STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017089	A. BUILDING: _____ B. WING _____	R-C 12/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR VIEW COMMUNITIES OF PEWAUKEE	W232N3471 HUNTERS RIDGE RD PEWAUKEE, WI 53072

(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 12/04/2024-12/16/2024, Surveyor conducted a verification visit and complaint investigation at Arbor View Communities of Pewaukee. Two deficiencies were identified. One of 2 deficiencies was a repeat violation (see statement of deficiency (SOD) 4NVT11, dated 02/22/2024 and SOD 4NVT12, dated 07/09/2024). The complaint was substantiated. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census: 19	{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 that Resident 21 received prompt and adequate treatment related to his/her right humerus fracture. Resident 21 had an activated power of attorney (POA) for healthcare and was on hospice services. On 11/05/2024, Resident 21 sustained a fall at approximately 12:10 AM. The record noted hospice was not notified until 7:03 AM. At 6:00	N 353		

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

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N 353	Continued From page 1 AM, upon getting up and dressed for the day, Resident 21 expressed pain/discomfort and verbalized they wanted to be seen by a doctor. Resident 21's record noted s/he did not receive pain medications until 8:55 AM. Resident 21 was later diagnosed with a closed fracture of proximal end of right humerus which was addressed with a comfort arm sling. Findings include: On 11/25/2024, the Department received a complaint alleging concerns following a resident fall. On 12/04/2024, Surveyor reviewed Resident 21's record and identified the following: Resident 21 was admitted to the provider on 08/22/2024. Resident 21 had an activated healthcare POA and was on hospice services. Resident 21 passed away on 11/08/2024 while at in-patient hospice facility. Resident 21's individualized service plan (ISP) dated 09/23/2024 documented: "Resident has been identified as a fall risk. Has had multiple falls prior to admission due to dizziness related to dehydration. Encourage fluids at meals and prn. Use wheelchair with staff assist. Pendant for assistance. On a daily blood thinner. If resident has fall notify ED/nurse immediately for follow up. Resident requires staff assistance with pain management. Resident has general pain with no specific area. Give prns as needed. Resident is able to verbalize need. Morphine ordered by hospice. Can have 10 mg for moderate pain or SOB or 20 mg for severe pain or SOB prn every hour." Resident 21's incident report dated 11/05/2024 at	N 353		

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N 353	Continued From page 2 12:10 AM documented: "Rt was observed lying on [his/her] bedroom floor after aides entered due to hearing a loud noise and call for help. Rt was laying on their R side just outside of the bathroom door. A stationary chair was flipped over nearby and Rt w/c was in the far corner of the room by the Rt's window. Rt claimed to have had shoulder and arm pain on the R side of their body. Rt claimed to have not hit their head. Rt also initially refused the option to go out to the hospital. Management was contacted after a general check and look over of the Rt showed no apparent signs of injury. Rt also seemed to be articulating and responding normally. Rt was then placed in bed and given PRNs for pain management. Rt slept for the remainder of the night. At 6am, Rt was approached with the option of getting up and dressed for the day. Rt expressed pain and discomfort and verbalized the want to be seen by a doctor. Hospice and POA were contacted but couldn't be reached. Injury: swollen & sore shoulder/arm. Supervisor updated at 12:23 AM, Hospice updated at 7:03 AM, Family (POA) updated at 6:10am." Resident 21's hospice notes documented: "11/5/24: PRN visit s/p fall. [Resident 21] sent to hospital. Determined to have R shoulder fx. Discharged back to the provider with arm sling to prevent excess movement. RN will visit daily for the week. Family will stay with [Resident 21] overnight. Planning care conference with facility and family." Resident 21's hospital discharge summary dated 11/05/2024 documented: "Reason for visit: Fall. Diagnosis: Closed fracture of proximal end of right humerus, unspecified fracture morphology, initial encounter. Instructions: use the comfort splint, continue your	N 353		

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N 353	Continued From page 3	N 353		

pain medications per hospice, follow up with orthopedic surgery."

Resident 21's November 2024 medication administration record (MAR) documented:
"11/05/2024 at 12:30 AM-Acetaminophen 325 mg tablet documented as given. Pain Level: 9
11/05/2024 at 8:55 AM-Morphine 20 mg documented as given.
11/05/2024 at 10:49 AM-Morphine 20 mg documented as given."

On 11/05/2024 at 6:00 AM, when Resident 21 first woke up and verbalized pain and discomfort to his/her right shoulder area, s/he was not given any pain medications until 8:55 AM (almost 3 hours later).

Resident 21's certificate of death with a state file date of 11/15/2024 documented:
"The conditions listed are the diseases, injuries, or complications that caused death: Fracture of right humerus in the setting of protein calorie malnutrition."

On 12/04/2024 at 12:01 PM, Surveyor interviewed Administrator X and Assistant Director Y regarding Resident 21's unwitnessed fall on 11/05/2024. Administrator X reported s/he received a call from staff following the fall, I (Administrator X) told staff to call hospice, and Resident 21's POA. Assistant Director Y stated when s/he reported to work on 11/05/2024 just after 7am, staff came to him/her reporting Resident 21 was in pain following a fall that occurred around 12am. Assistant Director Y reported s/he had staff call hospice to report the fall and was told a RN would be out to assess that morning. Surveyor questioned why Resident 21 was not given any PRN pain medications until

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N 353	Continued From page 4 8:55 AM. Assistant Director Y could not provide a reason. Administrator X stated after coming into work, staff reported they tried to call hospice but only got a voicemail. Surveyor questioned while Resident 21 had an activated healthcare POA, staff documented Resident 21's shoulder was swollen/sore post fall, but s/he allegedly denied seeking hospital treatment, when the POA should have made that decision. Administrator X acknowledged Resident 21's POA should had been contacted post fall. Administrator X stated s/he questioned staff's response of calling hospice because s/he knows hospice is on call 24/7. Administrator X acknowledged Resident 21 should have been given PRN pain medications as soon as s/he expressed pain/discomfort. Administrator X stated both staff who worked that night were no longer employed at the facility. On 12/16/2024 at 12:35 PM, Surveyor interviewed Hospice Supervisor AA regarding Resident 21's fall on 11/05/2024. Hospice Supervisor AA reported while reviewing Resident 21's chart, the only call documented on 11/05/2024, came at 7:06 AM from a caregiver, reporting Resident 21 fell at approximately 12:00 am. The caregiver reported Resident 21 woke up at 6am with pain to his/her right shoulder area. Hospice Supervisor AA reported the RN told staff to give Resident 21 PRN pain medications and a nurse from hospice would be out that am to assess. Hospice Supervisor AA confirmed hospice never received a call until 7:06 AM on 11/05/2024, and their agency had nurses on call 24/7.	N 353		
{N 388}	83.35(3)(c) Implement, follow the individual service plan	{N 388}		

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{N 388}	Continued From page 5 Implementation. The CBRF shall implement and follow the individual service plan as written. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that the CBRF implemented and followed the individual service plan (ISP) for 3 of 3 residents reviewed. Resident 5's, Resident 6's, and Resident 19's ISP directed staff to monitor their food consumption. From 10/07/2024-12/03/2024, there was 42 occurrences of meal consumption not being monitored by staff. This is a repeat deficiency. See statement of deficiency (SOD) 4NVT11, dated 02/22/2024, and SOD 4NVT12, dated 07/09/2024. Findings include: On 12/04/2024, Surveyor reviewed resident records and identified the following: Example 1-Resident 5 Resident 5 was admitted to the provider on 01/03/2024 with a diagnosis of protein-calorie malnutrition. Surveyors reviewed resident's current ISP, dated and signed by power of attorney (POA) on 01/31/2024. Surveyor observed the following: Under the "Consumption Monitoring" heading: "Resident requires staff to monitor food consumption." The schedule was set for monitoring to occur daily at breakfast, lunch, and dinner. Surveyor reviewed charting task history dated	{N 388}		

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{N 388}	Continued From page 6 10/07/2024-12/03/2024. This timeframe included 57 days, and 171 meals. Surveyor observed 42 occurrences where there was no evidence of consumption monitoring during that time frame. Example 2-Resident 6 Resident 6 admitted to the facility on 12/27/2016 with diagnosis of dementia, anxiety, and low back pain. Resident 6 had an activated healthcare power of attorney that made decisions on his/her behalf. Surveyor reviewed Resident 6's current ISP with an unknown date documented: "Consumption Monitoring-resident requires staff to monitor food consumption. The schedule was set for monitoring to occur daily at breakfast, lunch, and dinner." Surveyor reviewed charting task history dated 10/07/2024-12/03/2024. This timeframe included 57 days, and 171 meals. Surveyor observed 42 occurrences where there was no evidence of consumption monitoring during that time frame. Example 3-Resident 19 Resident 19 admitted to the facility on 09/24/2020 with diagnosis of brain damage, asthma, and rheumatoid arthritis. Resident 19 had a guardian that assisted in making decisions on his/her behalf. Surveyors reviewed resident's current ISP, with unknown date of most recent review. Surveyor observed the following: Under the "Consumption Monitoring" heading: "Resident requires staff to monitor food consumption." The schedule was set for monitoring to occur daily at breakfast, lunch, and dinner.	{N 388}		

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{N 388}	Continued From page 7 Surveyor reviewed charting task history dated 10/07/2024-12/03/2024. This timeframe included 57 days, and 171 meals. Surveyor observed 42 occurrences where there was no evidence of consumption monitoring during that time frame. On 12/04/2024 at 12:01 PM, Surveyor interviewed Administrator X and Assistant Director Y. The provider acknowledged Resident 5's, Resident 6's, and Resident 19's ISP directed staff to record meal consumption three times daily. Administrator X reported s/he started in late October 2024 and when going through resident records, it was clear the previous administrator was not ensuring ISP's were being followed. Administrator X reported s/he will work with staff to ensure meal consumption is recorded daily. On 12/04/2024 at 12:13 PM, Surveyor interviewed Caregiver Z regarding staff's responsibility to monitor residents' meal consumption. Caregiver Z reported residents who required assistance with eating, staff were supposed to document the percentage of their consumption in a binder. Caregiver Z noted the previous administrator did not ensure recording meal consumption was a priority, so staff often forgot. Caregiver Z reported Administrator X is trying to ensure staff are recording meal consumption.	{N 388}		