STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013383	A. BUILDING: _____ B. WING _____	C 10/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR HOUSE WISCONSIN DELLS MEMORY CARE	1950 STATE HWY 23 WISCONSIN DELLS, WI 53965

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N 000	Initial Comments On 08/24/2023, with information gathered through 10/04/2023, the Bureau of Assisted Living, Southern Regional Office conducted two complaint investigations at Our House Wisconsin Dells Memory Care, located at 1950 State Road 23 in Wisconsin Dells, WI. One citation of noncompliance is issued. Both complaints are substantiated. Census: 18	N 000		
N 431	83.38(1)(g) Health monitoring. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident ' s highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Health monitoring. 1. The CBRF shall monitor the health of residents and make arrangements for physical health, oral health or mental health services unless otherwise arranged for by the resident. Each resident shall have an annual physical health examination completed by a physician or an advanced practice nurse as defined in s. N 8.02(1), unless seen by a physician or an advanced practice nurse as defined in s. N 8.02(1) more frequently. 2. When indicated, a CBRF shall observe residents ' food and fluid intake and acceptance of diet. The CBRF shall report significant deviations from normal food and fluid intake patterns to the resident ' s physician or dietician. 3. The CBRF shall document communication with the resident ' s physician and other health care providers, and shall record any changes in the resident ' s health or mental health	N 431		

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N 431	Continued From page 1 status in the resident ' s record. This Rule is not met as evidenced by: Based on interview and record review, the provider did not ensure Resident 1's health was monitored to meet Resident 1's needs. Resident 1 was receiving warfarin [an anticoagulant medication taken to prevent blood clots] when admitted to the facility on 05/30/2023. Resident 1 continued to receive daily administration of coumadin, as prescribed, until Resident 1 was sent to an emergency room on 06/15/2023 with diagnoses including subarachnoid hemorrhage [brain bleed]. Resident 1 was due for an INR [international normalized ratio; a blood test used to check blood clotting times and determine dosing in people taking warfarin] blood test on 05/31/2023. The provider did not ensure Resident 1's INR requirement was clarified, scheduled, and/or completed on 05/31/2023, and Resident 1 did not have an INR completed before Resident 1 was hospitalized on 06/15/2023. Resident 1 died on 06/30/2023 in hospice care. The findings are: On 08/24/2023 at approximately 10:00 A.M., Surveyor conducted an interview with Administrator A regarding Resident 1's needs and	N 431		

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services. Administrator A told Surveyor Resident 1 was initially admitted from a local skilled nursing facility [SNF] to the neighboring community-based residential facility [CBRF] licensed by the same provider as this memory care facility on 05/08/2023 before being admitted to this memory care facility on 05/30/2023 related to Resident 1's increasing care needs. Administrator A told Surveyor Former Lead Caregiver E was the lead caregiver at the neighboring CBRF licensed by the same provider as this memory care facility until his/her termination from employment on 05/15/2023. Administrator A told Surveyor s/he was the administrator for both facilities between the time Resident 1 was admitted to both facilities and discharged from this memory care facility. Administrator A said Resident 1 was discharged to a local emergency room on 06/15/2023 related to a significant change in Resident 1's condition and did not return to either facility.

On 08/24/2023 at approximately 10:35 A.M., Administrator A, Facility Nurse B, and Surveyor reviewed Resident 1's facility record as provided by Administrator A and Facility Nurse B.
Resident 1's diagnoses included congestive heart failure, chronic kidney disease, transient cerebral ischemic attack [TIA], atrial fibrillation, history of venous thrombosis [blood clot] and embolism [obstruction of an artery], and long-term use of anticoagulants [medications that help prevent blood clots, including warfarin].
An email from Resident 1's discharging SNF Staff G dated 05/04/2023 to recipients including Former Lead Caregiver E included, "...INR [international normalized ratio; a blood test used to check blood clotting times and determine dosing in people taking warfarin] draws are on Wednesdays, [Resident 1's] INR's are monthly, next one is scheduled for 05/31/2023."

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N 431	Continued From page 3 Resident 1's "Transfer/Discharge Report" from SNF dated 05/08/2023 included a practitioner's prescription for warfarin 3 milligrams [mgs] to be administered to Resident 1 every Monday, Wednesday, Friday, and Sunday "...related to unspecified atrial fibrillation...long-term (current) use of anticoagulants..." The report included a practitioner's prescription for warfarin 2 mgs to be administered to Resident 1 every Tuesday, Thursday, and Saturday. Resident 1's transfer and discharge documentation included, "Most recent INR to follow along with Coumadin [warfarin] dosing - per coag [coagulation] clinic." Resident 1's medication administration record [MAR] for May 2023 included daily documentation of Resident 1's warfarin administration, as prescribed. Facility Nurse B told Surveyor caregivers were responsible for administering all of Resident 1's medications during May 2023. Resident 1's caregiver documentation by Administrator A dated 05/30/2023 included, "[Resident 1] moved to [this memory care facility]." Resident 1's assessment documentation dated 06/01/2023 included, "[Resident 1] receives anticoagulant warfarin for atrial fibrillation. [Resident 1] should be monitored closely for bruising, bleeding, or open areas. [Resident 1] will bruise easily and blood will not clot easily and so any injury could result in severe (possibly fatal) blood loss." The documentation included, "[Resident 1] takes an anticoagulant medication and has blood draws monthly." Resident 1's MAR for June 2023 included daily documentation of Resident 1's warfarin administration, as prescribed, until Resident 1's discharge from the facility on 06/15/2023. Facility Nurse B told Surveyor caregivers were responsible for administering all of Resident 1's medications during June 2023.	N 431		

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An email from Resident 1's Funding Agency Case Manager F to Administrator A dated 06/08/2023 included, "One thing [Funding Agency Case Manager F] missed this morning was confirmation of [Resident 1's] INRs being set-up. Did [s/he] have [his/her] INR on [05/31/2023]?"
Another email from Funding Agency Case Manager F to Lead Caregiver C dated 06/08/2023 included, "[Administrator A's] out of office notification came through so [Funding Agency Case Manager F] wanted to send to [Lead Caregiver C]." Based on review of emails received from Administrator A, Lead Caregiver C did not respond to Funding Agency Case Manager F's question about Resident 1's INR due on 05/31/2023.
An email from Administrator A to Funding Agency Case Manager F dated 07/12/2023 at 12:08 P.M. included, "So below [in reference to the email dated 05/04/2023 from SNF Staff G, see above] is the only email that says May 31 [referencing date of Resident 1's scheduled INR] and was sent to [Former Lead Caregiver E]. (That's what [Administrator A] figured). It says it was scheduled. Do you [Funding Agency Case Manager F] know where it was scheduled? I [Administrator A] am trying to write up an investigation on it."
An email from Funding Agency Case Manager F to Administrator A dated 07/12/2023 at 12:08 P.M. included, "At the time, [Resident 1's] INRs were being completed at the SNF. I [Funding Agency Case Manager F] am unsure what the intent was by stating it was scheduled for 05/31/2023 versus implying it was due for 05/31/2023."
An email from Funding Agency Case Manager F to Administrator A on 07/12/2023 at 12:12 P.M. included, "On [05/18/2023], [Funding Agency Case Managers F and I] traveled to [facility] and spoke with [Life Enrichment/Activities Staff H] in

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[his/her] office regarding upcoming appointments. A conversation ensued regarding having a staff member from your [Administrator A's] facility attend with [Resident 1] since [Resident 1] can not attend [self] and was to be scheduled by staff per scope of service."
An email from Administrator A to Funding Agency Case Manager F dated 07/12/2023 at 12:22 P.M. included, "Do you [Funding Agency Case Manager F] know if the INR was discussed?"
An email from Funding Agency Case Manager F to Administrator A dated 07/12/2023 at 12:25 P.M. included, "It was because [Resident 1] could not attend alone and required support from staff."
Resident 1's caregiver documentation by Lead Caregiver C dated 06/08/2023 included, "Spoke to [local healthcare clinic] as there is some confusion with [Resident 1's] appointment tomorrow [06/09/2023], as [Resident 1] has two appointments scheduled in two separate locations. One [appointment] for a sleep study, and the other for HCPOA [health care power of attorney] activation."
Resident 1's caregiver documentation by Lead Caregiver C dated 06/09/2023 included, "[Local healthcare clinic] called this morning and canceled [Resident 1's] appointment and requested [Resident 1] be seen at [local medical center] emergency department due to significant weight loss and [Resident 1] refusing to eat."
Lead Caregiver C's documentation included, "After visit summary for [Resident 1's] visit in the emergency department: Labs were taken for CBC [complete blood count] and differential, comprehensive metabolic panel, and magnesium."

On 09/18/2023, Surveyor received Resident 1's emergency room discharge summary documentation dated 06/09/2023. The

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documentation included, "Chief complaint: Weight loss." The documentation included, "[Resident 1] states [s/he] actually feels much better and weighing less than [s/he] did before." The documentation included, "Overall low clinical concern for significant malnourishment as [his/her] weight loss from 3 weeks ago is very minimal. [S/he] went from 157 to 155 pounds since 05/16/2023. Appears well-hydrated." There was no evidence Resident 1's INR was checked based on chief complaint of weight loss.

On 08/24/2023 at approximately 10:35 A.M., Administrator A, Facility Nurse B, and Surveyor reviewed Resident 1's facility record as provided by Administrator A and Facility Nurse B.
Resident 1's caregiver documentation by Caregiver D dated 06/15/2023 included, "[Resident 1] seemed to have an ok [okay] night, during both rounds [Resident 1] had small amounts of vomit on the disposable pad next to [him/her]. [Resident 1] did say [s/he] was not feeling well."
Resident 1's caregiver documentation by Lead Caregiver C dated 06/15/2023 included, "[Resident 1] is being admitted to [local medical center]."

On 09/18/2023, Surveyor received Resident 1's emergency room discharge summary documentation dated 06/15/2023. The documentation included, "They [facility staff] state [Resident 1] developed green emesis starting last night." The documentation included, "Had some 'flecks of blood' in [his/her] vomit this A.M. [morning]..." The documentation included, "...INR [test result] (>15) [general therapeutic range is between 2.0 and 3.0 for people taking warfarin. High INR result indicates risk for bleeding related to blood coagulation being too slow]." Resident

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1's final emergency room diagnoses included, "Non-traumatic subarachnoid hemorrhage [brain bleed]..." and "Abnormal coagulation profile [elevated INR]." Resident 1 was admitted to a different hospital on 06/15/2023 for inpatient treatment.

On 08/24/2023 at approximately 10:35 A.M., Administrator A, Facility Nurse B, and Surveyor reviewed Resident 1's facility record as provided by Administrator A and Facility Nurse B. Resident 1's caregiver documentation by Administrator A dated 06/27/2023 included, "[Resident 1] is being admitted to [hospice facility] and will not be returning [to facility]." Administrator A's "Investigation Summary" dated 07/12/2023 included, "Event: Missed INR. Event date: 05/31/2023." The documentation included dated 07/12/2023 at 12:15 P.M., "[Administrator A] reviewed [Resident 1's] chart. There were no documents in the file that stated what date [Resident 1] INR was to be done. Discharge summary from nursing home [SNF] had no documentation on when next INR was due. [Resident 1] was at [local emergency room] on 06/09/2023 as [Resident 1] was refusing to eat. No INR was drawn."

On 10/04/2023 at 2:19 P.M., Surveyor received a copy of the Resident 1's death certificate from Resident 1's Family Member J. Resident 1's death certificate, issued 07/14/2023, included, "The conditions listed are the diseases, injuries or complications that caused death. Conditions leading to the immediate cause are listed sequentially and the underlying cause is listed last. Immediate Cause (a) Non-trauma Subdural Hematoma [brain bleed]...Interval between onset and death: Months." The documentation included Resident 1's death was pronounced at a

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N 431	Continued From page 8 hospice care facility on 06/30/2023. On 08/24/2023 at approximately 2:30 P.M., Administrator A told Surveyor s/he was on leave from 06/01/2023 through 06/12/2023. Administrator A told Surveyor Resident 1's INR monthly appointment was never clarified and set up by Former Lead Caregiver E, and was missed after Resident 1 was admitted to this memory care facility. Administrator A told Surveyor s/he was on leave from 06/01/2023 through 06/12/2023 and was unaware of Resident 1's missed INR until after Resident 1's hospitalization on 06/15/2023. On 10/04/2023 at 1:14 P.M., Administrator A told Surveyor the facility put in place a new plan following Surveyor's onsite visit on 08/24/2023 regarding admission of residents receiving warfarin. Administrator A said the facility nurse, currently Facility Nurse B, will be notified immediately and before any perspective residents receiving warfarin are admitted to the facility.	N 431		