skin injury noted to lateral [outer side] portion of right lower leg. The burn area is mostly anterior [nearer the front] in nature...2. Partial-thickness injury with some blistering noted to left lower ankle and leg area." The documentation included, "Clinical impressions: 3rd degree burn of leg, right, initial encounter. Partial thickness burn of left lower leg, initial encounter. Acute UTI [urinary tract infection]." The documentation included, "[Resident 1] required complex management while in the emergency room [including intravenous "fluid rehydration", x-rays, pain medication administration of morphine and Dilaudid (opioid medications to treat moderate to severe pain), laboratory tests]" and "Will admit [Resident 1] to burn ICU [intensive care unit] given significant right lower extremity injury." Resident 1's hospital documentation included Resident 1 was admitted to the burn ICU on

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N 358	Continued From page 19 11/25/2023 and discharged on 12/06/2023 to a long-term acute care hospital. Resident 1's burn ICU documentation included, "[Resident 1] was admitted with 4.5% mostly full thickness burn to [his/her] bilateral legs and L [left] foot. After discussion with [Resident 1's] Legal Representative F] plan was to provide supportive cares with weekly burn dressing changes. Surgical interventions were not recommended d/t [due to] [Resident 1's] advanced dementia and poor baseline nutritional intake. Palliative care was consulted during [Resident 1's] inpatient stay. At discharge continue qweekly [every week]...dressing changes to burns on bilateral legs. Cellulitis [bacterial skin infection] of R [right] leg, treated with IV [intravenous] Ancef [antibiotic medication] and is resolving. Advanced care planning: Palliative care following. [Palliative care team] discussed with [Legal Representative F] that [s/he] could request a palliative care consult at [long-term acute care hospital] to continue GOC [goals of care] discussions pending clinical course including if [Resident 1's] wounds heal poorly and oral intake remains inadequate." The documentation included, "Inadequate oral intake prior to admission. NG [nasogastic tube] for enteral nutrition [tube feeding] while inpatient. Speech therapy also following. On minced, bite sized solids and thin liquids. Will consume Ensure [nutritional supplement]. Acute E. [Escherichia] Coli [bacteria] UTI [urinary tract infection] - treated with IV Rocephin [antibiotic medication]." On 01/03/2023 at 9:58 A.M., Surveyor conducted an interview with Resident 1's Legal Representative F. Legal Representative F told Surveyor Resident 1 was an inpatient at a long-term acute care hospital from 12/06/2023 until being discharged to an inpatient hospice	N 358		

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N 358	Continued From page 20 facility on 12/14/2023. Legal Representative F said Resident 1 continued to receive treatment to burn wounds and nutrition via tube feeding. Legal Representative F said Resident 1 died at the inpatient hospice facility on 12/16/2023. On 01/03/2024 at 11:26 A.M., Surveyor received a copy of the Resident 1's death certificate from Resident 1's Legal Representative F. Resident 1's death certificate, issued 12/21/2023, included, "The manner of [Resident 1's] death" as "accident." The documentation included, "The conditions listed are the diseases, injuries or complications that caused death. Conditions leading to the immediate cause are listed sequentially and the underlying cause is listed last. Immediate Cause (a) Complications of thermal injuries to bilateral lower extremities." The documentation included Resident 1's death was pronounced at a hospice care facility on 12/16/2023. Summary: The provider did not safeguard Resident 1 from an environmental hazard resulting in significant injury.	N 358		