STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0014183	A. BUILDING: _____ B. WING _____	R-C 01/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MATTHEWS OF OAK CREEK	7550 S13TH ST OAK CREEK, WI 53154

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{N 000}	Initial Comments On 01/16/2024, with information gathered through 01/29/2024, Surveyor conducted a standard survey, two complaint investigations, and a verification visit at Matthews of Oak Creek. One deficiency was identified. Two of two complaints were substantiated. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census: 16	{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 1 of 1 residents had an annual assessment to reflect current needs and abilities. Resident 1's assessment was not completed annually regarding his/her change in condition with falls and cognition.	N 381		

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

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N 381	Continued From page 1 Findings include: On 07/20/2023, the Department received a self-report which stated the following: "To Whom it may concern, On July 16th, 2023, [Resident 1], had an unwitnessed event resulting [his/her] death. [Resident 1] was admitted to [facility] on 01/29/2019. [Resident 1] had a diagnosis of dementia without behavior disturbance, Alzheimer ' s, Atrial Fibrillation, Arthritis, History of colon cancer, Diarrhea, Irritable bowel, Hypertension, Dyslipidemia, Urinary Retention, Generalized weakness, right lower extremity cellulitis, COVID-19. [Resident 1] is occasionally oriented to person and place, however, is not oriented to time or situation due to [his/her] diagnosis of dementia and Alzheimer ' s. [Resident 1] can ambulate with [his/her] two-wheeled walker. [Resident 1] is a high fall risk due to [his/her] using a walker and [his/her] diagnosis of dementia and Alzheimer ' s. At approximately 5:50am on 7/16/23, [Resident 1] was found by staff during frequent check, lying on [his/her] bed with his/her] neck and arm on the bed rail. Staff reported that [Resident 1] was stuck between the bed and the bed rail. Staff checked for a pulse and did not find one but stated [s/he] was still warm to the touch. Another staff member stated [s/he] had last checked on [Resident 1] between 4:00am and 4:30am; the employee noticed [his/her] legs were hanging off the bed around that time. Resident stated to the employee that [his/her] "legs were cold" so employee helped [Resident 1] put [his/her] legs back in bed and covered them up. Staff then called Hospice, the Regional Director, the on-call Wellness Director, and the Administrator. [Resident 1] was pronounced	N 381		

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deceased at 7:06am by Hospice. Coroner was called as well."

On 08/02/2023, the Department received a complaint alleging Resident 1 had passed away due getting caught in between his/her bed rail and bed.

On 01/16/2024 with information gathered through 01/29/2024 , Surveyor reviewed Resident 1's record and identified the following:
-Resident 1 was admitted to the facility on 01/29/2019.
-Resident 1 had an order for a bed rail on 03/20/2020 signed by his/her primary physician which stated "bed device to assist with getting out of bed. Discussed risk and benefits. Patient understands its use and how to use it. Patient to assist with safety measures regarding use of device."
-Resident 1 had a bed rail assessment completed on 11/12/2021.
-Resident 1's record did not contain an annual assessment for 2022 or 2023.
-Resident 1 had a hospital admission on 02/09/2023-02/13/2023 due to altered mental status and weakness.
-Resident 1 was admitted to hospice services on 02/20/2023.

Resident 1's progress notes stated the following:
-"3/2/21: Resident had fall. Resident fell into the shower on [his/her] right side. Resident said lost balance when [s/he] had fell. Care staff called the house manager and also called resident's daughter to let them know what had happen. Caregiver also called the case manager and left message.
-03/02/21: Resident returned from hospital. Hospital stated nothing was wring with resident.

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N 381	Continued From page 3 -03/07/21: Resident was being changed and caregiver noticed a bruise on right upper side and that both kneese [sick] were swollen and bruised. -05/29/21: Resident calls for assistance at 10:30 PM. Resident asked where were [s/he] and if this was [his/her] bedroom. Resident expressed not knowing where [s/he] lived. Resident asked how long has [s/he] been here. Writer assured Resident that [s/he's] in the right place. Resident appeared to be confused this evening. -11/28/21: Resident had a unwitnessed fall out of [his/her] bed at 1:50 AM. Resident doesn't know how it happen. Resident could not get [him/herself] up off the bedroom floor. Writer contact Resident's children. [Writer] also called the POA, Dr and text manager. The paramedic came out they put Resident back in [his/her] bed. Resident has carpet burn over [his/her] left shoulder. Resident express pain to [his/her] left pinky toe. There were no visible swollen or bruising at this time. Resident maybe stiff and sore as the day process. -12/11/21: Resident was being very rude to care staff when getting up this morning. Resident was very confused and was telling the care staff to "get out of [his/her] room, who told you, you could come in here." Resident then was trying to hit the caregiver that was assisting [him/her]. -12/12/21: Resident was being very hostile this morning again. When caregiver walked into [his/her] room, Resident started yelling at her and cussing at care staff in polish. Resident stated "[s/he] didn't need help and to leave [him/her] alone." -12/13/21: When care staff went into Resident's room to wake up Resident, Resident was still yelling at staff and being rude. Doctor is coming into the facility today, so we are requesting a U.A. to make sure everything is O.K. -04/5/22: Resident could not walk down to meals	N 381		

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this morning. Was in lots of pain in [his/her] legs. [S/he] was sent out to the hospital and are waiting for test.
-04/05/22: Resident returned from hospital. No new meds sent. Will be on 72-hour monitoring.
-04/7/22: While care staff was in Resident's room cleaning [him/her] up, staff noticed Resident has a big bruise on [his/her] private area on the left side. Resident is stating that [s/he] is not in pain there and it does not hurt.
04/12/22: Admin 2 [sic] call Resident's family to let them know Resident has swellen [sic] in [his/her] feet and none of [his/her] shoes fit.
-04/14/22: Resident were experiencing a nightmare. Writer went into room at 4:50 AM to check in on [him/her]. When wake Resident from [his/her] sleep, Resident expressed [s/he] thought [his/her spouse] was trying to "kill [him/her]." Resident said [s/he] ran to get the gun to shoot [him/her]. Writer assured Resident [s/he] is in a safe place.
-06/4/22: Resident woke up confused this morning. Resident came down to breakfast. [S/he] ate all [his/her] breakfast, went back to room. When it was time for lunch, Resident asked "what were we in [his/her] room for." Resident couldn't walk and was still confused. Care staff contacted [House Manager] and [s/he] stated to contact resident's doctor. Care staff called doctor, doctor instructed for care staff to send resident out. Resident was sent out to hospital. Care staff contact POA. Resident returned with meds at 4:00 PM. Resident is okay.
-06/7/22: Resident woke up very combative trying to hit care staff. Stated [s/he] was gona [sic] call the cops didn't want to shower.
-09/15/22: Resident was sent out after lunch being that [s/he] were very combative. Writer told supervisor that behavior is not Resident normal behavior. Writer told other caregiver Resident

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maybe experiencing an UTI. Resident returned after dinner. The results were Resident has UTI. [S/he] needs to follow up with primary Dr.
-05/17/23: Late entry On 05/16/23 Resident had very abnormal behavior. [S/he] made rude comments toward staff about the facility, [his/her] room, the food and other residents which is not like [him/her]. Normally Resident is very pleasant and cooperative. At the time of the abnormal behavior, Resident seemed anxious and spoke very fast and nonsense [sic]. Administrator notified.
-06/15/23: Resident had a fall at 9:30 PM. [S/he] fell out of [his/her] bed.
-06/17/23: Resident had an X-ray done this PM shift. No complaints at this time.
-06/19/23: Resident will be on 24 hour monitoring for symptoms of worsening symptoms of dementia/memory loss.
"-07/13/23: Resident call button keeps going off. Needs to be service.
-07/16/23: Resident was found deceased at 5:50 AM in [his/her] bedroom. Hospice and [Administrator A] was notified. Family came and corner came around 11 AM to take Resident.
-07/20/23 Late Entry: Residents call button was tested on several occasions and was received by page every time it was tested
-07/20/23: Call button on 07/14/2023 functioned correctly alerting staff with each test.
-07/24/23 Late Entry: Early morning about 4:00 AM writer checked in on Resident. Resident legs were falling off [his/her] bed. Writer put residents legs back on bed and resident went back to sleep. Resident was observed at baseline at time of interaction."

-Resident 1's death investigation dated 07/16/2023 stated the following:
"Approximately 0400-0430: The 3rd shift

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caregiver [Caregiver D] was doing rounds and found resident with legs off [his/her] bed. The caregiver [Caregiver D] put [his/her] legs back in [his/her] bed. The resident states [s/he] was cold, the caregiver [Caregiver D] then covered [his/her] legs with a blanket. Resident went back to sleep.

Approximately 0550: The 1st shift caregiver [House Manager C] came into work and began getting residents up starting with the north hallway. The caregiver [House Manager C] entered room 15 and noticed the resident was caught between [his/her] bed rail and the bed. The caregiver [House Manager C] checked for a pulse, but the resident did not have one. The caregiver [House Manager C] then called hospice, the Wellness Director on call, the Regional Director and the Administrator.

Approximately 0655: The 1st shift caregiver [Associate Administrator B] arrived at work and was called to room 15 and told by 1st shift caregiver [House Manager C] that resident was deceased. The resident was lying on [his/her] side with head stuck in the side rail attached to [his/her] bed. Residents left side of body was on the bed and right side was on the floor.

Approximately 0706: Hospice arrived and pronounced time of death. Hospice asked Caregiver [House Manager C] and caregiver [Associated Administrator B] to help lift resident up into bd [sic] so family could say their goodbyes. It was noted by the caregiver [Associated Administrator B] that they lifted the resident off the floor onto the bed and the resident was stiff and cold. The resident had a mark by [his/her] right side by [his/her] neck. The resident was pale and purple.

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N 381	Continued From page 7 Approximately 1100: Residents care team arrived approximately at this time. A coroner arrived approximately at this time also to take the resident." On 01/17/2024, at 2:00 PM, Surveyor interviewed Administrator A, Associate Administrator B and House Manager C regarding annual assessments. Administrator A reported the previous Registered Nurse (RN) was supposed to do the annual assessments or when there was a change in condition. Administrator A stated previous RN did not complete those and they were working on doing all the residents currently to make sure they are all up to date. Administrator A confirmed assessments were not completed annually for Resident 1 in 2022 and 2023 when there was a change in condition. Administrator A confirmed Resident 1 did not have an assessment since 2021 for his/her bed rail.	N 381		