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N 000	Initial Comments On 08/28/2024 with additional information gathered through 09/03/2024, Surveyor conducted two complaint investigations at Van Dyke. As a result one deficiency was identified. Two of 2 complaints were substantiated. Census: 8	N 000		
Y3244	50.09(1)(L) Care (1) RESIDENTS' RIGHTS. Every resident in a nursing home or community based residential facility shall, except as provided in sub. (5), have the right to (l) Receive adequate and appropriate care within the capacity of the facility. This Rule is not met as evidenced by: Based on interviews and record review, the provider did not ensure Resident 1 received adequate and appropriate care within the capacity of the facility. Resident 1 had the following risk factors for dehydration: functional impairments, cognitive impairments, need for assistance to eat/drink,	Y3244		

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

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difficulty swallowing, and use of a diuretic medication. Resident 1's ISP (Individual Service Plan) did not identify Resident 1 at risk for dehydration or direct staff to monitor the resident's fluid intake. A physician office visit on 07/24/2024 indicated the resident was having a decrease in appetite and fluid intake, was more fatigued and coughing with liquids. Following a swallow study on 07/25/2024, orders were received for nectar thick liquids. Resident 1's ISP was not updated to reflect the modification of fluids or direct staff to monitor the resident's fluid intake to determine the resident's acceptance of the thicken liquids. Resident 1 began having poor meal intakes starting around 08/06/2024 through 08/12/2024. There was no documentation the physician was notified of Resident 1 having poor oral intakes during this time nor were interventions added to the ISP to improve Resident 1's food/fluid intake. On 08/12/2024 at 12:45 PM, Resident 1 was weak, could barely sit up, was not eating or drinking and acting "off." Staff did not summons medical help until 10:54 PM (approximately ten hours later), when Resident 1 was sent to the ED (Emergency Department) and admitted to the hospital with diagnoses of acute hypernatremia (high sodium) and dehydration.

Findings include:

According to WebMD.com, Hypernatremia is the medical term to describe too much sodium in your blood...However, when there's too much, it is an imbalance in your body's electrolytes and can cause serious problems...Hypernatremia occurs when the balance of water and sodium in your blood is off: there's either too much sodium or not enough water. This can happen when too much water is lost or too much sodium is gained (or

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accumulated) in the body. Doctors define hypernatremia as a measurement of over 145 milliequivalents per liter - a normal level is considered between 136-145 milliequivalents per liter...Hypernatremia is usually a symptom of dehydration...Dehydration happens when your body doesn't have as much fluid as it needs...Dehydration Risk Factors: ...Older adults often don't realize they're thirsty. If they can't get around very well anymore, they may not be able to get a drink easily or may not be able to take in enough fluids due to medical conditions...People with a chronic disease...medicines such as water pills..."

On 08/27/2024, Surveyor reviewed Resident 1's closed medical record. The record indicated Resident 1 had a guardian, and was admitted to the facility on 01/29/2020 with diagnosis to include, intellectual disability, chronic constipation, kidney stones and history of aspiration pneumonia.

Resident 1's ISP dated and signed on 06/03/2024 indicated, Resident 1 was mostly nonverbal and required full assistance from staff to complete toileting, bathing, dressing, grooming and oral care. Resident 1 was non ambulatory, used a sit to stand lift for all transfers, and was incontinent of bowel and bladder. Additionally, the ISP stated, "Eating-[Resident 1] is on a general diet. Food is cut up; liquids are put in a cup with a lid and straw. [Resident 1] requires partial assistance from staff to complete eating tasks... [Resident 1] does not drink a lot throughout day so staff have to encourage [him/her] to do so... [Resident 1] has been identified as a choking risk, as [Resident 1] eats very fast and does not pay attention to how much food [s/he] puts on utensils...[His/her] liquids are regular liquids and

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[s/he] uses a cup with a lid and straw..." The ISP did not identify Resident 1's risk for dehydration, signs/symptoms staff were to monitor for dehydration, or address how the resident's fluid intake was to be monitored.

A Physician After Visit summary dated 07/24/2024 for Resident 1 indicated, "...[Resident 1] here for the following reasons: Low iron, Aspiration of liquid, initial encounter, Decreased appetite. [Resident 1] presents via wheelchair with caregiver with ongoing reports of decreased appetite and coughing with liquids...[Resident 1] is incontinent of urine at baseline. [Resident 1] has a swallow study scheduled for tomorrow. Caregiver endorses [Resident 1] has appeared to be more fatigued than [his/her] baseline. [S/he] has been drinking Ensure and water but has since decreased fluid intake. [Resident 1] has had these problems previously. [Resident 1] afebrile with normal vital signs at time of visit. Baseline cognitive function reported by caregiver. No other associated symptoms, aggravating or alleviating factors identified, or treatments tried. Assessment/Plan: ...Suspect symptoms may be secondary to behavioral condition. No evidence of dehydration or infection noted on exam. Potential diagnostic and treatment options discussed with caregiver in the setting of shared decision-making. Symptoms that warrant re-evaluation, urgent or emergent evaluation discussed... All questions were answered to the best of my ability. We reviewed signs and symptoms to monitor after this visit and when to notify me of any concerns or changes...Return if symptoms worsen or fail to improve."

A Speech-Language Pathology Evaluation dated 07/25/2024 for Resident 1 indicated, "[Resident 1] is developmentally disabled and unable to

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communicate functionally or follow commands... [Resident 1] intermittently coughs with meals [Resident 1] does have a prior history of aspiration pneumonia...ASSESSMENT...Today, [Resident 1] demonstrated fairly significant aspiration with thin liquids which was more pronounced when drawing from the straw which is [Resident 1's] typical form of drinking (per caregiver). With nectar (mildly) 2 thick liquid...and when drinking single drinks from the cup, swallow was safe with no aspiration...Would recommend nectar/mildly thick liquids take via cup to maximize safety of swallow. Would continue with bite sized soft solid foods for [Resident 1]... Recommendations: ...Liquid-Mildly Thick...Small bites/sips, Eat Slowly, No straws, Single Sips, Sit Upright, Remain sitting for 30 minutes following oral intake..."

***Surveyor noted Resident 1's ISP was not updated to include nectar thick liquids, the specific swallowing/positioning techniques, and the use of no straws until 08/15/2024. Additionally, the ISP did not address how staff were to monitor Resident 1's fluid intake to determine Resident 1's acceptance of the nectar thick liquids until 08/15/2024.

A ED (Emergency Department) report for Resident 1, dated 08/12/2024 at 11:25 PM indicated, "...Chief Complaint: Fatigue...[Resident 1], history of intellectual disability, epilepsy, nonverbal, non-ambulatory presents via EMS from assisted living facility...History is limited given resident nonverbal...Physical exam: Mouth: Mucous membranes are dry...Given profound hypernatremia likely in the setting of poor oral intake, discussed case with admitting doctor who agrees with admission...Clinical and Diagnostic Impression: Hypernatremia..."

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Y3244	Continued From page 5 A Hospital Clinical Note for Resident 1, dated 08/13/2024 at 12:58 PM indicated, "Per discussion with CMD (Care Management Director)-A...[Resident 1] was eating and drinking independently until about 3 months ago where [s/he] needed help eating. Could still drink from a tumbler with a straw by [him/herself]. In July, they noticed [Resident 1] was coughing a lot and [Resident 1] had an outpatient swallow study and recommended nectar thick liquids and no more straws. [CMD-A] shared [Resident 1] primarily drank out of straws prior to this. Last week, [Resident 1] stopped eating and pulled away from anybody trying to help [him/her] eat..." A Hospital Discharge Summary for Resident 1 indicated the resident was admitted on 08/12/2024 and discharged on 08/23/2024. The report stated, "[Resident 1]...was admitted to the hospital secondary to weakness and somnolence. [Resident 1] was essentially diagnosed with acute hypernatremia with sodium of 165. 1. Acute Hypernatremia-secondary to poor oral intake and dehydration ...Sodium improved from 165 to 139. Because of the ongoing poor oral intake, PEG tube was placed on 08/19/2024..." On 08/23/2024, the department received a MIR (Misconduct Incident Report) from the facility which indicated, "On 08/12/2024 it was reported [Resident 1] was not doing good, [Resident 1] had a decline in [his/her] eating. The DA (Division Administrator)-B received a text message stating [Resident 1] was leaning in [his/her] chair and didn't look right, [DA-B] then reached out to staff and told them to monitor [him/her] as [s/he] was told [s/he] was leaning in [his/her] chair and was not told [s/he] was not eating. [CMD-A] received a text message around 1:23 PM on 08/12/2024	Y3244		

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stating [Resident 1] was not doing well and [s/he] was not eating or drinking. [CMD-A] responded back to 911 [Resident 1] if they had to. Then around 10:30 PM, [DA-B] texted [CMD-A] and stated [Resident 1] was being 911'd. [CMD-A] asked why [Resident 1] was not taken in earlier as [CMD-A] instructed staff to do so. [DA-B] was unaware staff were instructed to call 911 earlier, and [DA-B] was not aware [Resident 1] was not eating well that day...[Resident 1] was admitted to the hospital for dehydration. It was also reported they would be placing a feeding tube in [Resident 1]...As soon as facility heard [Resident 1] was admitted [DA-B] started reviewing the charting that was done on [Resident 1] for the past few weeks. It was found [Resident 1's] eating had declined the most starting on 08/06/2024 and staff did not notify management of this decline until 08/12/2024. A staff meeting took place on 08/15/2024 where health monitoring policy and change of condition policy were discussed..."

Review of Observations notes for Resident 1 revealed the following:
*07/25/2024 at 2:45 PM- "[Resident 1] had a swallow study today (7/25). The physician recommended [Resident 1] starts taking thickened liquid (nectar thick) in a cup as opposed to non-thickened with a straw as this was shown to cause [Resident 1] to aspirate frequently during the study. If straw has to be used or [Resident 1] continues to aspirate, must give [Resident 1] single sips. The physician also kept [him/her] on a mechanical soft diet and urged to have staff ask [Resident 1] to swallow twice after every bite to help clear residual food in [his/her] mouth after the first swallow."
*08/12/2024 at 12:45 PM- "[Resident 1] is acting off today, [Resident 1] can barely sit up in [his/her] wheelchair and is not eating or drinking

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at all."
*08/12/2024 at 9:45 PM- "...Noticed [Resident 1] was dazed and lost and refused to transfer during night routine had to use a hoyer instead of the sit to stand because [s/he] refused to stand with the sit to stand, hoyer was used..."
*08/12/2024 at 10:45 PM- "[Resident 1] was sent out to the hospital at 10:54 PM."

On 08/27/2024, Surveyor requested intake and output monitoring documentation for Resident 1 for August 2024. The following documents were reviewed:

~Resident 1's electronic BM (bowel movement) record indicated the resident had no documented BMs from 08/07/2024 through 08/12/2024 (6 days).

~Resident 1's "Care History" reports from 08/01/2024 through 08/12/2024 for meal charting. All days had three meals listed except for 08/06/2024, which only showed two meals. The meal charting revealed the following:
*08/01/2024: 100% (First meal) ~ 75% (Second meal) ~ 25% (Third meal)
*08/02/2024: 100% ~ 50% ~ 25%
*08/03/2024: 25% ~ 100% ~ 25%
*08/04/2024: 100% ~ 100% ~ 50%
*08/05/2024: 100% ~ 75% ~ 100%
*08/06/2024: 25% ~ 50%
*08/07/2024: 100% ~ 25% ~ 75%
*08/08/2024: 25% ~ 0% ~ 25%
*08/09/2024: 0% ~ 50% ~ 25%
*08/10/2024: 0% ~ 25% ~ 25%
*08/11/2024: 25% ~ 0% ~ 0%
*08/12/2024: 25% ~ 0% ~ 50% (***Surveyor noted what was recorded on Resident 1's meal charting for this date was inconsistent with staff interviews. Staff interviewed indicated Resident 1

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Y3244	Continued From page 8 refused to eat all 3 meals on 08/12/2024) Although, staff monitored percentages of meals consumed, no fluid intake was recorded for any of the above meals. No other documentation of intake and output monitoring was provided for Resident 1. On 08/27/2024, Surveyor reviewed Resident 1's August 2024 eMAR (electronic Medication Administration Record). The eMAR indicated, Ensure (a nutritional shake) was given three times per day, but the amount of the shake consumed by Resident 1 was not documented. Additionally, the eMAR indicated, Resident 1 had a physician's order for Lasix (a diuretic/water pill) daily. Resident 1 received the medication daily from 08/06/2024 through 08/12/2024. ***Surveyor found no evidence the physician was notified to discuss the resident's status, or the appropriateness of the diuretic use given the resident's low food intake for several meals. (Note: the diuretic would further deplete the resident's fluid volume and exacerbate the risk of dehydration and electrolyte imbalance.) In addition, no interventions were added to the ISP to improve Resident 1's food/fluid intake. On 08/27/2024 at 9:40 AM, Surveyor interviewed DSP (Direct Support Professional)-F regarding Resident 1. DSP-F indicated Resident 1 was nonverbal, utilized a wheelchair, did not walk, or propel self in the wheelchair and was incontinent of bowel and bladder. DSP-F stated, "[Resident 1] would eat 100% of meals, but we had to start feeding [Resident 1] sometime around the end of June early July 2024. On 07/24/2024, [Resident 1] went to [his/her] doctor for not eating and had a swallow study done. [Resident 1] was placed on	Y3244		

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nectar thick liquids." Surveyor questioned DSP-F if s/he prepared [Resident 1's] liquids to the nectar thick consistency. DSP-F verified all liquids s/he served Resident 1 were nectar thick. Surveyor asked how liquids were documented. DSP-F stated, "We're supposed to record the percentage of what the resident eats, not drinks. We don't record liquid intake." Surveyor then asked what Resident 1 was like during the week of 08/06/2024 through 08/11/2024. DSP-F stated, "You could tell something was bothering [Resident 1], by the way [s/he] looked. [Resident 1] looked "drained." [Resident 1] would be at the table and would nod off and fall asleep. [Resident 1] would fall asleep when I tried to feed [him/her] ...[Resident 1] wouldn't take [his/her] pills. It took three attempts before [s/he] would take them. I noticed [Resident 1] was very quiet and wasn't eating much."

On 08/28/2024 at 1:30 PM, Surveyor interviewed DSP-C regarding Resident 1. DSP-C indicated s/he worked the AM shift with Resident 1 on 08/12/2024. DSP-C stated, "I got [Resident 1] up for the day and noticed [s/he] was weak. [Resident 1] wouldn't pull [him/herself] up. This was different because [Resident 1] was usually strong in [his/her] arms. [Resident 1] wouldn't hold [him/herself] up in the recliner or wheelchair and would slouch to one side. [Resident 1] wasn't interested in eating breakfast or lunch. [Resident 1] didn't eat or drink anything for breakfast or lunch or open [his/her] mouth. When I put a cup up to [his/her] lips, [s/he] wouldn't open [his/her] mouth. I would hand [Resident 1] [his/her] cup to drink several times, but [s/he] wouldn't take it. I would re-approach and give [Resident 1] enough time to eat/drink, but [Resident 1] didn't want anything...[Resident 1] just wasn't [him/herself]. [DSP-H] and I placed

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[Resident 1] in the recliner, and I noticed [Resident 1] couldn't breathe well, I thought maybe [s/he] was getting a cold. I felt uncomfortable with [Resident 1's] weakness and [him/her] not being quite right. I thought [Resident 1] should've gone to the ED during my shift, but [DA-B] wanted us to monitor [him/her]. When I left on 08/12/2024, I told the oncoming staff person to monitor [Resident 1] and check on [him/her] more often."

On 08/27/2024 at 9 AM, Surveyor interviewed DSP-D regarding Resident 1. DSP-D indicated Resident 1 was nonverbal, incontinent of bowel and bladder, dependent on staff for ADL's, chairfast and did not self propel. DSP-D stated s/he worked the PM shift alone and would have to feed Resident 1. DSP-D stated, "There were days [Resident 1] would turn [his/her] head and not want anything... [Resident 1] did not attempt to use [his/her] hands at all." Surveyor then asked about Resident 1's status on 08/12/2024. DSP-D stated, "I worked the PM shift alone on 08/12/2024. When I came into work [DPS-C] told me [Resident 1] wasn't eating or drinking anything and to keep an eye on [him/her]...[Resident 1] wouldn't eat dinner and ate nothing for me. [Resident 1] didn't drink [his/her] ensure that night either...I did get [Resident 1] to drink a little bit of water with [his/her] 8 PM meds, it was hard, but I did get [him/her] to take [his/her] meds. [Resident 1] sat in the recliner chair during my shift, and I couldn't get [him/her] up. It was unusual for [Resident 1] not to get up...I tried to get [Resident 1] up out of the recliner chair throughout the shift, but [s/he] wouldn't move." Surveyor asked DSP-D if s/he notified the guardian or management during the shift of these changes. DSP-D stated, "I didn't make any calls during my shift. I didn't think anything of it,

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because I was just told to keep an eye on [Resident 1]...When [DSP-G] came into work the night shift, we both tried to get [Resident 1] out of the recliner chair, but [s/he] wouldn't move. We then called [DA-B] and [Resident 1's] guardian, who told us to send [Resident 1] out to the ED...Right before we sent [Resident 1] out, I think [s/he] had a silent seizure...[Resident 1's] eyes were blood shot red and [his/her] arms and hands were shaking."

On 08/27/2024 at 12:50 PM, Surveyor interviewed Resident 1's guardian. Guardian-E indicated s/he received a call from facility staff on 08/12/2024 at 10:30 PM. Guardian-E stated, "Staff told me [Resident 1] was shaking, sweating and the whites of [his/her] eyes were red. Staff told me they called the manager, and the manager wasn't sure what to do and told staff to call me. I told staff to call 911. A few hours later the hospital called me and told me [Resident 1] was dehydrated and in critical condition. Hospital staff said [Resident 1's] mouth and tongue were so dry, it appeared [s/he] hadn't had any food or water in days." Surveyor asked Guardian-E if s/he had been made aware of any changes in Resident 1's behavior or meal intakes within the week leading up to the ED visit on 08/12/2024. Guardian-E indicated s/he had not been contacted. Guardian-E stated, "There had been several times when I did visit [Resident 1] at the facility and found [his/her] drink cup empty and [his/her] food cold."

On 08/27/2024 at 12:30 PM, Surveyor interviewed DA-B regarding Resident 1. DA-B indicated Resident 1 had a history of not eating and had a feeding tube in the past. DA-B stated at times Resident 1 would eat on his/her own and other times s/he would need assistance.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0014137	A. BUILDING: _____ B. WING _____	C 09/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VAN DYKE	1811 S VAN DYKE RD APPLETON, WI 54914

(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
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Surveyor then asked if Resident 1's fluid intake was being monitored. DA-B stated, "We monitor the amount of food [Resident 1] eats, but we do not monitor [Resident 1's] fluid intake, unless we have an order from the physician requesting this." DA-B went on to say, "[Resident 1] started having a decline with eating around July 2024. We brought [Resident 1] to [his/her] primary doctor on 07/24/2024 and [s/he] had a swallow study on 07/25/2024. [Resident 1] was placed on nectar thick liquids." Surveyor questioned DA-B if [Resident 1] accepted the nectar thick liquids. DA-B stated, "I don't know maybe that's how [s/he] got so dehydrated." Surveyor asked if the nectar thick liquids were being monitored to determine Resident 1's acceptance of the nectar thick liquids. DA-B stated, "No, we didn't monitor [Resident 1's] intake of nectar thick liquids. After we found out [Resident 1] was hospitalized for dehydration, [CMD-A] added liquid intake monitoring to [Resident 1's] ISP." DA-B verified Resident 1's ISP did not identify Resident 1 at risk for dehydration, signs/symptoms staff were to monitor for dehydration or how Resident 1's fluid intake was to be monitored. DA-B also confirmed Resident 1's ISP was not updated to include nectar thick liquids, specific swallowing/positioning techniques, and the use of no straws until 08/15/2024. Surveyor questioned DA-B about Resident 1's status on 08/12/2024. DA-B indicated s/he received a text message from [DSP-C] around 12:50 PM about how [Resident 1] was leaning to the side and didn't eat. DA-B stated, "I was off work on 08/12/2024, but did tell staff if [Resident 1] didn't seem normal, staff could send [him/her] out. The staff working during the AM shift also got a hold of [CMD-A] separately and [CMD-A] told them to send [Resident 1] out to the ED. I didn't hear anything until 10 PM at night, when [DSP-D]

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called and said [Resident 1's] eyes were weird, and it appeared like [s/he] was having a seizure. I told [DSP-D] to send [Resident 1] out to the ED." Surveyor asked if vitals were completed for Resident 1. DA-B stated, "No. We do weights monthly. We do not take vitals as that is a skilled task and we need doctor orders and parameters to do such." Surveyor then asked if the facility has policy regarding hydration. DA-B replied, "We do not have a policy specifically structured to nutrition/hydration monitoring. We have our change of condition policy and our health monitoring policy."

In conclusion, the provider did not identify Resident 1 at risk for dehydration even though the resident was intellectually disabled, had physical limitations, received a diuretic daily and had a history of kidney stones and chronic constipation. On 07/24/2024, during a physician office visit there had been reports from staff Resident 1 was having a decrease in appetite and fluid intake. The facility did not monitor Resident 1's fluid intake nor make changes to the ISP. Starting around 08/06/2024, Resident 1 began having poor meal intakes, staff did not notify the physician for potential interventions or update the ISP to improve Resident 1's food/fluid intake. On 08/12/2024 during the AM shift Resident 1 experienced a change of condition. Staff did not summons medical help until approximately 10 hours later, when Resident 1 was sent to the ED and hospitalized for hypernatremia and dehydration.