STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0011054	A. BUILDING: _____ B. WING _____	C 07/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTWOOD HOMES SENIOR LIVING INC III	1407 N MASON STREET APPLETON, WI 54914

(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 07/08/2024, with information gathered through 07/23/2024, Surveyor conducted a complaint investigation at Heartwood Homes Senior Living Inc III in Appleton. One (1) of 1 complaint was substantiated. As a result of the survey, 2 deficiencies were issued. Census: 16	N 000		
N 161	83.12(3)(a) Investigate injuries of unknown source. Investigating injuries of unknown source. A CBRF shall investigate any of the following: 1. An injury that was not observed by any person. 2. The source of an injury to a resident that cannot be adequately explained by the resident. 3. An injury to a resident that appears suspicious because of the extent of the injury or the location of the injury on the resident. This Rule is not met as evidenced by: Based on record review and interview, the provider did not investigate an injury that was not observed, could be adequately explained by the resident, or appeared suspicious because of the extent of the injury or the location of the injury on the resident for 1 of 1 (Resident 1) residents reviewed. Resident 1 was reported to have had a bruise and swollen right wrist. Resident 1's record did not contain an investigation into the bruising and swelling. Findings Include:	N 161		

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

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N 161	Continued From page 1 On 06/24/2024, the department received a complaint regarding injuries of unknown origin. On 07/08/2024, Surveyor conducted an onsite visit to the facility. A sample of residents was selected, including the closed record of Resident 1. Resident 1 was admitted to the facility on 04/24/2024 with diagnoses to include dementia, anxiety disorder, valve unspecified endocarditis and syncope and collapse. Resident 1 passed away on 06/17/2024. A facility shower/skin observation report dated 06/09/2024 at 8:00AM indicated Resident 1's skin was "abnormal" with the body diagram's right wrist circled with a note stating, "very bruised and swollen...on call notified." On 07/08/2024 at approximately 11:45AM, Surveyor interviewed RN (Registered Nurse) A. RN A stated Resident 1 had numerous falls and was unsteady on his/her feet. Sometimes Resident 1 would fall while in room and would be able to get him/herself back up and sometimes Resident 1 would just put him/herself on the floor. Additionally, RN A stated Resident 1 did have behaviors of hitting and punching staff. RN A indicated s/he felt the bruised and swollen right wrist was probably from a fall or hitting staff. RN A stated Resident 1 had full range of motion upon assessing the wrist. RN A indicated no xrays were conducted. RN A indicated s/he interviewed caregivers and no one was able to explain the bruising and swelling. Surveyor requested the written investigation into the bruising and swelling of the right wrist.	N 161		

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N 161	Continued From page 2 Surveyor reviewed Resident 1's resident record and noted 2 fall incident reports prior to 06/09/2024. -05/18/2024 at 6:20AM - Resident 1 rolled off edge of bed and "bumped forehead on side table, but no redness or bruising noted at moment." A post fall assessment form indicated no abrasions, skin tears, wounds, bruising or swelling was noted 8 hours after the fall. -05/23/2024 at 8:40PM - Resident 1 was found on dining room floor, appeared s/he tripped while reaching for something. A post fall assessment form indicated no abrasions, skin tears, wounds, bruising or swelling was noted 8 hours after the fall. On 07/08/2024 at approximately 1:30PM, Surveyor received an email from RN A. The email included an attachment which stated, "7/8/24: Re: [Resident 1's] Right Wrist Bruise On Sunday, June 9th, I, [RN (Registered Nurse) A] received a call from staff member [Caregiver C], informing me of a new, unexplained bruise on [Resident 1's] wrist. [Caregiver C] had worked the previous day, June 8th, and noted that the bruise was not present then, and no falls had been reported, making the cause of the bruise unknown. After speaking with [Caregiver C] on June 9th, I contacted the night shift to check if anything had occurred during the night, but they reported no incidents. Shortly after, [Caregiver D], who had worked the morning shifts on June 8th and 9th, called me. [Caregiver C] had informed [Caregiver D] about reporting [Resident 1's] bruised wrist to management due to the unknown cause. [Caregiver D] then reminded [Caregiver C] that [Resident 1] had been aggressive during cares on the morning of June 8th, hitting [Caregiver D] while [s/he] was trying to clean and change [Resident 1]. Consequently, [Caregiver D] then	N 161		

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N 161	Continued From page 3 called to inform me of the likely cause of the bruise, to which I agreed. Despite the bruising and discoloration, [Resident 1] had full range of motion and could move [his/her] wrist freely. I instructed staff to notify [Resident 1's physician] of the bruise and to offer ice and Tylenol as needed for pain." In summary, Resident 1 was noted to have bruising and swelling to the right wrist on 06/09/2024. Resident 1's closed record did not contain an investigation into the bruising and swelling until Surveyor was onsite and investigating the injury. RN A then provided a written statement dated 07/08/2024 with details into the bruising and swelling of Resident 1's right wrist.	N 161		
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 the resident's legal representative and the resident's physician when there was an injury for 1 of 1 (Resident 1) residents reviewed.	N 169		

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N 169	Continued From page 4 Resident 1 was reported to have had a bruise and swollen right wrist. Resident 1's physician and legal representative were not notify of the injury. Findings Include: On 06/24/2024, the department received a complaint regarding injuries of unknown origin. On 07/08/2024, Surveyor conducted an onsite visit to the facility. A sample of residents was selected, including the closed record of Resident 1. Resident 1 was admitted to the facility on 04/24/2024 with diagnoses to include dementia, anxiety disorder, valve unspecified endocarditis and syncope and collapse. Resident 1 passed away on 06/17/2024. A facility shower/skin observation report dated 06/09/2024 at 8:00AM indicated Resident 1's skin was "abnormal" with the body diagram's right wrist circled with a note stating, "very bruised and swollen...on call notified." On 07/08/2024 at approximately 11:45AM, Surveyor interviewed RN (Registered Nurse) A. RN A stated Resident 1 would fall while in room and would be able to get themselves back up and sometimes Resident 1 would just put him/herself on the floor. Additionally, RN A stated Resident 1 did have behaviors of hitting and punching staff. RN A indicated s/he felt the bruised and swollen right wrist was probably from a fall or hitting staff. RN A stated Resident 1 had full range of motion upon assessing the wrist. Surveyor requested the investigation into the injury and documentation that Resident 1's legal representative and	N 169		

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N 169	Continued From page 5	N 169		

physician were made aware of the injury.

On 07/08/2024 at approximately 4:20PM, Surveyor received an email from RN A. The email stated, "Upon reviewing [Resident 1's] chart, I was not able to find documentation of notifying [Resident 1's physician] about the wrist or any new orders."

On 07/08/2024 at 2:10PM, Surveyor interviewed Family Member B. Family Member B verified s/he was the activated HCPOA (health care power of attorney) for Resident 1. Family Member B was unaware of the bruising and swelling to Resident 1's right wrist. Family Member B stated, "This is the first I'm hearing of this, I was not aware of this before." Family Member B denied any caregiver abuse and stated Resident 1 was "clumsy" and had balance issues so it is possible s/he could have fallen and got him/herself back up and that is how s/he hurt the wrist. Additionally, Family Member B stated that Resident 1 would bump into something and would end up with a huge bruise, that was just the way Resident 1 was.

On 07/17/2024 at 1:06PM, Surveyor received an email from RN A. RN A stated, "After your visit, I spoke with [Resident 1's primary doctor's] medical assistant, who confirmed that I had notified them of the wrist injury on 6/10. However, they did not have a record of it because their primary concern was the head injury from the 6/9 fall."

On 07/23/2024 at approximately 2:00PM, Surveyor conducted an exit meeting with Licensee E and RN A. Licensee E acknowledged that staff did not notify Family Member B of the bruised and swollen wrist. Additionally, RN A indicated s/he spoke with Resident 1's primary

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N 169	Continued From page 6 doctor's office and while they indicated they were aware of the bruised wrist, they did not document it and the facility did not document notifying the physician of the injury.	N 169		