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	0019677	A. BUILDING: _____ B. WING _____	C 11/18/2024

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N 000	Initial Comments On 11/14/2024, Surveyor conducted 1 complaint investigation at LindenCourt New Berlin. Three deficiencies were identified. The complaint was substantiated. Census: 40	N 000		
N 381	83.35(1)(a) Pre-admission and ongoing assessments. Scope. The CBRF shall assess each resident ' s needs, abilities, and physical and mental condition before admitting the person to the CBRF, when there is a change in needs, abilities or condition, and at least annually. The assessment shall include all areas listed under par. (c). This requirement includes individuals receiving respite care in the CBRF. For emergency admissions the CBRF shall conduct the assessment within 5 days after admission. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure each resident's needs abilities, and physical and mental condition were accurately assessed. Resident 1's comprehensive assessment identified s/he had no vision problems when his/her vision was impaired and interfered with ability to feed self. Findings include:	N 381		

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

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N 381	Continued From page 1 From 11/14/2024 to 11/18/2024, Surveyor reviewed Resident 1's record. S/he was admitted 09/18/2024. Diagnoses (from MD progress note received 11/18/2024 at 9:12 AM from Licensed Practical Nurse (LPN)/Manager B via email) included unspecified dementia, personal history of transient ischemic attack (TIA); Parkinsonism, unspecified; and cerebral infraction without residual deficits. Speech Therapy note dated 11/01/2024 by SLP E- " ...Pt treated at lunch meal ...When aide reported patient does not receive one on one assistance during meals, writer inquired to nursing re: concerns. Nursing reported, aides reporting patient is eating all by [him/herself]. Patient is 97 lbs. and has lost weight since being at facility. Writer has not observed pt ability to eat independently as vision is poor, appetite appears to be good ..." Individual Service Plan (ISP) (dated 10/31/2024): The ISP did not address vision. On 11/15/2024 at 2:34 PM, Surveyor interviewed Family Member F who stated Resident 1 had macular degeneration with poor vision in left eye and extremely decreased vision in right eye which hindered his/her ability to feed self ..." On 11/18/2024 at 2:28 PM, Surveyor requested Resident 1's most recent comprehensive assessment from LPN/Manager B. On 11/18/2024 at 3:47 PM Surveyor received (via email) Resident 1's comprehensive assessment with 09/18/2024 effective date and signed/dated 11/18/2024 by LPN/Manager B. Comprehensive Assessment dated 11/18/2024:	N 381		

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N 381	Continued From page 2 In the area of Hearing, Vision, and Speech: "2. Does the resident have difficulty seeing with or without a device No 4. Please identify any devices used for hearing, vision, or communication needs? n/a ..." Cross Reference: Y3244 DHS 50.09(1)(l) Care	N 381		
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 observation, record review and interview, the provider did not ensure the individual service plan was implemented as written. Resident 2's individual service plan (ISP) was not implemented as written when staff did not provide Resident 2's fall mat when in bed, adequately reposition him/her every 2 hours or check for incontinence every 2 hours. Findings include: On 10/03/2024 the Department received a complaint regarding resident cares. On 11/21/2024 at 10:55 AM, Surveyor received via email from Family Member H with photos of Resident 2's Broda chair's make and model tags (Broda Midline Tilt Recliner) and a photo of Resident 2 in his/her Broda chair. Family Member H stated in the email s/he took the picture of Resident 2 in the Broda chair on 10/19/2024.	N 388		

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The photo depicted Resident 2's left shoulder leaning against the left arm rest, left foot on the elevated footrest and right foot on the floor.

According to the Broda chair's manual, " ...'Seat Tilt' refers to changing the relative angle between the chair's seat and the chair frame or ground without changing the relative angle between the back and the seat. 'Back Recline' refers to changing the relative angle between the chair's back and the seat ..." (Source: https://www.adaptivespecialties.com/PDF_Downloads/Midline-Operating-Instructions.pdf (retrieval date 11/21/2024)). The manual's illustrations depicted the back in its highest position (a 90 degrees angle from the seat) and lowest position (180-degree angle from its seat). (Note: the hands of a clock on 9 and 3 is approximately a 180-degree angle, on 12 and 3 is approximately a 90-degree angle, and 11 and 3 is approximately a 110-degree angle).

On 11/14/2024 at 10:16 AM, Surveyor observed Resident 2 in bed. The floor mat was folded and stored between the bedside table and dresser.

On 11/14/2024 at 10:42 AM, Surveyor observed Resident Aid D and certified nursing assistant/scheduler (CNA/Scheduler) G provide cares (including incontinence) and transfer Resident 2 into his/her Broda chair. Resident 2 was seated on the Hoyer sling used during the transfer. Due to contractures, Resident 2's hips and knees were bent and s/he was positioned in the Broda chair with both knees leaning to right. The right knee was propped against a pillow positioned between the right knee and the chair's right arm rest. A second pillow was positioned between Resident 2's knees. The back was slightly reclined (to approximately 110 degrees

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from the seat) and the seat was not tilted. A white board hanging on wall in Resident 2's room stated (written by Family Member H) " ...Please reposition [him/her] every 2-3 hours ..." (Photo 2).

On 11/14/2024 at 10:42 AM, Surveyor interviewed Resident Aid D and CNA/Scheduler G. Resident Aid D stated once Resident 2 was up in the Broda chair, staff repositioned him/her in the chair by adjusting the Hoyer sling and the recline and/or tilt of the chair. Resident Aid D stated Resident 2 was never incontinent because s/he did not eat or drink much. Resident Aid D stated 2 staff were needed for Hoyer transfers. Resident Aid D stated s/he was pulled from another unit at 8:00 AM so s/he did not know why the fall mat was not on the floor next to Resident 2's bed. CNA/Scheduler G stated staff usually got Resident 2 up at 10:00 AM, transferred him/her back in bed at 2:00 PM or 3:00 PM, and repositioned Resident 2 every 2-3 hours. CNA/Scheduler G showed Surveyor the incontinent brief taken off Resident 2 at 10:42 AM was slightly soiled with urine.

From 10:42 AM-1:49 PM, Surveyor remained in the common area (except for a few 2 to 3 minute trips to LPN/Manager B's office) to observe staff's activity in and out of Resident 2's room.

On 11/14/2024 at approximately 11:04 AM Surveyor observed Family Member H bring Resident 2 into the common area for a meeting with the managed care organization, and at approximately 11:45 AM take Resident 2 back into his/her room. At 12:14 PM Surveyor observed Resident 2 in his/her room with Family Member H. Resident 2 was seated in his/her Broda chair, back was tilted to approximately 110 degrees and knees were leaning to the right.

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N 388	Continued From page 5 On 11/14/2024 at 12:14 PM, Surveyor interviewed Family Member H who stated s/he had just fed Resident 2 lunch in Resident 2's room. Family Member H stated prior to feeding Resident 2, s/he put the back of the Broda chair from slightly reclined position [approximately 110 degrees] up to straight position [approximately 90 degrees] and when finished feeding him/her reclined the chair's back down slightly [to approximately 110 degrees]. Family Member H demonstrated the slightly reclined and "straight up" positions. On 11/14/2024 at 1:38 PM, Surveyor observed Activities I enter and leave Resident 2's room and at 1:45 PM, observed Resident Aid D enter and leave Resident 2's room. At 1:49 PM, Surveyor observed Activities I re-enter Resident 2's room then leave the room with Resident 2. Resident 2 was positioned in Broda chair with his/her knees leaning to the right and chair's seat back was reclined to approximately 110 degrees. On 11/14/2024, Surveyor reviewed Resident 2's record. S/he was admitted 01/17/2024 and admitted onto hospice 05/10/2024. Diagnoses included vascular dementia, severe, with agitation. ISP dated 02/16/2024: In the area of Falls- "The resident has had an actual fall with facial abrasions ...Fall mat in place next to bed ..." In the area of Toileting- " ...Dependent in toileting activities or unable to recognize need to use toilet ...Resident is not able to transfer to the toilet. Wears pull up briefs. Requires staff x1 to complete peri care while resident is in bed ..." In the area of Transferring- " ...Reposition every 2 hours ..." In the area of Cognition- "Has severe memory	N 388		

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loss ...Hygiene checks [sic] 2-3 hours ..."
In the area of Bladder- " ...Is incontinent of bladder ..."
In the area of Bowels- " ...Is incontinent of bowels ..."
In the area of Mobility- "Uses Broda chair, up in morning, laid down after lunch ..."

On 11/14/2024 at 1:45 PM, Surveyor interviewed Resident Aid D who stated when s/he entered Resident 2's room at 1:45 PM on 11/14/2024, the Broda's seat back was reclined all the way down (approximately 180 degrees) and s/he repositioned it up to a slight recline as it was at 10:42 AM (approximately 110 degrees).

On 11/14/2024 at 1:49 PM, Surveyor interviewed Activities I who stated Resident 2's Broda chair's back was reclined slightly at 1:38 PM, but now at 1:49 PM it was more upright.

On 11/14/2024 at approximately 2:00 PM, Surveyor interviewed Executive Director A and LPN/Manager B. LPN/Manager B stated Resident 2's fall mat should have been on floor next to bed when Resident 2 was in bed.

On 11/15/2024 at 10:49 AM and 2:48 PM, Surveyor interviewed Family Member H. At 10:49 AM Family Member H stated on 11/14/2024 before feeding Resident 2 lunch, s/he positioned the back of Resident 2's Broda straight up [from approximately 110 degrees to 90 degrees] then slightly back [to approximately 110 degrees] after lunch. Family Member H stated s/he did not reposition Resident 2 any other way before or after lunch. Family Member H stated s/he assumed transferring Resident 2 out of his/her Broda chair and providing incontinence care was part of staff's repositioning every 2-3 hours.

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Family Member H stated s/he knew Resident 2's ISP directed staff to reposition and provide incontinence care every 2 hours, and LPN/Manager B told him/her if Resident 2 needed to be repositioned every 2 hours s/he would need to move to the attached skilled nursing facility. Family Member H stated because the unit was only staffed with 1 person and Resident 2 required 2 staff to transfer him/her, s/he was more lenient and thus wrote "reposition every 2-3 hours" on the white board in Resident 2's room. At 2:48 PM, Family Member H stated CNA J informed him/her on 11/15/2024 that Resident 2 had a tiny red spot on his/her bottom on 11/15/2024.

On 11/15/2024 at 3:12 PM, Surveyor interviewed Managed Care Organization (MCO) RN K who stated Resident 2 needed to be repositioned side to side in Broda chair or transferred into bed for repositioning. MCO RN K stated slightly reclining the Broda chair would relieve pressure off buttocks but s/he would try to get Resident 2 off the side of body s/he was sitting on. MCO RN K stated Resident 2 should be checked for incontinence with every repositioning.

On 11/18/2024 at 2:50 PM, Surveyor interviewed CNA J who stated staff were unable to reposition Resident 2's body when seated in the Broda chair. CNA J stated typically Resident 2 was repositioned in bed at 7:00 AM, transferred from bed to Broda chair between 10:00 AM and 10:30 AM, and transferred back to bed after lunch. CNA J stated on 11/15/2024 s/he had informed Family Member H and LPN/Manager B that on 11/15/2024 s/he observed a slightly red area on the back side of Resident 2's left hip bone.

On 11/18/2024 at 2:58 PM, Surveyor discussed

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N 388	Continued From page 8 concern of staff not implementing Resident 2's ISP as written with LPN/Manager B and Nurse Consultant C. LPN/Manager B stated adjusting pillows in Broda chair would help reposition Resident 2. LPN/Manager B stated staff would need to transfer Resident 2 out of Broda chair to check for incontinence and that should be done prior to breakfast and after activities. Nurse Consultant C stated they would provide staff education. Nurse Consultant C stated repositioning in Broda chair should involve moving Resident 2 from left to right and fluffing pillows, but any type of movement would be considered repositioning and even a 1-millimeter recline or decline of the Broda chair's seat back would relieve pressure.	N 388		
Y3244	50.09(1)(L) Care (1) RESIDENTS' RIGHTS. Every resident in a nursing home or community based residential facility shall, except as provided in sub. (5), have the right to (l) Receive adequate and appropriate care within the capacity of the facility.	Y3244		

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This Rule is not met as evidenced by:
Based on observation, record review, and interview, the provider did not ensure the resident right to receive adequate and appropriate care within the capacity of the facility.

Staff did not assist Resident 1 to eat and did not monitor Resident 1 for aspiration during meals as recommended by speech therapy and ordered by the physician, increasing his/her risk for aspiration and malnutrition.

Speech therapy assessed Resident 1 to be at risk for aspiration and malnutrition due to dysphagia (swallowing difficulties), poor vision and poor cognition.
A nurse practitioner's order directed staff to provide one on one assistance to Resident 1 during all meals for safe and adequate eating and swallowing.
Resident 1's individual service plan (ISP) identified s/he was dependent with eating. Per management the facility was unable to accommodate residents who needed to be fed.

Findings include:

83.02(3) defines "Activities of daily living" as bathing, eating, oral hygiene, dressing, toileting and incontinence care, mobility and transferring from one surface to another such as from bed to chair.

10/03/2024 the Department received a complaint regarding resident cares.

The facility is licensed as a Class CNA (nonambulatory) CBRF able to serve up to 49 residents within the client groups of irreversible

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dementia/Alzheimer's. Resident 1's memory care unit had an open concept area with a kitchenette, dining area, sitting room and television nook.

On 11/14/2024 at 12:38 PM, Surveyor observed Resident 1 in the dining area. S/he had a plate of carrots and meat loaf. The food was minced and moist and approximately 70% of food remained on plate. Resident 1 was seated in a wheelchair. Resident 1 appeared distracted as evidence by backing up away from table, turning around and talking to another resident seated in the sitting area, then returning to table for the next bite. From 12:38 PM to 12:51 PM Surveyor observed Resident 1 take a few bites and did not observe staff interact with him/her.

On 11/14/2024 at 12:42 PM, Surveyor observed a sign taped to the upper cupboard in kitchenette stating "[Handwritten] [Resident 1's room number] is now a minced/moist diet, thick it added to all liquids of mod thick consistency. And is also a feeder." A second set of recommendations taped to the 1st stated "[Handwritten] [Resident 1] is on a Level 3 moderately thick liquids (this consistency should still be able to flow through a straw [sic] [typed] DYSPHAGIA Thickened Liquids Guidelines LIQUIDS THAT SHOULD BE THICKENED ...AVOID FOODS THAT MELT ... [copyright] 2021 Chung Hwa Brewer." (Photo 1).

On 11/14/2024 at 12:42 PM, Surveyor observed Resident Aid D seated and talking to other residents in the television nook. No other staff were observed in the general vicinity of the dining area.

On 11/14/2024 at 12:51 PM, Surveyor observed Resident Aid D approach Resident 1, ask him/her if s/he was finished eating, and scrape left-over

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food from Resident 1's plate into a garbage can.

From 11/14/2024 to 11/18/2024, Surveyor reviewed Resident 1's record. S/he was admitted 09/18/2024. Diagnoses (from MD progress note received 11/18/2024 at 9:12 AM from Licensed Practical Nurse (LPN)/Manager B via email) included unspecified dementia, personal history of transient ischemic attack (TIA); Parkinsonism, unspecified; cerebral infraction without residual deficits; generalized muscled weakness; and unspecified severe protein-calorie malnutrition.

According to the national Library of Medicine " ...Malnutrition, in particular protein-energy malnutrition, is a highly prevalent condition in older adults, and is associated with low muscle mass and function, and increased prevalence of physical frailty. Malnutrition is often exacerbated in the residential care setting due to factors including lack of dentition and appetite, and increased prevalence of dementia and dysphagia ..." (Source: https://pubmed.ncbi.nlm.nih.gov/34237434/ (retrieval date: 11/22/2024)).

Facility Progress Note dated 10/04/2024 by LPN/Manager B- " ...Writer, [sic] and staff have noted that during meals, and drinking resident has coughing episodes. [Name of onsite physician services] in doing rounds. Writer did mention findings to the [nurse practitioner]. New orders received, noted, and ordered."

Speech Therapy Notes:
10/26/2024 by Speech Language Pathologist (SLP) E - " ...Pt [Patient] seen during lunch meal. Difficult to provide instructions [due to] pt hard of hearing. Pt unable to see most of food to pick up to eat, and pt did not appear to have assist during

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Y3244	Continued From page 12 meal. Oral clearance was [moderately] impaired with residue remaining in mouth after swallow. Pt unable to follow directions to assess oral-motor strength, coordination and [range of motion]. Pt presents with [signs/symptoms] of aspiration during meal, including frequent coughing on both solids and thin liquids ...Pt followed instructions to clear throat during meal ...Pt is not a candidate to be an active participant in ST services [due to] cognitive deficits (dementia) and inability to follow cues or directions ...Will see pt 1-2 times to provide facility with education and follow up on dysphasia recommendations with facility ..." 11/01/2024 by SLP E- " ...Pt treated at lunch meal. Pt not receiving one on one assist during meal as ordered. Spoke with director of nursing re [sic] aspiration precautions and dysphagia recommendations. Per nursing patient was ordered nectar thickened liquids/minced and moist with SLP [speech therapist] completed evaluation. When aide reported patient does not receive one on one assistance during meals, writer inquired to nursing re: concerns. Nursing reported, aides reporting patient is eating all by [him/herself]. Patient is 97 lbs. and has lost weight since being at facility. Writer has not observed pt ability to eat independently as vision is poor, appetite appears to be good. Pt is at aspiration risk [sic] appears extremely malnourished and emancipated. Pt not receiving appropriate assistance that was recommended. Discussed with case manager and nursing. Continued Education [sic] provided to staff re: diet [recommendations] and appropriate liquid consistency as patient received liquids not thickened to moderately thick liquids ..." 11/05/2024 by SLP E- " ...Discussed diet and feeding [recommendations] with nursing director.	Y3244		

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	0019677	A. BUILDING: _____ B. WING _____	C 11/18/2024

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Y3244	Continued From page 13 Nursing director reported concern of patient losing independence if someone feeds [him/her]. Educated director re: order for one-on-one assistance during all meals does not entail pt requires someone feeding him, rather pt requires assistance during meals due to vision and attention difficulties. Continued education provided to staff re: thickened liquids, aspiration precautions and safe swallowing guidelines with written handouts provided. Staff expressed understanding. Discussed [recommendations] with [Family Member F] who was present for some of the session. Pt [discontinued] from therapy as pt has achieved maximum potential from direct services. [Treatment] primarily targeting assessment and implementation of safest and least restrictive oral diet, and education of staff for aspiration precautions and dysphagia recommendation's [sic] ..." "Patient Care Order" dated 11/05/2024 by SLP E and signed by APNP 11/06/21024- " ...ST RECOMMENDATIONS Solids Level 6 soft and bite sizes Liquids Level 3 moderately thick [sic] Patient requires one on one assistance during all meals for safe and adequate eating and swallowing ...Start Date 11/5/2024 ..." On 11/19/2024 at 5:21 PM, Surveyor received email from SLP E with copy of handout s/he provided to facility regarding Resident1's speech therapy recommendations which stated "*Requires assistance during ALL meals *Offer drinks after every 1-2 bites *Present small bites, one at a time ...DYSPHAGIA Thickened Liquids Guidelines LIQUIDS THAT SHOULD BE THICKENED ...AVOID FOODS THAT MELT ... [copyright] 2021 Chung Hwa Brewer." (Note: recommendations were on same form as recommendations taped to cupboard).	Y3244		

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Y3244	Continued From page 14 Comprehensive Assessment On 11/18/2024 at 2:28 PM, Surveyor requested Resident 1's most recent comprehensive assessment from Manager B. On 11/18/2024 at 3:47 PM Surveyor received (via email) Resident 1's comprehensive assessment effective date 09/18/2024 and signed/dated 11/18/2024 by LPN/Manager B. In the area of Dietary and Nutrition Management: " ...2. Diet Order: regular ...2. Has the resident had a change in weight No ...4. Does the resident require assistance with dining? Independent ..." In the area of Hearing, Vision, and Speech: "2. Does the resident have difficulty seeing with or without a device No 4. Please identify any devices used for hearing, vision, or communication needs? n/a ..." Individual Service Plan (ISP) (dated 10/31/2024): In the area of Eating/Meals: "Will maintain independence with eating/meals ...Diet: Regular minced moist/thick it to all liquids moderate thickening consistency with supplement shakes ...Revision on 11/14/2024 ...Is dependent with meals and eating and drinking ...Revision on 11/01/2024 ..." Weights: On 11/15/2024 at 10:39 AM. Surveyor emailed LPN/Manager B request for Resident 1's weights since 09/01/2024. On 11/15/2024 at 2:02 PM Surveyor received email from LPN/Manager B identifying Resident 1's weight on 9/15/2024 was 97.8 lbs., 10/04/2024 100.4 lbs., and 10/15/2024 97.4 lbs. On 11/14/2024 at 12:51 PM, Surveyor interviewed and reviewed the sign taped on the kitchenette	Y3244		

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Y3244	Continued From page 15	Y3244		

cupboard regarding Resident 1 with Resident Aid D. Resident Aid D stated "feeder" meant staff was to feed Resident 1 and "But as you can see, [s/he] can feed [him/herself]."

On 11/14/2024 at approximately 2:00 PM, Surveyor interviewed Executive Director A and LPN/Manager B. LPN/Manager B stated SLP E recommended staff feed Resident 1 but s/he was able to feed him/herself. LPN/Manager B stated s/he had not seen speech therapy recommendations for safe swallowing and SLP E "kept pushing" for staff to feed Resident 1. LPN/Manager B stated during first visit SLP E recommended minced diet with thickened liquids and during second visit SLP E was upset staff was not feeding Resident 1. LPN/Manager B stated s/he explained to SLP E Resident 1 used a lip plate so was able to feed self. When Surveyor asked LPN/Manager B if s/he had requested the safe swallowing guidelines referred to in SLP E's 11/05/2024 note from SLP-E, LPN/Manager B stated s/he had not. Executive Director A stated they were unable to accommodate residents who needed to be fed and if they needed to be fed, they would be moved the attached skilled nursing facility. Executive Director A stated they did not have a policy regarding not feeding residents and it was not addressed in the admission agreement. Executive Director A stated they marketed a continuum of care from assisted living to the attached skilled nursing facility.

On 11/15/2024 at 2:34 PM, Surveyor interviewed Family Member F who stated s/he was aware Resident 1 was not eating well and had been recently seen by speech therapy. Family Member F stated s/he had recently observed Resident 1's difficulty swallowing certain foods. Family Member F stated Resident 1 had macular

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Y3244	Continued From page 16	Y3244		

degeneration with poor vision in left eye and extremely decreased vision in right eye which hindered his/her ability to feed self. Family Member F stated Resident 1 was not on hospice services, s/he was never told staff was not allowed to feed Resident 1. Family Member F stated no one discussed with him/her the need to move Resident 1 to the skilled nursing facility.

On 11/18/2024 at 2:50 PM, Surveyor interviewed CNA/J who stated no residents needed to be fed, that Resident 1 was newer to him/her and was able to feed him/herself.

On 11/18/2024 at 2:58 PM, Surveyor discussed concern of staff not feeding Resident 1 with LPN/Manager B and Nurse Consultant C. When Surveyor reviewed Resident 1's ISP (in the area of eating and meals) with them, Manager B stated "dependent" meant s/he needed assistance with meals. Nurse Consultant C stated s/he understood the concern and they would check into it.

On 11/18/2024 at 5:59 PM, Surveyor interviewed SLP E who stated facility staff told him/her that Resident 1 fed him/herself and they were a no-feed facility. SLP E stated s/he recommended staff assist Resident 1 to eat with specific swallowing guidelines due to risk of aspiration and poor vision and had expressed concerns regarding aspiration and nutritional risks.

Cross Reference:
N0381 DHS 83.51(1)(a) Preadmission And Ongoing Assessments