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	0018673	A. BUILDING: _____ B. WING _____	C 02/09/2024

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N 000	Initial Comments On 02/08/2024, with information obtained through 02/09/2024, the Bureau of Assisted Living, Southern Regional Office, conducted a complaint investigation at Mission Creek, a community-based residential facility (CBRF) located in Waukesha, WI. As a result of the survey, 2 deficiencies were identified. Both deficiencies are repeat deficiencies. See Statement of Deficiency (SOD) 5XJJ12, dated 05/18/2022, SOD 45ON13, dated 07/27/2022, and SOD 45ON15, dated 04/27/2023. The complaint was substantiated. Census: 72	N 000		
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 record review and interview, the provider did not ensure that Resident 1's individual service plan (ISP) was implemented and followed as written. The ISP for Resident 1, who experienced falls, directed for a fall mat to be used when s/he was in bed. The fall mat was not used on 3 occasions in January 2023. This is a repeat deficiency. See Statement of Deficiency (SOD) 45ON13, dated 07/27/2022.	N 388		

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

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N 388	Continued From page 1 Findings include: On 02/08/2024, Surveyor conducted a complaint investigation into allegations of injury prevention measures not being used for residents who experienced falls out of bed. On 02/08/2024, at approximately 10:07 a.m., Surveyor interviewed Caregiver D. Caregiver D identified 3 different residents who utilized fall mats, which included Resident 1. Caregiver D reported that Resident 1's fall mat was to be laid out on the floor next to Resident 1's bed anytime s/he was in bed. Caregiver D reported that s/he typically worked the morning shift and that s/he "sometimes" has come into work and not seen the fall mats being used for residents who need them. Caregiver D estimated that this has maybe happened 3 or 4 times since the start of the new year. Caregiver D reported thinking that maybe the overnight (NOC) shift was forgetting to lay them out on these occasions. On 02/08/2024, at approximately 10:27 a.m., Surveyor interviewed Nurse Case Manager C, from Resident 1's hospice organization. Nurse Case Manager C reported that Resident 1 used a fall mat, which staff were directed to use anytime Resident 1 was in bed. Nurse Case Manager C reported that Resident 1's hospice care team has been alerted to 3 different falls sustained by Resident 1 since 01/01/2024. On 02/08/2024, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider on 07/21/2021 with diagnoses including generalized muscle weakness. Surveyor reviewed Resident 1's current ISP, which included the intervention of fall mat use implemented on 12/15/2023. As part of Resident	N 388		

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1's record, Surveyor reviewed 3 incident reports for 3 different falls that occurred since 01/01/2024, with the following information:

- 01/08/2024 (4:25 p.m.): "...Resident seen on floor via camera in Resident's room. Prior to fall care staff assist Resident to bed for afternoon nap. When care staff arrived, Resident was on floor on top off[sic] fall mat with right leg caught in between bed frame. Resident [complains of] pain in both legs. Resident has skin tear to right leg..."

- 01/17/2024 (3:09 p.m.): "Care staff was doing routine check and saw resident on floor. Resident landed on fall mat no pain or injury noted. Resident states [s/he]'s doing fine and wanted to get out of bed..."

- 01/18/2024 (2:25 p.m.): "Care staff found resident laying on [his/her] back next to [his/her] bed. Resident did not push [his/her] pendant. No signs of injuries noted. Resident stated [s/he] was trying to get up out of bed."

On 02/08/2024, Surveyor reviewed various screenshots across 3 days from a video camera feed in Resident 1's room, provided by Person E, who was Resident 1's power of attorney for healthcare (POA). The screenshots showed the following:

- 01/18/2024: One screenshot, timestamped 1:33 p.m., shows Resident 1 laying in his/her bed with an unidentified caregiver present in his/her room. No fall mat is observed at Resident 1's bedside. The next screenshot, timestamped 1:57 p.m., shows Resident 1 mid-fall out of his/her bed, with no mat observed at his/her bedside. The next screenshot, timestamped 2:04 p.m., shows Resident 1 laying on the floor with no fall mat. A

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N 388	Continued From page 3 screenshot at 2:32 p.m. shows unidentified staff in Resident 1's room with him/her. - 01/26/2024: One screenshot, timestamped 3:33 a.m., shows Resident 1 lying in bed with no fall mat observed at his/her bedside. Additional screenshots, timestamped 5:44 a.m. and 6:01 a.m., also show Resident 1 lying in bed with no fall mat observed next to his/her bed. - 01/30/2024: One screenshot, timestamped 1:47 a.m., shows Resident 1 lying in bed with no fall mat observed at his/her beside. One additional screenshot, timestamped 6:03 a.m., also shows Resident 1 lying in bed with no fall mat observed next to his/her bed. On 02/08/2024, at approximately 2:09 p.m., Surveyor interviewed Executive Director A and Director of Wellness B. Both reported they were unaware that staff were not consistently using Resident 1's fall mat as directed in his/her ISP but they would look into it.	N 388		
N 389	83.35(3)(d) Service plans updated annually or on changes Individual service plan review. Annually or when there is a change in a resident ' s needs, abilities or physical or mental condition, the individual service plan shall be reviewed and revised based on the assessment under sub. (1). All reviews of the individual service plan shall include input from the resident or legal representative, case manager, resident care staff, and other service providers as appropriate. The resident or resident ' s legal representative shall sign the individual service plan, acknowledging their involvement in, understanding of and agreement	N 389		

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N 389	Continued From page 4 with the individual service plan. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that the individual service plans (ISPs) for 3 of 3 residents were updated when there were changes in their needs. From 01/01/2024 - 02/08/2024, Resident 1 experienced 3 falls, only 1 of which had a documented intervention in his/her ISP. Staff reported additional fall prevention / fall risk mitigation interventions that have been utilized but were not documented in his/her ISP. Resident 1 has had a documented injury secondary to a fall. From 01/01/2024 - 02/08/2024, Resident 2 experienced 7 falls, only 3 of which had documented interventions in his/her ISP. Therapy notes documented that Resident 2 has been participating in physical therapy since 12/06/2023 with goals related to improved safety in ambulation and transferring, however, this information was not in his/her ISP. Resident 2 has had documented injuries secondary to a fall. From 01/01/2024 - 02/08/2024, Resident 3 experienced 8 falls, only 2 of which had documented interventions in his/her ISP. Staff reported additional fall prevention / fall risk mitigation interventions that have been utilized but were not documented in his/her ISP. Resident 3 has had documented injuries secondary to his/her falls. This is a repeat deficiency. See Statement of Deficiency (SOD) 5XJJ12, dated 05/18/2022,	N 389		

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N 389	Continued From page 5 SOD 45ON13, dated 07/27/2022, and SOD 45ON15, dated 04/27/2023. Findings include: Example 1 - Resident 1 On 02/08/2024, at approximately 12:15 p.m., Surveyor interviewed Executive Director A about Resident 1's call light use. Executive Director A reported that staff had been feeling that Resident 1 has not been using his/her call light appropriately - both from a physical standpoint and cognitive standpoint - related to him/her showing more sings of confusion. On 02/08/2024, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider on 07/21/2021 with diagnoses including generalized muscle weakness. As part of Resident 1's record, Surveyor reviewed 3 incident reports for 3 different falls that occurred since 01/01/2024, with the following information: - 01/08/2024 (4:25 p.m.): "...Resident seen on floor via camera in Resident's room. Prior to fall care staff assist Resident to bed for afternoon nap. When care staff arrived, Resident was on floor on top off[sic] fall mat with right leg caught in between bed frame. Resident [complains of] pain in both legs. Resident has skin tear to right leg..." - 01/17/2024 (3:09 p.m.): "Care staff was doing routine check and saw resident on floor. Resident landed on fall mat no pain or injury noted. Resident states [s/he]'s doing fine and wanted to get out of bed..." - 01/18/2024 (2:25 p.m.): "Care staff found resident laying on [his/her] back next to [his/her]	N 389		

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bed. Resident did not push [his/her] pendant. No signs of injuries noted. Resident stated [s/he] was trying to get up out of bed."

Surveyor reviewed Resident 1's current ISP. The ISP documented that Resident 1 uses a wheelchair with assistance of 1 person for ambulation and transfers with the assistance of a hoyer lift and 2 people. One focus area within the ISP documented, "[Resident 1] is at risk for falls [related to] weakness. Resident has had an actual fall with injury." The correlated interventions in this section documented the following:

- An intervention initiated on 01/15/2024 documented, "Fall 1/8 Remind resident to use call device pendant for assistance as needed."

Surveyor did not observe any other fall prevention / fall risk mitigation interventions documented in Resident 1's ISP, including after 01/15/2024, despite Resident 1 experiencing 2 falls since then and Executive Director A's report, documented above, that Resident 1 has not been using his/her call light appropriately.

On 02/08/2024, at approximately 2:09 p.m., Surveyor interviewed Executive Director A and Director of Wellness B regarding Resident 1's fall prevention / fall risk mitigation interventions. Both reported that other measures have been utilized by the provider, including: implementing use of a scoop mattress sometime after Resident 1's 01/08/2024 fall, having staff assist Resident 1 to remove his/her pants and socks prior to going to bed due to him/her often getting too hot while sleeping and trying to get out of bed to take them off, discouraging naps, and psychotropic medication initiation in accordance with hospice

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orders in order to address Resident 1's behaviors. Director of Wellness B confirmed Surveyor's observation that these interventions were not addressed in Resident 1's ISP.

Example 2 - Resident 2

On 02/08/2024, Surveyor reviewed Resident 2's record. Resident 2 was admitted to the provider on 11/10/2023 with diagnoses including mild cognitive impairment, muscle wasting and atrophy, and monoplegia of his/her left upper limb post cerebral infarction. As part of Resident 2's record, Surveyor reviewed 7 incident reports for 7 different falls that occurred since 01/01/2024, with the following information:

- 01/07/2024 (2:30 p.m.): "Care staff went into residents[sic] room due to the pendant went off. When care staff went into [his/her] room [s/he] was sitting on the bathroom floor next to the shower. No injuries noted at this time...Resident is unable to give a reason for why [s/he] fell..."

- 01/08/2024 (1:30 p.m.): "Care staff went into resident's room and [s/he] was on the floor. Resident does not know how [s/he] got on the floor. Care staff helped resident up off the floor. No injury noted at this time..."

- 01/08/2024 (2:44 p.m.): "Care staff responded to Resident call light. When care staff arrives Resident was on floor in middle of bathroom sitting on bottom. No [complaint of] pain or discomfort noted. Resident is confused and unable to give description of fall..."

- 01/11/2024 (5:20 p.m.): "Care staff was told by residents[sic] [spouse] that resident was on [his/her] left side in [his/her] room on the

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floor...Resident unable to give a reason for why [s/he] fell..."

- 01/13/2024 (2:28 p.m.): "Care staff found the resident on the floor in front of [his/her] wheelchair...Resident states [s/he] just slid off [his/her] wheelchair and fell on the floor..."

- 01/22/2024 (2:28 p.m.): "Care staff went into residents[sic] room and found [him/her] on [his/her] bottom...Resident states [s/he] was up walking around [his/her] room without [his/her] wheelchair and lost [his/her] balance...Care staff found a scrape on [his/her] knuckle on [his/her] right hand and [s/he] had two small bruises on the top of [his/her] bottom area..."

- 01/24/2024 (11:35 a.m.): "Care staff went into residents room and care staff found [him/her] on the floor. Resident was found on [his/her] bottom in between bathroom and door. Resident did not give a reason for the fall..."

Surveyor reviewed Resident 2's current ISP. The ISP documented that Resident 2 uses a wheelchair for ambulation, which s/he is able to self-propel, and transfers with the assistance of one person. An entry on 11/10/2023 documented, "[Physical therapy (PT)]/[Occupational therapy (OT)] evaluation and treatment as per [medical doctor] orders." One focus area within the ISP documented, "The resident has had an actual fall with no injuries [related to] gait imbalance." The correlated interventions in this section documented the following:

- An intervention initiated on 01/07/2024 (after Resident 2 experienced 1 fall as documented above on that same day): "Remind resident to use call device pendant for assistance as

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needed."

- An intervention initiated on 01/16/2024 (after Resident 2 experienced 3 additional falls as documented above from 01/08/2024 - 01/11/2024): "Fall 1/11 Invite, encourage and assist the resident to attend activities that promote exercise and strength building and balance per resident preference."

- An intervention initiated on 01/28/2024 (after Resident 2 experienced 3 total falls as documented above on 01/13/2024, 01/22/2024, and 01/24/2024): "Remind resident to use assistive devices."

Surveyor did not observe any other fall prevention / fall risk mitigation interventions documented in Resident 2's ISP.

Surveyor reviewed therapy notes for Resident 2, which indicated that Resident 2 has been participating in physical therapy since 12/06/2023 with goals related to improved safety in ambulation and transferring.

On 02/08/2024, at approximately 2:09 p.m., Surveyor interviewed Executive Director A and Director of Wellness B regarding Resident 2's fall prevention / fall risk mitigation interventions. Both acknowledged Surveyor's concern that the services provided by physical therapy in accordance with Resident 2's fall risk mitigation needs were not specified in his/her ISP. Neither reported any additional interventions being utilized by the provider to help prevent Resident 2's falls or mitigate his/her fall risk.

Example 3 - Resident 3

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N 389	Continued From page 10 On 02/08/2024, Surveyor reviewed Resident 3's record. Resident 3 was admitted to the provider on 06/28/2023 with diagnoses including unspecified dementia with psychotic disturbance. As part of Resident 3's record, Surveyor reviewed 8 incident reports for 8 different falls that occurred since 01/01/2024, with the following information: - 01/02/2024 (12:11 p.m.): "Resident's one on one arrived and seen that Resident had injury to left elbow and was bleeding. Resident did not receive medical treatment. No complaints of pain or discomfort at time of fall. Resident unable to give description of incident..." - 01/17/2024 (11:00 p.m.): "Care staff checked on resident at 9:45pm and [s/he] was sitting on [his/her] bed. At 10:55pm care staff was informed that [s/he] was sitting on the floor on [his/her] side of [his/her] bed. It was observed [s/he] had a visible skin tear to [his/her] right elbow...Resident unable to give a reason for why [s/he] fell..." - 01/19/2024 (12:38 p.m.): "Activity Director saw Resident slip from dinning[sic] room chair while eating dinner. Care staff assist resident from floor into chair and checked [him/her] for pain or injury. Resident has skin tear to left elbow...Unable to give description of fall..." - 01/22/2024 (12:02 p.m.): "Housekeeper saw Resident on floor in bathroom next to toilet covered in loose stool. Housekeeper informed care staff. Care staff checked Resident for pain/injury. No visible injury noted. Resident [complained of] pain on left side of body...Care staff assist Resident in shower. Care staff noticed resident became very weak in shower and was off balanced. Resident slipped in shower care staff caught [him/her] before hitting	N 389		

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floor...Resident is confused and unable to give description of fall..."

- 01/22/2024 (12:24 p.m.): "Care staff went into Resident room to assist [him/her] with getting ready for breakfast when [s/he] saw [him/her] on floor lying on back. Resident walker was not near [him/her]. No visible injury [complained of] body being sore. Resident did not receive medical treatment for fall...unable to give description of fall..."

- 01/22/2024 (12:58 p.m.): "Care staff was in dinning[sic] room and heard a loud thump from Resident's room. Care staff checked on Resident and saw that Resident was on the floor sitting on [his/her] bottom with head against closet door. Care staff checked resident for pain/injury. No visible injury some soreness to head...Resident was transported to hospital by [emergency medical technicians]...Unable to give description of fall..."

- 01/30/2024 (3:45 p.m.): "Care staff found resident on floor in front of the recliner. Resident was previously sitting in the movie room area. Resident was alert and conscious. Resident unable to give a reason for why [s/he] fell..."

- 02/04/2024 (4:30 p.m.): "Care staff witnessed resident have a fall. Resident was sitting in chair and tried to get up and fell back out of [his/her] chair...Resident reopened up old wounds on [his/her] left elbow. Area cleaned up..."

Surveyor reviewed Resident 3's current ISP. The ISP documented that Resident 3 uses a wheelchair for ambulation and transfers with the assistance of one person. One focus area within the ISP documented, "The resident has had an

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actual fall with no injuries [related to] disease process." The correlated interventions in this section documented the following:

- An intervention initiated on 01/11/2024 (after Resident 3 experienced 1 fall as documented above on 01/02/2024): "Fall 1/2/24 Invite, encourage and assist the resident to attend activities that promote exercise and strength building and balance per resident preference."

- An intervention initiated on 01/18/2024 (after Resident 3 experienced 1 fall as documented above on 01/17/2024): "Fall 1/18 Encourage resident to be out in the foyer area and invite to activities."

Surveyor did not observe any other fall prevention / fall risk mitigation interventions documented in Resident 3's ISP, including after 01/18/2024 despite Resident 3 experiencing 6 additional falls since then.

Surveyor reviewed therapy notes that were part of Resident 3's record, which indicated that Resident 3 participated in physical therapy for 4 sessions from 01/30/2024 - 02/06/2024 with goals related to decreasing his/her fall risk. Resident 3 was documented as being discharged from physical therapy on 02/06/2023 due to being admitted to the hospital.

On 02/08/2024, at approximately 2:09 p.m., Surveyor interviewed Executive Director A and Director of Wellness B regarding Resident 3's fall prevention / fall risk mitigation interventions. Executive Director A reported that Resident 3 has Parkinson's disease and has been experiencing an overall decline in his/her condition the last couple of months. Executive Director A reported

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018673	A. BUILDING: _____ B. WING _____	C 02/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MISSION CREEK	3217 FIDDLERS CREEK DRIVE WAUKESHA, WI 53188

(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 389	Continued From page 13 that the provider moved Resident 3 from the "assisted living" unit where s/he resided to the "memory care" unit sometime in December 2023 (all within the same licensed CBRF) so that staff could keep better eyes on him/her. Executive Director A reported that approximately 3 weeks ago staff moved Resident 3's room to be right off the dining area so that s/he could be in the general vicinity of more staff and that staff could keep better supervision on him/her. Director of Wellness B reported that staff were also trying to keep Resident 3 out in the dining area more for increased supervision. Both acknowledged Surveyor's concern that it wasn't clear from Resident 3's ISP what interventions have been used with what intervals due to the last updated intervention being 01/18/2024 and Resident 3 experiencing 6 falls since then.	N 389		