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	0017088	A. BUILDING: _____ B. WING _____	C 07/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACY ASSISTED LIVING	N26W26511 COLLEGE AVE 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 07/24/2023 with information gathered through 07/26/2023, the department conducted a complaint investigation and review of a facility self report at Legacy Assisted Living. Four deficiencies were identified. Two of the four deficiencies were repeat deficiencies. The complaint was substantiated. Census: 19	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 observation, record review and interviews, the provider did not follow the individual service plan for 3 out of 4 resident reviewed. Resident 1 who was to be assisted to the dining room for all meals and fed by staff due to risk of choking was not assisted to the dining room, was not fed by staff in the dining room, had a choking episode and died. Resident 2 and Resident 3 who were identified as 'at risk for falls' were observed in bed without a fall mat in place as identified on the individual service plan. Findings include: Example 1- Resident 1	N 388		

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

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N 388	Continued From page 1 On 07/24/2023, Surveyor conducted a review of a facility self-report related to Resident 1 who choked on food when staff fed Resident 1 in Resident 1's room while Resident 1 was in bed. Staff administered the Heimlich procedure and Resident 1 died. The incident occurred on 07/15/2023 at approximately 6:00 PM. Surveyor reviewed Resident 1's record on 07/24/2023. Resident 1's diagnoses included diabetes mellitus, hypertension and cerebral infarction. Resident 1 had a physician order dated 06/09/2023 for a "regular diet with food cut up." Resident 1's most current individual service plan dated 05/18/2023 noted "Diet to general with cut up items." "Risk for Choking- Daily at breakfast, lunch, dinner and as needed. Resident has been identified as a choking risk. All meals should be in dining room as decline is present. Cut all food into bite size portions. Monitor fluids during meals for coughing." According to the incident report dated 07/15/2023- 6:00 PM, "Shortly before 6:00 PM caregiver went to resident room to feed [him/her]. After resident took a bite, resident appeared to be choking. Caregiver immediately went to get lead/med passer in charge for the shift. Med passer immediately went into resident's room and noticed resident appeared to be choking and immediately called 911...." On 07/24/2023, at 11:08 AM, Surveyor interviewed Executive Director A regarding Resident 1 and the 07/15/2023 choking incident. Executive Director A stated Lead Medication Passer C directed Agency Caregiver B to feed Resident 1 in Resident 1's room. Executive Director A stated Resident 1 should have been assisted to the dining room and fed the evening	N 388		

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N 388	Continued From page 2	N 388		

meal in the dining room as this is identified in the individual service plan due to risk of choking and need for assistance with feeding. Surveyor asked if Executive Director A knew why Lead Medication Passer C directed Caregiver B to feed Resident 1 in Resident 1's room. Executive Director A stated Resident 1 was anxious. Surveyor asked if Resident 1 was fed in bed or in the Broda chair. Executive Director A stated s/he believed it was the chair.

On 07/25/2023, at 4:44 PM, Surveyor interviewed Agency Caregiver B regarding the incident. Agency Caregiver B stated Lead Med Passer C told them to keep Resident 1 in bed and feed Resident 1 but put the head of the bed up. Agency Caregiver B stated Resident 1 was served 2 bites of food when Resident 1 started to choke. Agency Caregiver B stated s/he did what s/he was told as this was the first time working at this facility.

Example 2- Resident 2

On 07/24/2023, at 3:02 PM, Surveyor observed Resident 2 in bed asleep. Their fall mat was observed propped against the wall. Surveyor showed RN E and Executive Director A the fall mat and asked if the mat should be on the floor by the bed. RN E immediately placed the mat by the side of Resident 2's bed. Surveyor asked RN E if the mat should have been on the floor by the bed. RN E stated yes.

A review of Resident 2's individual service plan (ISP) dated 01/23/2023, noted Resident 2 was a fall risk. The ISP stated "Bed in low position. Pillows for repositioning. May use SR on bed for positioning. Likes to hold on to it when turning. Broda chair for comfort. Mat by side of bed. To

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N 388	Continued From page 3 be free of falls, to remain safe and free of injury through next review. Mat on floor." Example 3- Resident 3 On 07/24/2023, at 2:51 PM, Surveyor observed Resident 3 in bed asleep. The fall mat was on the floor approximately 2 feet from the side of the bed. Surveyor showed RN E and Executive Director A the fall mat. Surveyor asked if the fall mat was positioned correctly on the floor by the bed. RN E immediately placed the mat by the side of Resident 3's bed and stated it was not. Surveyor asked RN E if the mat should have been on the floor by the bed. RN E stated yes and it would not do any good if Resident 3 fell from the bed. A review of Resident 3's individual service plan (ISP) dated 07/18/2023, noted Resident 3 was a fall risk. The ISP stated "identified as fall risk. Has floor mat, Broda chair. Pillows for positioning in bed and Broda. Chair alarm in Broda chair. To be free of falls, to remain safe and free of injury through next review." On 07/24/2023 at approximately 3:30 PM, Surveyor interviewed RN E and Executive Director A about the implementation of resident ISPs. RN E stated staff should be following the ISP as they do have ISPs in a book that all staff have access to view.	N 388		
N 415	83.37(2)(d) Documentation of medication administration. Documentation of medication administration. As required under s. DHS 83.42(1)(o), at the time of medication administration, the person	N 415		

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N 415	Continued From page 4 administering the medication or treatment shall document in the resident record the name, dosage, date and time of medication taken or treatments performed and initial the medication administration record. Any side effects observed by the employee or symptoms reported by the resident shall be documented. The need for any PRN medication and the resident ' s response shall be documented. This Rule is not met as evidenced by: Based on record review and interviews, the provider did not ensure that at the time of medication administration, staff documented the administration of medication in the resident record, the name, dosage, date and time of medication taken. This is a repeat deficiency see Statement of Deficiency #ERND11 dated 06/06/2022. Findings include: On 07/24/2023, Surveyor asked RN E to provide Resident 4's the medication administration record for the months of March and April 2023. Resident 4 was admitted to the provider on 03/21/2023 with a diagnoses including type 2 diabetes. Resident 4 had physician orders dated 04/06/2023 for Hydroco/Apap 5-325 MG one tablet every 6 hours scheduled. The medication administration record noted it was to be dispensed at 2 AM; 8 AM; 2 PM; 8 PM. Resident 4 had physician orders dated 03/21/2023 for Lisinopril 5 MG one tablet daily and Metoprolol Suc 25 MG.	N 415		

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N 415	Continued From page 5 A review of the medication administration record for the month of April 2023 noted on 04/12/2023 at 8:00 AM Lisinopril 5 MG and Metoprolol Suc 25 MG not signed out as administered. The Hydroco/APA 5-325 MG was not documented as administered on 04/11/2023 at 2 AM; 04/12/2023 at 8 AM; 04/15/2023, 04/16/2023, 04/17/2023 at 2 AM; 04/21/2023 and 04/22/2023 at 2:00 PM not signed out as administered. On 04/29/2023 at 2:00 AM and 8:00 PM not signed out as administered. On 04/30/2023 at 2:00 AM not signed out as administered. A review of the medication administration record for the month of May 2023 noted the following: Hydroco/APAP 5-325 MG on 05/01; 05/02; 05/03; 05/06; 05/09; 05/12; 05/13; 05/14; 05/16; 05/17; 05/20; 05/23/;05/26; 05/27; 05/30; 05/31/23 at 2 AM not documented as administered. Hydroco/APAP 5-325 MG on 05/24/23 at 8:00 AM not documented as administered. Hydroco/APAP 5-325 MG 05/11; 05/13; 05/20/2023 at 2:00 PM not documented as administered. Hydroco/APAP 5-325 MG on 05/06/2023 at 8:00 PM not documented as administered. In addition, Elquis 5 MG ordered on 03/21/2023 not documented as administered on 05/06/2023 at 8 PM Atorvastatin 20 MG ordered on 03/28/2023 not documented as administered on 05/06/2023 at 8 PM. Sennexon-S 8.6 MG ordered on 03/21/2023 not documented as administered on 05/06/2023 at 8 PM. Lisinopril 5 MG ordered on 03/21/2023 not	N 415		

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N 415	Continued From page 6 documented as administered on 05/24/2023 at 8 AM. Metoprolol Suc 25 MG ordered on 03/21/2023 not documented as administered on 05/24/2023 at 8 AM. Lantus Solostar 20 Units ordered on 03/21/2023 not documented as administered on 05/06/2023 at 8 PM. On 07/24/2023, at approximately 3:30 PM, Surveyor interviewed Executive Director A and RN E regarding the incomplete medication administration records. RN E stated staff should have documented the administration as RN E felt that Resident 4 received all the medications but they did not chart this. RN E stated Resident 4 was very particular with timing of the medications. RN E stated that if the resident refused the medication, staff is expected to document this as a refusal.	N 415		
N 419	83.37(3)(c) Medication storage: locked cabinet. Administered by facility. The CBRF shall keep medicine cabinets locked and the key available only to personnel identified by the CBRF. This Rule is not met as evidenced by: Based on observation and staff interview the provider did not ensure that all medicine cabinets were locked. Findings include: Legacy Assisted Living is a class CNA (non-ambulatory) facility with a capacity to care for 32 residents. The facility serves advanced aged, irreversible dementia, developmentally disabled and terminally ill.	N 419		

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N 419	Continued From page 7 On 07/24/2023, at 9:34 AM, Surveyor observed the medication room located toward the front of the facility. The door contained a coded key pad. The door to the room was open. Inside the room was a medication cart which contained the PM medications for 19 residents of the facility. The medication cart was not locked and the drawers could be opened to access the medication. Stored in the unsecured cabinet in the medication room was a cycle fill of medication for the month of August 2023 for 19 residents. Surveyor observed the door open and unsecured at 9:44 AM, 10:00 AM, and 10:30 AM. Several staff members including Assistant Manager G walked past the room. At 10:33 AM, the door was partially closed and the room contained one locked medication cart and the PM medication cart. Surveyor opened the door and promptly closed the door tightly. On 07/24/2023 at 2:09 PM, Surveyor interviewed RN E regarding the medication not being secured. Surveyor showed RN E the door and the door was locked at that time. RN E stated the door should have been closed at secured at all times. RN E confirmed that new cycle fill of medications was in that room unsecured.	N 419		
Y3234	50.09(1)(e) Treatment (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: (e) Be treated with courtesy, respect	Y3234		

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and full recognition of the resident's dignity and individuality, by all employes of the facility and licensed, certified or registered providers of health care and pharmacists with whom the resident comes in contact.

This Rule is not met as evidenced by:
Based on observation and interviews, the provider did not ensure each resident was treated with dignity and respect in relation to responding to calls for assistance, providing grooming, and meal service.

This is a repeat deficiency. See Statement of Deficiency #ERND12 dated 10/17/2022.

Findings include:

Legacy Assisted Living is a class CNA (non-ambulatory) facility with a capacity to care for 32 residents. The facility serves advanced aged, irreversible dementia, developmentally disabled and terminally ill.

Example 1 - Resident 2

On 07/24/2023, at approximately 9:36 AM, Surveyor observed Resident 2 seated in a Broda chair in the back television lounge. Resident 2's mouth was observed to be covered with a crusted on fluid, their lips appeared dry, hair very disheveled, finger nails were long and dirty, was unshaven with several days' worth of stubble, t shirt was stained in multiple areas and was pulled

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upward on the body exposing Resident 2's stomach and adult incontinence product. At approximately 10:21 AM, Caregiver D approached Resident 2 and wiped off Resident 2's mouth.

Surveyor interviewed Caregiver F at approximately 1:14 PM, on 07/24/2023. Caregiver F stated Resident 2 is dependent on staff for all cares.

Example 2 - Resident 3

On 07/24/2023, at 9:36 AM, Surveyor observed Resident 3 seated in a Broda chair in the back television lounge. Resident 3 had a neck pillow around the back of Resident 3's neck. The pillow had a thick accumulation of dried food particles dried to the cover. Resident 3 was slouched down in the chair. Resident 3's hair was long, appeared greasy to the touch, not combed and covering eyes. Resident 3's incontinence product was observed at the top of the green jogging pants. Food crumbs from breakfast were observed on the sides of the broda chair and on Resident 3's clothing. Resident 3 remained in the television lounge until taken into the dining room for the noon meal.

Surveyor interviewed Caregiver F at approximately 1:14 PM, on 07/24/2023. Caregiver F stated Resident 3 is dependent on staff for all cares.

Example 3 - Resident 5

On 07/24/2023, at 11:40 AM, Surveyor interviewed Resident 5. Resident 5 stated staff do not take the time to respond to your call pendant. When staff do respond to the call

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pendant they will say, "why are you calling us?" Resident 5 told Surveyor the response time can be very long. Surveyor asked Resident 5 push the pendant. Resident 5 pushed the pendant 3 times at 11:41 AM. Resident 5 stated staff do not cut up food for you and residents are not provided with butter knives to cut food. This morning they were served a sausage patty which was cut in half and many folks struggle with using the side of the fork so Resident 5 will just pick up the entire half of the patty and eat it. S/he is not able to propel his/her own Broda chair so staff will just shove him/her into their room. Resident 5 expressed frustration when staff do not tell you their names and staff turnover is very high.

At 12:07 PM, Surveyor noted no staff members responded to Resident 5's call pendant until a staff member entered the room to speak with Surveyor. Surveyor explained to staff that Resident 5 also had activated the call pendant. Surveyor asked Caregiver F and Caregiver D if they were aware Resident 5 had placed the call pendant on. Caregiver F stated the call goes to a phone or the tablet but they did not have either with them and were not aware of the need for assistance. Caregiver F and Caregiver D went to the manager's office and obtained the phone and located the tablet. The tablet identified that Resident 5 had activated the pendant at 11:41 AM, 32 minutes ago. The phones did not show any activation of the pendant and Caregiver F stated the phones did not appear to be working at this time.

Surveyor then observed the noon meal in the dining room. Residents were served meat balls cut in half. Several residents including Resident 5 were observed attempting to cut their meal balls into quarter size pieces using the side of their

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Y3234	Continued From page 11 forks. Several residents struggled with cutting the meat balls. None of the residents in the dining room had knives or were assisted by staff to cut the balls. On 07/24/2023, at approximately 3:30 PM, Surveyor interviewed Executive Director A and RN E regarding dignity of the residents and the resident concern related to call pendants. RN E stated they recently purchased a brand new system with the use of the phones and tablets and are working on the system. Regarding the meal service, RN E stated that the kitchen cuts the meat balls in half for the residents. Regarding the grooming, RN E stated staff are uncomfortable shaving Resident 2 so s/he will do so.	Y3234		