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 _____	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIMENSIONS LIVING PEWAUKEE EAST	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 01/28/2025, with information gathered and reviewed through 03/06/2025, Surveyor conducted 3 complaint investigations at Arbor View Communities of Pewaukee. All 3 complaints were substantiated. Three violations of Chapter DHS 83 were identified. One violation is a repeat deficiency, see statement of deficiency (SOD) 4NVT11, dated 02/22/2024. Census: 20	N 000		
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 Resident 1's physician when there was an incident, injury, or significant change in his/her physical condition. On 12/27/2024, Resident 1 had a fall. From 12/27/2024 - 12/29/2024, Resident 1 had a	N 169		

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

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change of condition.
Resident 1's physician was not updated of the incident or change of condition.

This is a repeat deficiency. See statement of deficiency (SOD) 4NVT11, dated 02/22/2024.

FINDINGS INCLUDE:

On 01/01/2025, the Department received a complaint regarding resident care.
On 01/28/2025, Surveyor completed an onsite complaint investigation.

RECORD REVIEW:

On 01/28/2025, Surveyor reviewed Resident 1's record.

Resident 1 admitted to the provider on 12/23/2024 with diagnosis including dementia, urinary retention, and falls. Resident 1 had an activated healthcare power of attorney (POA) who made decisions for him/her.

Surveyor reviewed Resident 1's pre-admission assessment, temporary individualized service plan (ISP), incident reports, and observation notes. These records documented the following:

Pre-admission assessment:

"History of falling- [Husband/wife] believes s/he may have had 1-2 unwitnessed falls in the past 6 months ...
Bed mobility- Low bed related to fall risk ...
Comments: Independent with mobility and highly mobile without aid.
History of dehydration- No.
Pain or discomfort- Location and description: Left

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knee pain since hospitalization. Known cause: Triggers cold weather, over and under activity. Scale of 0-10: 3. How long: 2 days. Activities that make it worse: Immobility or strain/overuse. Activities that make it better: Heat, analgesia. Interventions: Non-medical- Repositioning. Sensory and communication- ... Changes in verbal skills related to cognition: Yes. Describe: Advancing dementia ...
Clinical review- Medication management: Staff management.
Cognition- Diagnosis of: Advanced dementia. Decline current status: Confusion, orientated to self ...
Capacity for self-determination- Unable to make good decisions but directs care. Unable to direct care. POA activated. Staff to anticipate needs."

Temporary ISP:

"Capacity for self care- Needs some assistance. Needs total assistance.
Capacity for self direction- Needs assistance.
Ambulation- Independent with ambulation ... Requires partial assistance from care staff when ambulating.
Risk- fall- [Resident 1] has been identified as a fall risk.
Chronic illnesses- [Resident 1] has chronic illnesses that require proper treatment and management.
Pain history and management- Hx of pain to bilateral knees and lower back. Denies at this time.
Mental illness: Impaired cognitive function related to dementia."

Incident reports:

One incident report on file dated 12/27/2024.

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N 169	Continued From page 3 "[S/he] as walking inn (sic) the living room and lost balance and fell ... Questioned about pain: Yes. Pain level: 6 ... Physician notified? No ... Injury information: Did [Resident 1] sustain any injuries? Yes. Notes: Redness to knees ..." Observation notes: "12/27/2024- 4:45 PM: [Resident 1] was somnolent when writer assessed. Per staff [s/he] was very active the first day or two at facility and became more sleepy once started getting full dose of [his/her] Seroquel. Per [POA A] report, [Resident 1] has seasonal variation to [his/her] activity/energy level and this is normal for [him/her] this time of year when the weather gets cold ... Does not appear to be in any pain or discomfort. In no apparent distress ... 12/31/2024- 10:15 AM: [Resident 1]'s [POA A] was reluctant to send him to hospital per report. [S/he] did finally agree once she came to facility to visit him. He was admitted to the hospital ... INTERVIEW: On 01/28/2025, at 2:00 PM, Surveyor interviewed Executive Director B and Assistant Executive Director C. Executive Director B summarized Resident 1's time at the facility, stating Friday December 27th, s/he called POA A on two occasions to notify him/her Resident 1 seemed unsteady on his/her feet and does not seem him/herself, to notify him/her Resident 1 had a fall, and to request Resident 1 be sent out for evaluation. Executive Director B stated POA A denied request to send Resident 1 to hospital, and informed Executive Director B Resident 1	N 169		

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changes with the weather. Executive Director B stated s/he went to the facility on Saturday 12/28/2024 and called POA A again to notify him/her that Resident 1 was sleeping a lot and not eating much. POA A did not answer, and Executive Director B stated s/he did not leave a voicemail. Executive Director B stated the facility was not familiar yet with Resident 1's baseline as s/he was newly admitted. Executive Director B stated s/he called the facility on Sunday 12/29/2024 to check on Resident 1 and Assistant Executive Director C, who was working the floor, stated his/her condition had not improved. POA A was called and arrived at the facility shortly after the call. Assistant Executive Director C stated Resident 1 did not want to get up from the chair s/he was sitting in and was unable to ambulate and required a wheelchair to be brought to his/her room. After POA A was able to observe Resident 1's condition, s/he agreed Resident 1 should be sent out for evaluation.

Executive Director B did not have documentation of any communication attempts noted above. Executive Director B did not have documentation of Resident 1's progressive change of condition, assessment of those changes, or response to the changes, until days to weeks after the events leading to his/her hospitalization.

Off-site review of additional records was completed as provider sent more documentation over the following weeks. Additional interviews and records were also collected from POA A.

ADDITIONAL RECORD REVIEW:

Observation Notes-

01/29/2025- 4:30 PM: Late entry from 01/03/2025

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N 169	Continued From page 5 at 10:21 AM: ...Advised admitting diagnosis was elevated LFTs (liver function tests) and generalized weakness ... [Executive Director B] also expressed concerns and advised she had reached out to [POA A] approximately 6-7 times over the several days leading up to [his/her] hospitalization, advising [POA A] each time that [Resident 1] was experiencing weakness and tiredness. Per report, [POA A] advised this was "normal for [Resident 1]" this time of year related to seasonal affective disorder. Per report, [Executive Director B] asked multiple times about sending [Resident 1] out to hospital to be further evaluated and [POA A] refused each time, stating [Resident 1] was fine. Finally, [POA A] agreed to come in person to see [Resident 1] and then at that time [s/he] did agree to [him/her] going to Aurora Summit for further evaluation." Hospital Records after leaving facility on 12/29/2024: "12/29/2024 8:13 PM- Chief Complaint: Found slumped over in chair at rehab facility. Right hip pain. History of Present Illness: [Resident 1] is a 64 year old male/female with a history of moderate to severe Alzheimer's dementia, urinary retention, hypothyroidism who is being admitted to the hospitalist service for generalized weakness with immobility resulting in mild rhabdomyolysis ... [S/he] went to see [him/her] today and found [him/her] slumped over in a chair leaning on [his/her] right side. [S/he] tried to help [him/her] sit up and [s/he] yelled out in pain. It took 3 people to get him out of the chair and into a wheelchair and back into [his/her] bedroom. During this time [s/he] was noted to favor [his/her] right leg. [S/he] would not move it on [his/her] own. Visiting nurse	N 169		

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N 169	Continued From page 6 came to perform Foley care and noted that [his/her] Foley catheter was kinked and stool ... ... 2. Rhabdomyolysis secondary to prolonged immobility ... Mild rhabdomyolysis: -Likely from prolonged sitting ..." ADDITIONAL INTERVIEWS: On 02/10/2025, Surveyor interviewed POA A via phone call. POA A confirms s/he received 1 call on Friday, 12/27/2024 related to Resident 1's fall. S/he was told by staff Resident 1 went to sit on the couch and missed, and slid down to the ground, no injuries. POA A had been informed Resident 1's mood had changed to which s/he told staff was normal for Resident 1's mood to change with the weather. POA A stated s/he was never asked to consent to Resident 1 being sent out for evaluation. POA A denies having any missed calls from Saturday, 12/28/2024. POA A stated s/he received a call Sunday 12/29/2024 morning requesting s/he brings in a wheelchair for Resident 1 to use so s/he went to the facility to check on Resident 1. Upon entering, POA A observed Resident 1 sitting in a chair in the common area, hunched over and crying. POA A stated Resident 1 had dried and went urine on his/her pants. Resident 1 had a Foley catheter, and POA A could not recall if the bag was full at the time. A home health nurse was due for a visit related to Resident 1's catheter, so in preparation for the visit, staff assisted Resident 1 back to his/her room and into bed, where s/he could be cleaned up and rest. POA A stated it took 3 staff members to assist Resident 1 into the wheelchair, then again into bed. POA A recalled Resident 1 screaming and crying in pain during transfers.	N 169		

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N 169	Continued From page 7 On 02/18/2025, Surveyor interviewed Executive Director B via phone call. Executive Director B denied updating any physician of Resident 1's fall or change of condition leading to his/her hospitalization. Executive Director B stated Resident 1 was not on the rounding providers online portal yet, so s/he didn't have anyone to update. Executive Director B agreed there was poor documentation of Resident 1's changes from 12/27/24 - 12/29/2024.	N 169		
N 230	83.19 Orientation Before an employee performs any job duties, the CBRF shall provide each employee with orientation training which shall include all of the following: (1) Job responsibilities; (2) Prevention and reporting of resident abuse, neglect and misappropriation of resident property; (3) Information regarding assessed needs and individual services for each resident for whom the employee is responsible; (4) Emergency and disaster plan and evacuation procedures under s. HFS 83.47(2); (5) CBRF policies and procedures; (6) Recognizing and responding to resident changes of condition. This Rule is not met as evidenced by: Based on interview and record review, the provider did not ensure 2 of 2 employees reviewed, obtained orientation training as required. Caregiver D and Housekeeper E did not have training in emergency, disaster, and evacuation procedures before performing job duties.	N 230		

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N 230	Continued From page 8 FINDINGS INCLUDE: On 01/22/2025 the Department received a complaint regarding staffing/supervision concerns. On 01/28/2025, Surveyor completed an onsite complaint investigation. Training records for 2 staff were reviewed, on site and virtually, through 02/18/2025 due to the provider being unable to locate all training records at the time of the visit. Orientation Training- Emergency, Disaster, and Evacuation Procedures On 01/28/2025 at approximately 10:30 AM, Surveyor interviewed Assistant Executive Director C, who stated Caregiver D and Housekeeper E were the only two staff scheduled for night shift on 01/06/2025, both as caregivers. Assistant Executive Director C confirmed both staff had been employed by the provider for less than 3 weeks at that time. Police involvement occurred during this shift resulting in the termination of these staff. On 01/28/2025 at approximately 1:20 PM, Surveyor interviewed Caregiver F. Caregiver F stated s/he'd worked at the facility for almost 1 year. Caregiver F could not recall receiving any training on emergency, disaster, or evacuation procedures during orientation, or at any time since hire. The record for Caregiver D, hired 12/27/2024, did not contain evidence of training on emergency,	N 230		

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N 230	Continued From page 9 disaster, and evacuation procedures, during orientation or prior to assuming job responsibilities. The record for Housekeeper E, hired 12/18/2024, did not contain evidence of training on emergency, disaster, and evacuation procedures, during orientation or prior to assuming job responsibilities. On 02/18/2025 at approximately 8:33 AM, Surveyor interviewed Executive Director B. Executive Director B confirmed the provider submitted all training records on file for Caregiver D and Housekeeper E. The provider believed the training was completed but could not validate this with documentation. Cross Reference N0397 DHS 83.36(1)(b) Qualified Staff in Change, On Duty and Awake.	N 230		
N 397	83.36(1)(b) Qualified staff in charge, on duty and awake. The CBRF shall ensure all of the following: 1. An administrator or other designated qualified resident care staff in charge is on the premises of the CBRF daily to ensure the CBRF is providing safe and adequate care, treatment and services. 2. At least one qualified resident care staff is present in the CBRF when one or more residents are present in the CBRF. 3. At least one qualified resident care staff is on duty and awake if at least one resident in the CBRF is in need of supervision, intervention or services on a 24-hour basis to prevent, control or improve the resident ' s constant or intermittent mental or physical condition that may occur or may become critical at any time including residents who are at risk of	N 397		

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N 397	Continued From page 10 elopement, who have dementia, who are self-abusive, who become agitated or emotionally upset or who have changing or unstable health conditions that require close monitoring. 4. At least one qualified resident care staff is on duty and awake if the evacuation capability of at least one resident is 4 minutes or more. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure at least 1 qualified staff was on duty and awake when at least 1 resident in the CBRF was in need of supervision, intervention, or services on a 24-hour basis to prevent, control, or improve the resident's constant or intermittent mental or physical condition that may occur, including residents who have unstable health conditions that required close monitoring. Caregiver D and Housekeeper E were discovered to be sleeping during the 3rd shift on 01/06/2025. FINDINGS INCLUDE: On 01/22/2025, the Department received a complaint regarding an incident on 01/06/2025 alleging Caregiver D and Housekeeper E had been sleeping on the job. On 01/27/2025, Surveyor reviewed the Department's records in preparation for the complaint investigation. The provider submitted a self-report related to an incident on 01/06/2025, that matched the allegations of the complaint. The report summarized on 01/06/2025 around 11:27 PM Resident 2 called 911 to request assistance due to staff not responding to his/her calls for help. When law enforcement arrived, it	N 397		

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took approximately 30 minutes for a staff member to respond. The officers tried calling the facility, ringing the doorbell, and knocking on the doors during this time. Housekeeper E answered the door, and upon entrance, they noted Caregiver D still sleeping and another make-shift bed from where Housekeeper E had been sleeping. It was also observed the facility lights had all been turned off, and the fire doors leading to the resident rooms were all closed. Officers rounded on the residents to ensure safety and well-being, including Resident 2, who had been incontinent of stool which covered his/her hands, legs, feet, and bed. Executive Director B and Assistant Executive Director C were notified and reported to the facility. They investigated the events of the shift, determined Caregiver D and Housekeeper E had been sleeping, terminated them, then stayed to cover the remaining hours of the 3rd shift.

On 01/28/2025, Surveyor conducted an on-site complaint investigation and identified the following:
The provider is licensed to serve up to 31 residents within the client groups of terminally ill, irreversible dementia/Alzheimer's, and physically disabled.

The provider's Residency and Services Agreement stated, "There is twenty-four (24) hour awake staff for your safety and security."

INTERVIEWS:

On 01/28/2025 at 10:30 AM, Surveyor interviewed Assistant Executive Director C regarding the incident on 01/06/2025. S/he confirmed the self-report, and the complaint were both accurate and factual. Assistant Executive

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N 397	Continued From page 12 Director C stated 2 staff is the minimum staffing for 3rd shift, and the provider did not permit sleeping on any shift. Assistant Executive Director C stated all staff were aware of the expectations and Caregiver D and Housekeeper E had worked on 3rd shift before without concerns. S/he denied having similar incidents reported prior to 01/06/2025. Assistant Executive Director C stated the facility had 4 landline phones, each in different locations, and the ringing was the same regardless of time of day. RECORD REVIEW: On 01/28/2025, Surveyor reviewed employee records for Caregiver D and Housekeeper E. Caregiver D had been hired 12/27/2024 and did not receive training in emergency, disaster, or evacuation procedures. Housekeeper E had been hired 12/18/2024 and did not receive training in emergency, disaster, or evacuation procedures. On 01/28/2025, Surveyor reviewed the provider's self-report again that was submitted to the Department on 01/07/2025, confirming both Caregiver D and Housekeeper E were terminated on 01/07/2025. On 01/28/2025, Surveyor reviewed the provider's staff schedule for Monday, 01/06/2025. The schedule documented Caregiver D was scheduled to work 6:00 AM-2:15 PM and 10:00 PM-6:15 AM. The schedule documented Housekeeper E was scheduled to work 7:00 AM-3:00 PM and 10:00 PM-6:00 AM. The schedule dated 12/29/2024-01/06/2025 reflected a pattern of double shifts for Caregiver D. This did not appear to be a recurring pattern for other staff.	N 397		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIMENSIONS LIVING PEWAUKEE EAST	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 397	Continued From page 13 ADDITIONAL INTERVIEWS: On 01/28/2025 at 1:20 PM, Surveyor interviewed Caregiver F. Caregiver F stated s/he was never pressured to pick up additional shifts or to work extended hours. At 1:42 PM, Surveyor interviewed Caregiver G, who stated s/he was not pressured to pick up shifts or work extended hours. Caregiver F and Caregiver G denied having knowledge of similar incidents. On 01/28/2025 at approximately 3 PM, Surveyor interviewed Executive Director B and Assistant Executive Director C. They stated they would continue searching for additional training documents for Caregiver D and Housekeeper E, as they believed all required training had been completed. Assistant Executive Director C stated s/he completes orientation with the new employees and does review the expectation of 24-hour awake staff. Assistant Executive Director C also stated s/he would review the orientation information to add anything that may had been missing. Cross Reference N0230 DHS 83.19 Orientation.	N 397		