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	0014734	A. BUILDING: _____ B. WING _____	C 02/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHCREST	247 THOMAS DR PORT WASHINGTON, WI 53074

(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
M 000	INITIAL COMMENTS On 02/07/2024, Surveyor conducted an abbreviated survey and complaint investigation at Northcrest. Three deficiencies were identified. The complaint was substantiated. Census: 2	M 000		
M 134	88.03(5)(e)1 SIGNIFICANT CHANGE TO THE RESIDENT Within 24 hours, a significant change in resident status, such as but not limited to an accident requiring hospitalization, missing from the home or a reportable death. A death shall be reported if there is reasonable cause to believe the death was related to use of a physical restraint or psychotropic medications, was a suicide or was accidental. This Rule is not met as evidenced by: Based on record review and interview, the provider did not report to the department within 24 hours, when Resident 1 sustained a fractured left distal fibula and tibia following a fall. Findings include: On 11/24/2023, the Department received a complaint alleging concerns a resident did not receive prompt and adequate care following a fall. On 02/02/2024, Surveyor reviewed the record of	M 134		

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

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M 134	Continued From page 1	M 134		

Resident 1. Resident 1 had an unknown date of admission. Resident 1 had diagnosis including degenerative joint disease, anxiety, and post meningitis developmental delay. Resident 1 had a guardian that made decisions on his/her behalf.

Resident 1's individual service plan (ISP) dated 09/23/2023 documented:
"[Resident 1] is dependent on staff for toileting and toileting hygiene. [Resident 1] is on a toileting schedule. [Resident 1] is being monitored for any skin breakdown. [Resident 1] is incontinent of bowel and bladder at times therefore uses incontinence products.
[Resident 1] is dependent on staff for transferring using a hoyer lift. [Resident 1] is non-ambulatory. Hoyer lifts are done with two staff assistance except in the case of an emergency and the transfer can be done safely one person can transfer with a Hoyer lift. Staff needs to assist with repositioning while in bed. [Resident 1] uses a wheelchair and is dependent on staff to move [him/her]."

Resident 1's incident report dated 11/17/2023 documented:
"I[Caregiver D] went into the bathroom myself and staff member attempted to put sling for hoyer lift under [Resident 1] on the shower chair. During us trying to put under [his/her] behind [s/he] slid off the chair and on to the floor. [S/he] was on the floor and I [Caregiver D] knew we needed help in getting [him/her] up. I [Caregiver D] went next door and got another staff for assistance. We got the sling under [him/her] as [s/he] was on the floor and hoyered [him/her] back into [his/her] wheelchair. Resident remained calm and showed no signs of comfort.
Plan of future corrective actions: Ensure that [s/he] is placed properly in the shower chair to

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M 134	Continued From page 2 begin and [s/he] secured with seatbelt. Follow up comments: Writer [Nurse C] was notified by [House Coordinator E] on 11/18/2023 about blistering to left outer ankle. Picture sent of blisters showed resident's usual edema and intact blisters, slight amount of redness noted around blisters. Per staff blister areas were tender to touch. Writer was notified by [House Coordinator E] on 11/19/2023 of blisters worsening, pics to area looked the same as previous day. Staff noted increased pain in left lower leg 11/19/2023 into 11/20/2023 ....On Monday 11/20/2023, Resident was admitted at ER for fractures of left distal fibula and tibia." A review of department records noted as of 02/01/2024, the department did not receive any report related to the incident from the provider. On 02/02/2024 at 9:33 AM, Surveyor interviewed Director B regarding the above incident. Director B did not know Resident 1's incident was a reportable incident to the department. Surveyor reviewed the code with Director B and noted a review of department records did not reveal a self-report was submitted for Resident 1's incident on 11/17/2023. Director B acknowledged Resident 1's incident should have been reported. Cross Reference: N0580 DHS 88.10(3)(p) Prompt And Adequate Treatment	M 134		
M 570	88.10(3)(l) Safe Physical Environment Individuals, except for correctional residents, have basic rights which they do not lose when they enter an adult family home. A resident shall	M 570		

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M 570	Continued From page 3	M 570		

have a safe environment in which to live. The adult family home shall safeguard residents who cannot fully guard themselves from environmental hazards to which they are likely to be exposed, including conditions which would be hazardous to anyone and conditions which would be or are hazardous to a particular resident because of the resident's condition or disability.

This Rule is not met as evidenced by:
Based on observation and interview, the provider did not safeguard residents from environmental hazards when 2 of 2 faucets accessible to residents reached unsafe water temperatures of 129° and 130° Fahrenheit (F).

Findings include:

The provider is licensed as an ambulatory adult family home (AFH) that may serve up to 3 residents in the client groups of developmentally disabled and physically disabled.

On 02/02/2024 at 10:29 AM and 10:34 AM, Surveyor measured the hot water temperature of the homes 2 bathroom sinks. The main bathroom water temperature was 130° F. The other bathroom was inside Resident 2's bedroom and the water temperature measured at 129° F. Both bathrooms are accessible to residents. The hot water was visibly steaming.

Exposure to hot water is a potential environmental danger for residents. Elderly residents and residents with mental and physical disabilities may have neurological conditions that prevent instant recoil from hot water. Because these individuals do not instantly react to

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M 570	Continued From page 4 dangerous temperature levels, they are at particular risk for injury. Hot water can cause scalding; e.g., second and third degree burns in which the skin blisters and swells. In such instances, skin does not return to normal and forms scar tissue upon healing. These burns may lead to permanent disability. (DQA Publication-01942, Hot Water Temperatures in Adult Family Homes, August 2017.) On 02/07/2024 at 11:01 AM, Surveyor interviewed CEO A, Director B, and Nurse C. Director B noted their maintenance director came to the facility on 02/02/2024 while the Surveyor was onsite to turn down the hot water heater. Surveyor confirmed seeing the provider's maintenance staff before leaving the facility. Surveyor noted not seeing hot water checks completed by staff and recommended staff complete monthly or quarterly checks as part of their safety inspections. The provider's management team acknowledged the above temperatures were too hot.	M 570		
M 580	88.10(3)(p) Prompt and Adequate Treatment Prompt and adequate treatment. To receive prompt and adequate treatment and services 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 Resident 1 received prompt and adequate treatment. Resident 1 sustained a fall on 11/17/2023, experienced symptoms of being in pain, and treatment was not provided until 11/20/2023. Findings include:	M 580		

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M 580	Continued From page 5 On 11/24/2023, the Department received a complaint alleging concerns a resident did not receive prompt and adequate care following a fall. On 02/02/2024, Surveyor reviewed the record of Resident 1. Resident 1 had an unknown date of admission. Resident 1 had diagnosis including degenerative joint disease, anxiety, and post meningitis developmental delay. Resident 1 had a guardian that made decisions on his/her behalf. Resident 1's individual service plan (ISP) dated 09/23/2023 documented: "[Resident 1] is non-verbal and will communicate with limited sign language. [Resident 1] also is unable to hear ... ...[Resident 1] is unable to express [his/her] basic needs. [S/he] will make loud noises "bah bah" when [s/he] wants attention from others. [S/he] can answer simple questions using sign language, Yes and No but unable to determine if responses are reliable. [Resident 1] is dependent on staff for toileting and toileting hygiene. [Resident 1] is on a toileting schedule. [Resident 1] is being monitored for any skin breakdown. [Resident 1] is incontinent of bowel and bladder at times therefore uses incontinence products. [Resident 1] is dependent on staff for transferring using a hoyer lift. [Resident 1] is non-ambulatory. Hoyer lifts are done with two staff assistance except in the case of an emergency and the transfer can be done safely one person can transfer with a Hoyer lift. Staff needs to assist with repositioning while in bed. [Resident 1] uses a wheelchair and is dependent on staff to move [him/her]." Resident 1's incident report dated 11/17/2023 documented:	M 580		

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"I[Caregiver D] went into the bathroom myself and staff member attempted to put sling for hoyer lift under [Resident 1] on the shower chair. During us trying to put under [his/her] behind [s/he] slid off the chair and on to the floor. [S/he] was on the floor and I [Caregiver D] knew we needed help in getting [him/her] up. I [Caregiver D] went next door and got another staff for assistance. We got the sling under [him/her] as [s/he] was on the floor and hoyered [him/her] back into [his/her] wheelchair. Resident remained calm and showed no signs of comfort.
Plan of future corrective actions: Ensure that [s/he] is placed properly in the shower chair to begin and [s/he] secured with seatbelt.
Follow up comments: Writer [Nurse C] was notified by [House Coordinator E] on 11/18/2023 about blistering to left outer ankle. Picture sent of blisters showed resident's usual edema and intact blisters, slight amount of redness noted around blisters. Per staff blister areas were tender to touch. Writer was notified by [House Coordinator E] on 11/19/2023 of blisters worsening, pics to area looked the same as previous day. Staff noted increased pain in left lower leg 11/19/2023 into 11/20/2023 ....On Monday 11/20/2023, Resident was admitted at ER for fractures of left distal fibula and tibia."

Resident 1's progress notes dated 11/17/2023-11/20/2023 documented:
"11/17/2023 8p-8a: [Resident 1] was assisted into bed by this writer and other staff. [S/he] slept through the night. Medications administered. After [his/her] shower and dressing, [s/he] rolled on to the floor from [his/her] toilet chair when both staff were trying to put [his/her] sling on. Staff got [him/her] up with the assistance from staff next-door. [S/he] is now in [his/her] wheelchair waiting for breakfast. [S/he] was calm during this

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incident. No injuries were seen on [Resident 1] at this time.
11/17/2023 8am-8pm: I [Caregiver F] did notice [him/her] biting extremely hard on [his/her] finger on the right side of [his/her] mouth. I [Caregiver F] gave [him/her] a chewy instead and [s/he] bit on that. [S/he] was toileted at 7pm and put to bed.
11/18/2023 8pm-8am: [Resident 1] was on the toilet when this writer arrived. [S/he] was assisted to bed by this writer and other staff. [S/he] woke up at 5:30 am and started to make noise.
...When this writer was dressing [Resident 1] [s/he] noticed blisters on [his/her] left ankle. This staff left [his/her] sock off and tried to call [House Coordinator E], had to leave a message.
11/18/2023 8am-8pm: I [Caregiver F] was informed by third shift of line type blisters near the front left of [Resident 1's] ankle. [S/he] stated [s/he] called staff. [S/he] was watching football most of the day and didn't have much of an appetite. [His/her] ankle was warm to touch and [s/he] seemed bothered by touching that area. I [Caregiver F] texted [House Coordinator E] a picture. [Resident 1] did not really take any naps today. [Resident 1] was not really eating on [his/her] own. Staff did assist [Resident 1] with eating [his/her] breakfast, lunch, and dinner.
11/19/2023 8pm-8am: [Resident 1] had talked a lot during the night. This writer heard [him/her] at 10:30 pm, 11:30 pm, and 4:00 am. Staff got [him/her] up at 7:00 am ....[Resident 1] still has a swollen foot that when touched [s/he] cries out.
11/20/2023 8pm-8am: [Resident 1] was very uncomfortable last night ....[His/her] ankle has a yellowish color to it with purple farther up. [His/her] ankle is swollen. [S/he] is not acting [him/her] usual self."

A review of Resident 1's progress notes dated 09/01/2023-11/16/2023, show consistently

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Resident 1 sleeping through the night, eating his/her daily meals, and napping throughout the day.

On 02/02/2024 at 9:25 AM, Surveyor interviewed Caregiver F. Caregiver F stated s/he was working the day Resident 1 fell of his/her shower chair. Caregiver F stated Caregiver D asked for assistance and when trying to get a sling behind Resident 1 s/he leaned to far forward and slid to the floor. Caregiver F confirmed Resident 1 did not appear to be in pain initially. Caregiver F stated s/he worked a 12 hour shift on 11/18/2023 and noted s/he was told by 3rd shift about blisters discovered on Resident 1's left ankle. Caregiver F stated Resident 1 seemed bothered anytime that areas was touched. Caregiver F stated s/he reported the incident to House Coordinator E, sent a picture, but do believe Resident 1 should have gotten care sooner.

On 02/02/2024 at 10:10 AM, Surveyor interviewed House Coordinator E. House Coordinator E stated staff reported the fall on 11/17/2023 to him/her. House Coordinator E stated s/he observed Resident 1 on 11/17/2023 and s/he did not have any signs of being in pain. House Coordinator E stated Caregiver D was a newer staff at the time of the above incident and s/he did not properly position him/her self when trying to apply the Hoyer sling behind Resident 1. House Coordinator E confirmed s/he received a picture on 11/18 from Caregiver F and sent the picture to Nurse C. Surveyor asked if any other symptoms were reported by staff other than blisters observed. House Coordinator E stated "no."

On 02/07/2024 at 11:01 AM, Surveyor interviewed CEO A, Director B, and Nurse C. Nurse C stated

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M 580	Continued From page 9 s/he received a picture of Resident 1's left ankle on 11/18 and 11/19 and both pictures looked similar. Nurse C stated Resident 1 had edema in his/her ankle's prior to the above incident, so all that was observed were blisters, which Resident 1 did get in other parts of his/her body. Nurse C stated s/he spoke with House Coordinator E and could only go off what was reported from him/her. Nurse C stated s/he does not read resident progress notes over the weekend and when getting reports that Resident 1 was not eating or voiding on 11/19, him/her and management team thought Resident 1 was experiencing symptoms of a UTI. Nurse C noted when reviewing progress notes on the morning of 11/20, s/he could see Resident 1 was experiencing increased pain in left lower leg 11/19 into 11/20. Surveyor expressed concern staff were documenting as earlier on the morning of 11/18, Resident 1's ankle was warm to touch and seemed bothered when touching that area. Nurse C stated s/he understands the Surveyors concern after reviewing progress notes, but at the time of the incident, s/he only had the picture to assess the injury. Nurse C stated s/he spoke to the surgeon while Resident 1 was hospitalized and the surgeon noted the blisters were fracture blisters. CEO A noted the provider has never denied residents access to medical care and during this incident, the provider was going off the information that was reported to management. Cross Reference: N0134 DHS 88.03(5)(3)1 Significant Change To The Resident	M 580		