STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0012820	A. BUILDING: _____ B. WING _____	R-C 12/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE ASSISTED LIVING	1320 WISCONSIN ST HUDSON, WI 54016

(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 12/20/2023, Surveyor conducted a complaint investigation and verification visit at Pine Ridge Assisted Living. Data was collected through 12/21/2023. The complaint was substantiated. Three violations were identified. One of 3 violations was a repeat deficiency. See Statement of Deficiency (SOD) 7XN411, dated 11/22/2019. Census: 39	{N 000}		
N 388	83.35(3)(c) Implement, follow the individual service plan Implementation. The CBRF shall implement and follow the individual service plan as written. This Rule is not met as evidenced by: Based on interview and record review, the provider did not ensure Resident 1's individual service plan (ISP) was implemented as written. This is a repeat deficiency. See Statement of Deficiency (SOD) 7XN411, dated 11/22/2019. Findings include: On 11/10/2023, the Department received a complaint related to resident care and services. On 12/20/2023 at approximately 12:45 PM, Surveyor interviewed Director A. Director A shared recent concerns that were brought to his/her attention regarding resident care. Director A stated Resident 1's family contracted with a 3rd party personal care worker (PCW) to provide Resident 1 with additional one-on-one time and	N 388		

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

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N 388	Continued From page 1 Resident 1's PCW voiced concerns to Director A. Director A held a care conference on 11/29/2023. Surveyor reviewed the notes from the 11/29/2023 care conference, which included a statement about staff not providing services when the PCW was present. Surveyor asked Director A about the statement and Director A said it was true. Director A said staff were relying on the PCW to provide services to Resident 1. Director A stated s/he re-educated staff on their responsibility to provide services to Resident 1 at all times. At approximately 12:50 PM, Surveyor interviewed Nurse Manager (NM) B. NM B stated Resident 1 had a long-term PCW that enjoyed providing cares to Resident 1. NM B said facility staff became accustomed to this and stopped performing those tasks when Resident 1's contracted caregivers were on site. Surveyor reviewed Resident 1's ISP (updated 08/10/2023). The ISP indicated staff were responsible for assisting Resident 1 with dressing, grooming, bathing, toileting, and encouraging participation in daily activities. At 6:55 PM, Surveyor interviewed Family Member (FM) C. FM C stated s/he visited the facility frequently and was involved in Resident 1's care. FM C said s/he was frustrated with Resident 1's care and believed staff were not following Resident 1's care plan. FM C stated s/he was alarmed one day when s/he overheard a facility staff member tell Resident 1's PCW, "When you're here, you are [Resident 1's] one-to-one, not us."	N 388		

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N 389	Continued From page 2	N 389		
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 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 observation, interview, and record review, the provider did not ensure Resident 1's individual service plan (ISP) was updated when Resident 1 had changes in service needs. Findings include: On 12/20/2023 at approximately 11:00 AM, Surveyor interviewed Caregiver E. Caregiver E identified Resident 1 as a hospice patient and fall risk. Caregiver E stated staff were provided a daily assignment sheet that included each resident's care needs. Surveyor reviewed Resident 1's daily assignment sheet, which indicated Resident 1 needed A1 (assist of 1) with dressing, bathing, transfers, and toileting, and Resident 1 required a modified diet	N 389		

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N 389	Continued From page 3 (soft & bite-sized) . The assignment sheet noted Resident 1 did not have a wheelchair and s/he ambulated via A1 and a 4-wheeled walker. At 11:42 AM, Surveyor observed Resident 1 seated in a Broda chair in the dining room. Resident 1 had an alarm attached to the back of his/her chair that was not on; the cord was dangling from the alarm and not attached to Resident 1. Surveyor reviewed Resident 1's record. Resident 1 was admitted on 07/19/2023. His/her ISP was dated 08/10/2023. The ISP indicated Resident 1 was able to transfer and ambulate independently with a walker and s/he was a high fall risk. The ISP did not include interventions to prevent falls or the need for a modified diet. Surveyor reviewed Resident 1's progress notes for dates 07/20/2023 through 12/20/2023. Notes indicated Resident 1 had 43 falls since admission. Neither the ISP or the staff daily assignment sheet included reference to Resident 1's hospice enrollment or Broda chair. At approximately 12:30 PM, Surveyor interviewed Nurse Manager (NM) B. NM B stated Resident 1 required cues and stand-by assistance with activities of daily living upon admission, and s/he had gradually declined due to his/her falls. Resident 1 was admitted to hospice services on 11/02/2023 per the family's request. NM B stated Resident 1's fall interventions included a floor alarm, clip alarm, repositioning, a fall mat next to his/her bed, one-to-one care with a 3rd party provider, and daily activity.	N 389		

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N 389	Continued From page 4 NM B stated Resident 1's ISP was last updated on 08/10/2023. NM B stated s/he thought ISPs needed to be updated annually. At approximately 12:45 PM, Surveyor interviewed Director A. Director A stated Resident 1 had a care conference on 11/29/2023 due to family's concerns about his/her care. Director A stated they addressed the family's concerns by adding additional cleaning and hygiene services for Resident 1. Director A provided a note s/he posted for staff after the meeting that included directions to assist Resident 1 with eating as needed and to provide adaptive utensils and cups at meals. At 12:55 PM, Surveyor observed Caregiver D provide care to Resident 1. Caregiver D propelled Resident 1 in his/her Broda chair to and from his/her room and transferred him/her to the toilet. Resident 1's alarm was not on/attached throughout the observation. Resident 1's room included a large mattress/fall mat, hospital bed lowered to the floor, and a motion alarm. At 1:16 PM, Surveyor interviewed Caregiver D. Caregiver D stated Resident 1's alarm should be attached and on whenever s/he was in his/her chair. Caregiver D stated s/he was unaware Resident 1's alarm was not on him/her during the observed care.	N 389		
N 454	83.42(1) Resident record maintained. The CBRF shall maintain a record for each resident at the CBRF. Each record shall include all of the following: (a) Resident ' s full name, sex, date of birth, admission date and last known address; (b)	N 454		

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N 454	Continued From page 5 Name, address and telephone number of designated contact person, and legal representative, if any; (c) Medical, social, and, if any, psychiatric history; (d) Current personal physician, if any; (e) Results of the initial health screening under s. DHS 83.28(4) and subsequent health examinations under s. DHS 83.38(1)(g); (f)Admission agreement; (g) Documentation of significant incidents and illnesses, including the dates, times and circumstances; (h) Assessments completed as required under s. DHS 83.35(1); (i) Individual service plan and resident satisfaction evaluation; (j) Documentation to accurately describe the resident's condition, significant changes in condition, changes in treatment and response to treatment; (k) Results of the annual resident evacuation evaluation; (l) Documentation of sensory impairment of the resident as required under s. DHS 83.48(7)(b); (m) Summary of discharge information as required under s.DHS 83.31(7); (n) Any department-approved resident-specific waiver, variance or approval; (o) Physician ' s orders or other authorized practitioner ' s written orders for nursing care, medications, rehabilitation services and therapeutic diets; (p) Current list of the type and dosage of medications or supplements; (q) Results of the quarterly psychotropic medication assessments as required in s. DHS 83.37(1)(h)1; (r) Documentation of administration of all medications, supplements, the person administering the medications or supplements, any side effects observed by the employee or symptoms reported by the resident, the need for PRN medications and the resident ' s response, refusal to take medication, omissions of medications, errors in the administration of medications and drug reactions; (s) Photocopy of	N 454		

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N 454	Continued From page 6	N 454		

any court order or other document authorizing another person to speak or act on behalf of the resident, or other legal documents as required which affect the care and treatment of a resident; (t) Documentation of all other services including rehabilitation services, treatments and therapeutic diets; (u) Completed notice of pre-admission assessment requirement under s. DHS 83.30; (v) Nursing care procedures and the amount of time spent each week by a registered nurse or licensed practical nurse in performing the nursing care procedures. Only time actually spent by the nurse with the resident may be included in the calculation of nursing care time; (w) Plans of care for terminally ill residents; (x) Date, time and circumstances of the resident's death, including the name of the person to whom the body is released.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure resident records were maintained. The provider utilized a paper charting system to communicate resident changes, incidents, etc., to oncoming shifts. The communication record was discarded monthly and the information was not consistently transferred to individual resident records. Resident 1's record did not include documentation that accurately described Resident 1's changes in condition or interventions.

Findings include:

The Department received a complaint related to resident changes and services.

On 12/20/2023 at approximately 11:00 AM,

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N 454	Continued From page 7 Surveyor interviewed Caregiver E. Caregiver E stated staff charted resident incidents, changes, behaviors, showers, refusals, and concerns every shift in the 24-hour book. Caregiver E showed Surveyor the 24-hour book which contained shift notes for dates going back about 1 month. Caregiver E identified Resident 1 as a hospice patient and fall risk. Caregiver E stated Resident 1 utilized a Broda chair and had a fall mat next to his/her bed to prevent injury due to rolling out of bed almost daily. Surveyor reviewed Resident 1's record. Resident 1 was admitted on 07/19/2023. His/her individual service plan (ISP) was dated 08/10/2023. The ISP did not accurately reflect his/her current condition. Resident 1's ISP indicated Resident 1 was able to transfer independently and ambulate independent with a walker. His/her progress notes for dates 07/20/2023 through 12/20/2023 included 43 falls. Interventions referenced in the fall notes included a floor alarm, Posey alarm, pillows placed at the edge of the bed, frequent checks, and bed in lowest position, but documentation did not indicate when these interventions were initiated. Notes did not provide a clear picture on Resident 1's change in condition. At approximately 12:30 PM, Surveyor interviewed Nurse Manager (NM) B. NM B stated Resident 1 required cues and stand-by assistance with activities of daily living upon admission, and s/he had gradually declined due to his/her falls. NM B stated Resident 1's fall interventions included a floor alarm, tab alarm, repositioning, a fall mat next to his/her bed, one-to-one care with a 3rd party provider, and daily activity. NM B said there	N 454		

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N 454	Continued From page 8 was no way to see when the interventions were implemented or discontinued. NM B said the information would have been recorded on the 24-hour report and those were only retained for about 1 month. Surveyor asked if the other information recorded by staff each shift was retained elsewhere after the 24-hour reports were discarded. NM B said the provider transcribed fall notes into the resident's electronic progress notes and resident health changes could be reviewed through physician or hospice notes.	N 454		