STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	390225	A. BUILDING: _____ B. WING _____	C 08/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ORCHARD VIEW ADULT FAMILY HOME	W6429 HWY 12 FORT ATKINSON, WI 53538

(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
M 000	INITIAL COMMENTS On 07/18/2024, with information gathered through 08/05/2024, the Bureau of Assisted Living, Southern Regional Office conducted a standard licensing survey and complaint investigation at Orchard View Adult Family Home located at W6429 Hwy 12 in Fort Atkinson, WI. Two citations of noncompliance were issued, 1 of which is a repeat citation of noncompliance. The complaint was substantiated. Census: 4	M 000		
M 230	88.04(2)(f) CONDITION WHICH REPRESENTS RISK OR HARM The licensee may not permit the existence or continuation of a condition in the home which places the health, safety or welfare of a resident at substantial risk of harm. This Rule is not met as evidenced by: Based on observation, interview, and record review, the provider did not ensure the existence or continuation of a condition did not exist in the home which placed Resident 1's health, safety, or welfare at substantial risk of harm. Resident 1 was admitted to the home with a practitioner's order for all meals and snacks to be pureed and liquids to be thickened to a nectar-thick consistency. The practitioner's order directed caregivers to provide Resident 1 with "1-on-1" supervision with "hand-on-hand guidance" from caregivers at meals. The practitioner's order directed caregivers to cue Resident 1 to slow down as Resident 1 would	M 230		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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M 230	Continued From page 1	M 230		

feed himself/herself "too quickly." A written practitioner's order to change or discontinue this mechanical diet order for Resident 1 was not received by Licensee A during Resident 1's stay at the home.

On 08/13/2023, Resident 1 experienced choking after being provided food by a caregiver that was not pureed. The caregiver performed the Heimlich maneuver on Resident 1 and Resident 1's choking episode was cleared. The caregiver called 911 and the emergency medical technicians (EMTs) arrived at the home, assessed Resident 1's condition, and did not transport Resident 1 to the hospital.
Licensee A did not ensure Resident 1's physician, or practitioner, legal guardian, or placing agency were informed of Resident 1's choking episode on 08/13/2023.
On 08/28/2023, Licensee A developed Resident 1's ISP. The documentation included, "Staff will use methods such as sippy cups or Thick-It for beverages to allow [Resident 1] to drink liquids without aspirating. Staff will blend, cut up finely, and/or feed [Resident 1] [his/her] food to keep [Resident 1] from aspirating (breathing in of food or fluid into the lungs) [his/her] food." Licensee A had not received an order to change Resident 1's mechanical diet. Licensee A and 2 caregivers had not completed training/education in mechanically altered diets in order to make determinations regarding Resident 1's dietary needs or abilities.

On 11/26/2023, Resident 1 experienced choking after being provided food by a caregiver that was not pureed and fluid that was not thickened, as ordered. The caregiver repeatedly performed the Heimlich maneuver on Resident 1 and believed Resident 1's airway had been cleared without

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	390225	A. BUILDING: _____ B. WING _____	C 08/05/2024

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ORCHARD VIEW ADULT FAMILY HOME	W6429 HWY 12 FORT ATKINSON, WI 53538

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M 230	Continued From page 2	M 230		

observing anything come out of Resident 1's mouth. During this incident, the caregiver left Resident 1 without supervision and within reach of Resident 1's food while the caregiver went to request assistance from a caregiver no longer on duty and located in the lower level apartment of the home. When the caregiver returned to Resident 1, Resident 1 had been able to access his/her food and continued to feed himself/herself. Resident 1 continued to choke and the caregiver repeatedly attempted to clear Resident 1's airway without success. Resident 1 lost consciousness and stopped breathing. The other caregiver came to the kitchen and called 911. The EMTs arrived at the home, continued to provide both physical and mechanical CPR before transporting Resident 1 to a local hospital. Resident 1 required mechanical ventilation and was later transported that day to a larger hospital.

Resident 1 was hospitalized on an intensive care unit and received life support care following Resident 1's choking incident at the home on 11/26/2023. Resident 1 died at the hospital on 12/02/2023.

This requirement is being cited for the third time. See Statement of Deficiency (SOD) K7EJ11, issued 08/09/2022, and SOD K7EJ12, issued 01/17/2023.

The findings include:

On 05/30/2024, the department received an allegation of a resident's choking incident resulting in substantial harm.

On 11/27/2023, the department received a documented report from Licensee A of a choking incident on 11/26/2023. The documentation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	390225	A. BUILDING: _____ B. WING _____	C 08/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ORCHARD VIEW ADULT FAMILY HOME	W6429 HWY 12 FORT ATKINSON, WI 53538

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M 230	Continued From page 3	M 230		

included, "[Licensee A] was notified that [Caregiver B] implemented the 911 system at 1709 [5:09 P.M.] at 1710 [5:10 P.M.] (sic) for a choking event with [Resident 1]. [Caregiver B] had called stating that [Resident 1] was choking and that [s/he] had dialed 911. [Licensee A] immediately got on [his/her] way to the group home and arrived at 1713 [5:13 P.M.]. [Licensee A] parked to the left of the ambulance, in front of the large garage overhead door. When [Licensee A] got into the group home [Licensee A] saw fire department EMS [emergency medical services] crew working on [Resident 1] between island and the table. [Licensee A] was going to offer assistance, but [Licensee A] decided that they had the engine crew as well, so [Licensee A] assisted other clients out of the room so [the residents] could remain in peace. [Resident 1] was having chest compressions done and intubation performed (placement of flexible plastic tube into trachea to maintain open airway and/or administer medications). After what seemed to be 15 minutes of chest compressions done, the crew felt for pulses and they indicated that they felt them."

On 11/28/2023, the department received a documented report from Licensee A. The documentation included, "Worker: [Caregiver B]. Date: 11/26/2023. Resident: [Resident 1]. Incident took place: Kitchen. What staff/resident were doing: Dinner, feeding [Resident 1]. Incident Summary: [Caregiver B] gave [Resident 1] a spoonful of food which [s/he] seemed to be getting down fine but then started struggling slightly. [Caregiver B] handed [Resident 1] [his/her] water bottle to assist in getting the food down, [Resident 1] was coughing and was still responsive. [Caregiver B] attempted to do the Heimlich [maneuver] and then when that was not

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	390225	A. BUILDING: _____ B. WING _____	C 08/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ORCHARD VIEW ADULT FAMILY HOME	W6429 HWY 12 FORT ATKINSON, WI 53538

(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
M 230	Continued From page 4	M 230		

working [Caregiver B] went to the door downstairs to call [Caregiver C] to come up and assist [Caregiver B] since the last time it proved difficult to assist [Resident 1] on [Caregiver B's] own. When [Caregiver B] came back to the kitchen [Resident 1] was taking a spoonful of food and continuing to eat, [Caregiver B] removed the spoon from [Resident 1's] hand and attempted to assist as [Resident 1] was now choking worse than before. [Caregiver B] continued to try to do the Heimlich and when that wasn't effective [Caregiver B] held [Resident 1] and elevated [him/her] slightly until the EMTs had arrived."

On 07/18/2024, Licensee A provided Surveyor with a document titled, "Assisted Living Facility Self-Report." Licensee A told Surveyor s/he submitted this documentation to the department with the other 2 documented reports from Licensee A. The self-report documentation dated 11/27/2023 included, "[Resident 1] choking on food leading to cardiac arrest." The incident date was documented "11/26/2023" at "5:09." The documentation included, "[Resident 1] was eating spaghetti at the dining room table assisted by [Caregiver B]. [Caregiver B] was feeding [Resident 1] spaghetti with a spoon. [Caregiver B] noticed [Resident 1] struggling, so [s/he] handed [Resident 1] the water bottle to help wash down the food that [Resident 1] was coughing on. The water seemed to be unsuccessful, so [Caregiver B] performed the Heimlich maneuver on [Resident 1] without success. [Caregiver B] dialed 911 and then called to get help from [Caregiver C]. As soon as [Caregiver B] got back to [Resident 1] at the table, [Resident 1] spoon fed [self] some more spaghetti. At this point, [Resident 1] was choking even worse than before. [Caregiver B] continued to do the Heimlich without success until EMS crews

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	390225	A. BUILDING: _____ B. WING _____	C 08/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ORCHARD VIEW ADULT FAMILY HOME	W6429 HWY 12 FORT ATKINSON, WI 53538

(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
M 230	Continued From page 5	M 230		

arrived. Once the crew had arrived, [Resident 1] was unconscious and they performed CPR [cardiopulmonary resuscitation]. The LUCUS (Lund University Cardiopulmonary Assist System; mechanical chest compression) device was started and paramedics were pushing drugs (medications) and had to intubate [Resident 1]." The documentation included, "[Resident 1] was revived by the (local) paramedic crew and taken to (a local) hospital."

On 07/18/2024 at 8:45 A.M., Surveyor conducted an interview with Caregiver C. Caregiver C told Surveyor s/he had worked at the home as a caregiver for approximately 2 years. Caregiver C told Surveyor s/he and Caregiver B lived in the home's lower level/basement apartment. During a tour of the facility, Surveyor observed the doorway leading from the home's first floor to the home's lower level apartment included a locked door and descending staircase to the lower level. Caregiver C told Surveyor the basement door was kept locked at all times to prevent any resident gaining access to the staircase unassisted. Surveyor observed the home's kitchen and resident's dining area were located on the home's first floor.

On 07/18/2024 at 9:00 A.M., Surveyor conducted an interview with Licensee A. Licensee A told Surveyor Resident 1 was admitted to the home on 03/09/2020 from a different assisted living facility. Licensee A told Surveyor Resident 1 was hospitalized with mechanical, respiratory ventilation (or mechanical life-support) for approximately 2 weeks following Resident 1's choking incident on 11/26/2023 before Resident 1's Legal Guardian D discontinued Resident 1's life support.

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	390225	A. BUILDING: _____ B. WING _____	C 08/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ORCHARD VIEW ADULT FAMILY HOME	W6429 HWY 12 FORT ATKINSON, WI 53538

(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
M 230	Continued From page 6 On 07/18/2024 at 9:57 A.M., Caregiver C told Surveyor Resident 1 had diagnoses including cognitive or intellectual disabilities and was able to ambulate independently. Caregiver C told Surveyor Resident 1 was known to have issues with swallowing when Resident 1 was admitted to the home and was at risk for choking. Caregiver C told Surveyor Resident 1's food needed to be pureed and liquids thickened before consumption when Resident 1 was admitted to the facility. Caregiver C told Surveyor Resident 1's pureed diet with thickened liquids was "deemed unnecessary at some point" although s/he was not sure when this change occurred. Caregiver C told Surveyor Resident 1 required constant supervision with meals, snacks, and any food items related to Resident 1's behavior of eating too fast and being at risk for choking. Caregiver C said s/he had seen Resident 1 struggle with swallowing after taking a bite of food before the incident on 11/26/2023 occurred. Caregiver B said s/he would have to tell Resident 1 to stop, give him/her a drink of water or give him/her a moment to try and swallow before asking Resident 1 to say "Ah" so s/he could look in Resident 1's mouth to check s/he had swallowed the food. Caregiver C told Surveyor Resident 1 would attempt to eat food from other resident's plates if within Resident 1's reach. Caregiver C told Surveyor Resident 1 would "wander" and get in to the home's refrigerator attempting to eat food without supervision. Caregiver C told Surveyor s/he was in the home's lower level apartment on 11/26/2023 when Caregiver B was on duty and Resident 1 experienced the choking incident. Caregiver C said s/he had worked the day shift and was no longer on duty when it occurred. Caregiver C told Surveyor s/he heard Caregiver B yell for him/her to come upstairs. Caregiver C said s/he observed	M 230		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ORCHARD VIEW ADULT FAMILY HOME	W6429 HWY 12 FORT ATKINSON, WI 53538

(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
M 230	Continued From page 7	M 230		

Caregiver B performing the Heimlich maneuver on Resident 1 in the standing position when s/he got to the kitchen. Caregiver C said s/he could tell Resident 1 was not breathing and s/he told Caregiver B to start cardiopulmonary resuscitation (CPR). Caregiver C said s/he called 911 at that point and Caregiver B continued to perform CPR on Resident 1 until the EMTs [emergency medical technicians] arrived. Caregiver C told Surveyor Licensee A was also an EMT and s/he called Licensee A after calling 911.
Caregiver C told Surveyor s/he believed Resident 1 would continue to attempt to eat any food s/he could get his/her hands on despite choking based on Resident 1's behavior of "shoveling it fast" in to Resident 1's mouth.

On 07/18/2024 at 11:23 A.M., Surveyor conducted an interview with Caregiver B. Caregiver B told Surveyor s/he had worked at the home as a caregiver for less than 1 year. Caregiver B said s/he had no experience working as a caregiver in a licensed home prior to being hired by Licensee A. Caregiver B said s/he had completed training in first aid and choking following hire. Licensee A provided Surveyor with documentary evidence Caregiver B was hired on 9/12/2022 and completed training in first aid and choking on 02/08/2023. Caregiver B told Surveyor s/he had not completed any training regarding mechanically altered food, including preparation of pureed food. Caregiver B told Surveyor s/he had seen Resident 1 served and consume pureed food and thickened liquids at Resident 1's daily programming site. Caregiver B told Surveyor Resident 1's fluids were not thickened and his/her food was not pureed when at the home because Resident 1's food could be cut up. Caregiver B told Surveyor s/he would

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	390225	A. BUILDING: _____ B. WING _____	C 08/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ORCHARD VIEW ADULT FAMILY HOME	W6429 HWY 12 FORT ATKINSON, WI 53538

(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
M 230	Continued From page 8	M 230		

mash foods like pasta with a fork and cut up meats for Resident 1 so it was not necessary to puree it with a blender. Caregiver B told Surveyor s/he was not aware if the home ever had a blender to puree food, as s/he looked at Licensee A who was observing this interview. Licensee A told Surveyor the home did have a blender available and it was currently located in the lower level of the home in his/her office.
Caregiver B told Surveyor Resident 1 experienced an incident of choking in August 2023, prior to Resident 1's incident on 11/26/2023. Caregiver B told Surveyor s/he was working while Resident 1 was eating the evening meal when Resident 1 choked on food served. Caregiver B said s/he performed the Heimlich maneuver on Resident 1 and "released" a bolus of food from Resident 1's mouth. Caregiver B said s/he called 911 when the choking incident occurred, but Resident 1 had not lost consciousness and was no longer choking when the EMTs arrived. Caregiver B said the EMTs checked Resident 1 and left the facility.
Caregiver B told Surveyor s/he could not remember what Resident 1 was served and eating during that incident but did recall the food was chopped on the plate and not pureed.
Caregiver B told Surveyor Resident 1 exhibited a "raspy voice" for a couple days but was not hospitalized following this incident. Caregiver B told Surveyor s/he thought s/he contacted Licensee A right away after the incident and Caregiver B documented an incident report of this incident.
Licensee A provided Surveyor with a document titled, "Provider Incident Report Form." The form included Resident 1's name and was dated 08/13/2023. Caregiver B told Surveyor the documentation was written in his/her handwriting. The document did not include what time the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	390225	A. BUILDING: _____ B. WING _____	C 08/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ORCHARD VIEW ADULT FAMILY HOME	W6429 HWY 12 FORT ATKINSON, WI 53538

(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
M 230	Continued From page 9	M 230		

incident occurred, who documented the form, and staff involved in the incident were not identified. The documentation included, "Choking" regarding the "type and extent of harm/injury experienced by [Resident 1] as a result of the incident." The documentation included, "EMS came to check on [Resident 1]" regarding the documented question "Did the member or others require medical attention?" The document did not include "where the incident took place." The documentation included, "Dinner, feeding [Resident 1]" regarding "describe what was occurring prior to the incident." The "incident summary" documentation included, "Feeding, began choking. [Caregiver B] asked [Resident 1] to spit food out. Provided Heimlich. Called 911 after [Resident 1] did not respond." The documentation did not include Resident 1's Legal Guardian D, Resident 1's practitioner, and/or Resident 1's managed care team were notified of the incident. Licensee A told Surveyor s/he did not recall when s/he was made aware of this incident of choking on 08/13/2023. Licensee A said s/he did not recall being called by Caregiver B regarding this incident on 08/13/2023. Licensee A told Surveyor s/he would have picked up the documented incident report from a drawer in the kitchen, which s/he collected on a weekly basis, and it "slipped through the cracks." Licensee A told Surveyor Resident 1 was seen by Resident 1's practitioner on 08/16/2023 for a scheduled, routine appointment. Licensee A said s/he accompanied Resident 1 to the appointment and discussed Resident 1's concerns with ongoing, unexplained weight loss with Resident 1's practitioner. Licensee A provided Surveyor with a documented summary of Resident 1's "annual wellness visit" with Resident 1's practitioner on 08/16/2023. The document included "[Resident 1] did have a choking incident with other caregiver. Rare

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	390225	A. BUILDING: _____ B. WING _____	C 08/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ORCHARD VIEW ADULT FAMILY HOME	W6429 HWY 12 FORT ATKINSON, WI 53538

(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
M 230	Continued From page 10	M 230		

occurrence." The documentation did not specify Resident 1's choking incident on 08/13/2024 was discussed with Resident 1's practitioner during this visit. Licensee A said s/he did not recall discussing the choking incident experienced by Resident 1 on 08/13/2023 with Resident 1's practitioner during the visit on 08/16/2023. Caregiver B told Surveyor Resident 1 experienced an incident of choking on 11/26/2023 while being fed spaghetti with ground meat by Caregiver B at the home's kitchen table. Caregiver B told Surveyor Resident 1's meal was not pureed. Caregiver B said s/he mashed the spaghetti noodles on the plate with a fork and the meat was ground. Caregiver B told Surveyor s/he recalled Resident 1 took a breath and it sounded like something got stuck in his/her throat and Resident 1 began to choke. Caregiver B said s/he attempted without success to have Resident 1 take a drink of water to clear Resident 1's throat. Caregiver B said Resident 1's water was not thickened. Caregiver B said s/he attempted to provide the Heimlich maneuver with Resident 1 seated in a chair at the table. Caregiver B said s/he then attempted to provide the Heimlich maneuver by assisting Resident 1 to a standing position at the table with Resident 1's back of chair under Resident 1's ribcage. Caregiver B said s/he did not see anything come out of Resident 1's mouth but Caregiver B believed Resident 1 was breathing at that point. Caregiver B said s/he assisted Resident 1 to sit back down in the chair at the kitchen table. Caregiver B said s/he believed s/he attempted to call Licensee A on the phone, but s/he was not sure. Caregiver B said s/he pushed Resident 1's food to the center of the table and left Resident 1 seated at the table while Caregiver B walked from the kitchen table, through the home's living room, and to the basement door in the hallway. Caregiver B said

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	390225	A. BUILDING: _____ B. WING _____	C 08/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ORCHARD VIEW ADULT FAMILY HOME	W6429 HWY 12 FORT ATKINSON, WI 53538

(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
M 230	Continued From page 11	M 230		

s/he yelled downstairs to Caregiver C to come up and assist with Resident 1. Caregiver B said s/he walked back to the kitchen and observed Resident 1 had grabbed his/her food and was feeding himself/herself. Caregiver B observed Resident 1 could not swallow the food so Caregiver B attempted to provide the Heimlich maneuver with Resident 1 seated in the chair at the table before standing Resident 1 up and attempted to provide the Heimlich maneuver in the standing position. Caregiver B said s/he then assisted Resident 1 to the floor on Resident 1's back and began administering abdominal thrusts. Caregiver B said Caregiver C was in the kitchen at this point, called 911, and was on the phone with EMS. Caregiver B said s/he started to provide Resident 1 with CPR when Caregiver B observed Resident 1's face turning blue, purple, and then Resident 1 lost all color in Resident 1's face. Caregiver B said the EMTs arrived at the home and took over administering CPR to Resident 1 before they transported Resident 1 to the hospital.

On 07/18/2024, Surveyor reviewed Resident 1's record, as provided by Licensee A. Resident 1 was admitted to the home on 03/10/2020 from another licensed assisted living facility located in a nearby community where Resident 1 resided for approximately 1 year. Resident 1's diagnoses included profound intellectual disabilities and Resident 1 was "nonverbal."
Licensee A provided Resident 1's individual service plan [ISP], dated 08/13/2019, developed by Resident 1's previous facility and received by Licensee A upon Resident 1's admission to the home. The documentation included, "Pureed diet; consistency needs to be medium. If too thick, will gag. If too thin, [Resident 1] won't [sic] be able to scoop food into spoon." The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	390225	A. BUILDING: _____ B. WING _____	C 08/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ORCHARD VIEW ADULT FAMILY HOME	W6429 HWY 12 FORT ATKINSON, WI 53538

(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
M 230	Continued From page 12	M 230		

documentation included, "Nectar thick liquids."
Licensee A provided Resident 1's practitioner's notes and order dated 03/06/2020. The documentation included, "[Resident 1] is transferring to a different group home and needs an admission physical done..." The practitioner's orders included, "[Resident 1] must have pureed meals 3 times a day and pureed snacks and liquids thickened to nectar-thick consistency. [Resident 1] needs 1-on-1 supervision w/[with] hand-on-hand guidance from caregiver [at] meals. Cue [Resident 1] to slow down as [Resident 1] feeds [self] too quickly."
Licensee A provided Resident 1's ISP dated 08/28/2023. Licensee A told Surveyor s/he developed Resident 1's ISP. The documentation included, "Staff will use methods such as sippy cups or Thick-It for beverages to allow [Resident 1] to drink liquids without aspirating. Staff will blend, cut up finely, and/or feed [Resident 1] [his/her] food to keep [Resident 1] from aspirating [his/her] food. Staff keeps food and beverages out of [Resident 1's] access by keeping them locked up in the garage. Cold food and beverages are kept in the refrigerator or freezer and room temperature food and beverages are kept in a cabinet."
At 12:41 P.M., Licensee A told Surveyor Resident 1's access to food was supervised at all times because Resident 1 would devour and pocket food within Resident 1's mouth if Resident 1 was not supervised when eating. Surveyor asked Licensee A how caregivers were to determine when "sippy cups" or Thick-It was to be utilized for Resident 1's liquids and how caregivers were to determine if they should "blend, cut up finely, and/or feed" Resident 1's food as documented within Resident 1's ISP. Licensee A told Surveyor the caregiver would have used their judgement to decide which method to use on any given day.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	390225	A. BUILDING: _____ B. WING _____	C 08/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ORCHARD VIEW ADULT FAMILY HOME	W6429 HWY 12 FORT ATKINSON, WI 53538

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M 230	Continued From page 13 Surveyor asked Licensee A if s/he, Caregiver B, or Caregiver C had completed training in the preparation of mechanical diets in order to make those determinations or judgments with Resident 1's food and fluid intake. Licensee A told Surveyor s/he, Caregiver B, and Caregiver C had not completed any training specific to mechanically altered/prepared diets. Licensee A said s/he was not sure where s/he could receive that type of training. Licensee A told Surveyor s/he had not received a written practitioner's order changing or discontinuing Resident 1's pureed food and thickened liquids order as received on 03/06/2020. On 07/24/2024 at 8:47 A.M., Surveyor conducted an interview with Resident 1's managed care Provider Quality Manager E including a request for records related to Resident 1's choking incidents at the home on 08/13/2023 and 11/26/2023. On 07/25/2024 at 3:46 P.M., Surveyor received an email from Provider Quality Manager E. The email included, "In review of the [08/13/2023] incident involving choking for [Resident 1]; [Resident 1's managed care organization] did not receive an incident report from the provider. This should have been reported even though they [caregivers] were able to remediate the situation. It would have then been reviewed to determine if it was DHS [Department of Health Services] reportable or not and afforded [Resident 1's managed care organization] the opportunity to partner/support the provider in ensuring [Resident 1's] care plan was clear and that training to staff around a pureed diet was understood. It is unfortunate that this occurred a second time with a negative outcome." Provider Quality Manager E's email to Surveyor	M 230		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	390225	A. BUILDING: _____ B. WING _____	C 08/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ORCHARD VIEW ADULT FAMILY HOME	W6429 HWY 12 FORT ATKINSON, WI 53538

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M 230	Continued From page 14	M 230		

included Resident 1's managed care case notes between 11/01/2023 and 12/31/2023. A case note dated 11/27/2023 included, "[Resident 1] is currently at [hospital] ICU (intensive care unit) on a vent (ventilator). It was reported by [Licensee A] that they were eating dinner on 11/26/2023 and [Resident 1] began to choke on the spaghetti. The staff person attempted to do Heimlich maneuver but was not able to get [Resident 1] to stop choking. The staff person called 911 and got assistance from another staff person. In this time, [Resident 1] was able to grab [his/her] plate of food and keep eating. [Resident 1] kept eating regardless of the fact that [s/he] was choking. [Resident 1] ended up passing out and became unconscious before EMS was able to get there. EMS was able to revive [Resident 1] by incubating (sic) [Resident 1] and transport [Resident 1] to [local hospital]. [Resident 1] was transferred to [a second/different hospital] ICU because they oversee patients that experience a respiratory and cardiac event. [Legal Guardian D] has been contacted and [s/he] been (sic) in communication with the hospital. [Legal Guardian D] is coming here [Wisconsin] to see [Resident 1] from [a different state]."
A case note dated 11/28/2023 included, "[Hospital Staff F] called [Case Coordinator G] back to provide an update. [Hospital Staff F] reports that [Resident 1] has not been responding to anything. [Hospital Staff F] reports that since [Resident 1] was still eating while [s/he] was choking, it made it difficult for EMS to intubate pass (sic) the esophagus to [Resident 1's] lungs. They [hospital staff] have put [Resident 1] on a 72 hr [hour] trial to see how [s/he] does, but [s/he] has not been responding. [Resident 1] arrived at [a second/different hospital] about midnight of 11/26/2023. [Hospital Staff F] reports that [Legal Guardian D] was there, as well as [Legal

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	390225	A. BUILDING: _____ B. WING _____	C 08/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ORCHARD VIEW ADULT FAMILY HOME	W6429 HWY 12 FORT ATKINSON, WI 53538

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M 230	Continued From page 15	M 230		

Guardian D's] spouse."
A case note dated 12/01/2023 included, "PC [phone call] with [Hospital Staff F] who states [Legal Guardian D] had decided to do end of life care with organ donation. [Resident 1] is not officially brain dead; however, [Resident 1] had a catastrophic anoxic [without oxygen] brain injury with severe consequences."
Another case note dated 12/01/2023 included, "Late Entry: [Case Coordinator G] had received a call from [Licensee A]. [Case Coordinator G and Licensee A] were discussing the current status of [Resident 1]. [Case Coordinator G] checked in with how [Licensee A's] staff that were involved with the incident were doing. While talking to [Licensee A] about the situation it was a great time to offer some education going forward. [Case Coordinator G] stated that it's (sic) scary when you are in the moment an (sic) emergency, but we need to remember that we need to stay in control of the situation, meaning we clear the area to ensure health and safety. If [Resident 1] was eating, then they [caregivers] need to move [Resident 1's] plate and out of reach. [Licensee A] agreed and stated that [s/he] will pass this onto [his/her] staff."

On 07/25/2024 at 12:43 P.M., Surveyor conducted an interview with Resident 1's Legal Guardian D. Legal Guardian D told Surveyor s/he visited Resident 1 at the home in June 2023 and observed a caregiver served Resident 1 a pot pie with gravy that was not pureed. Legal Guardian D said Resident 1 had to be cued to slow down while eating. Legal Guardian D said all of Resident 1's food was pureed at Resident 1's previous assisted living facility so s/he asked either Licensee A or one of the caregivers about Resident 1's food not being pureed at this home. Legal Guardian D said s/he was told by either

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	390225	A. BUILDING: _____ B. WING _____	C 08/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ORCHARD VIEW ADULT FAMILY HOME	W6429 HWY 12 FORT ATKINSON, WI 53538

(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
M 230	Continued From page 16	M 230		

Licensee A or one of the caregivers that Resident 1 did not need to have food pureed. Legal Guardian D said s/he let Licensee A or a caregiver know that Resident 1's previous assisted living facility pureed all of Resident 1's food. Legal Guardian D told Surveyor s/he was never informed of any changes to or a discontinuation of Resident 1's pureed diet order. Legal Guardian D told Surveyor s/he was not aware of any choking incidents experienced by Resident 1 at this home in August 2023 or any other time before 11/26/2023. Legal Guardian D told Surveyor s/he immediately traveled to Wisconsin to be with Resident 1 at the hospital following notification of Resident 1's choking incident on 11/26/2023 and had to make the difficult decision to take Resident 1 off of life support.

On 07/31/2024, Surveyor received Resident 1's hospital discharge summary. The documentation included Resident 1 was hospitalized in an intensive care unit from 11/26/2023 until Resident 1's death on 12/02/2023. Resident 1's diagnoses included, "1. Severe anoxic brain injury secondary to cardiac arrest. 2. Aspiration event. 3. Anoxic brain injury related to myoclonic jerking [sudden, involuntary muscle spasm]. 4. Shock, unspecified, but suspect neurogenic [originating in nervous system]. 5. Hypertension [elevated blood pressure], likely in setting of neurologic herniation [life-threatening pressure in skull]. 6. Acute proximal respiratory failure..." The documentation included, "Briefly, [Resident 1] was hospitalized after aspiration event 11/26/2023 and found unresponsive after unknown amount of time at ALF [assisted living facility] ultimately found to have severe irreversible anoxic brain injury with ultimate decision to proceed with OPO (organ

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	390225	A. BUILDING: _____ B. WING _____	C 08/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ORCHARD VIEW ADULT FAMILY HOME	W6429 HWY 12 FORT ATKINSON, WI 53538

(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
M 230	Continued From page 17 procurement organization) and organ donation with transition to withdrawal of cares and organ procurement process undertaken on 12/02/2023 and was declared deceased at 1303 [1:03 P.M.]." Summary: The provider did not ensure the existence or continuation of a condition did not exist in the home which placed Resident 1's health, safety, or welfare at substantial risk of harm. Cross Reference: M0450 DHS 88.07(2)(b)6 Notification of Changes	M 230		
M 450	88.07(2)(b)6 NOTIFICATION OF CHANGES Notifying the placing agency, if any, the guardian, if any, of any significant changes in the resident's medical condition, including any life-threatening, disabling or serious illness, any illness lasting more than 3 days, an injury sustained by the resident, medical treatment needed by the resident or the resident's absence from the home for more than 24 hours. This Rule is not met as evidenced by: Based on interview and record review, the provider did not ensure Resident 1's placing agency and legal guardian were notified of Resident 1's choking incident on 08/13/2023 that required the use of the Heimlich maneuver.	M 450		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	390225	A. BUILDING: _____ B. WING _____	C 08/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ORCHARD VIEW ADULT FAMILY HOME	W6429 HWY 12 FORT ATKINSON, WI 53538

(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
M 450	Continued From page 18 On 08/13/2023, Resident 1 experienced choking after being provided food by a caregiver that was not pureed, as ordered. The caregiver performed the Heimlich maneuver on Resident 1 and Resident 1's choking episode was cleared. The caregiver called 911 and the emergency medical technicians (EMTs) arrived at the home, assessed Resident 1's condition, and did not transport Resident 1 to the hospital. The Licensee A did not ensure Resident 1's legal guardian and placing agency were informed of Resident 1's choking episode on 08/13/2023. On 11/26/2023, Resident 1 experienced another choking after being provided food by a caregiver that was not pureed and fluid that was not thickened, as ordered. As a result of this incident, Resident 1 was hospitalized on an intensive care unit and received life support care. Resident 1 died at the hospital on 12/02/2023. The findings include: On 07/18/2024 at 9:00 A.M., Surveyor conducted an interview with Licensee A. Licensee A told Surveyor Resident 1 was admitted to the home on 03/09/2020 from a different assisted living facility. Licensee A told Surveyor Resident 1 was hospitalized with mechanical, respiratory ventilation (or mechanical life-support) for approximately 2 weeks following Resident 1's choking incident on 11/26/2023 before Resident 1's Legal Guardian D discontinued Resident 1's life support. On 07/18/2024 at 9:57 A.M., Caregiver C told Surveyor Resident 1 had diagnoses including cognitive or intellectual disabilities and was able to ambulate independently. Caregiver C told Surveyor Resident 1 was known to have issues	M 450		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	390225	A. BUILDING: _____ B. WING _____	C 08/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ORCHARD VIEW ADULT FAMILY HOME	W6429 HWY 12 FORT ATKINSON, WI 53538

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M 450	Continued From page 19	M 450		

with swallowing when Resident 1 was admitted to the home and was at risk for choking. Caregiver C told Surveyor Resident 1's food needed to be pureed and liquids thickened before consumption when Resident 1 was admitted to the facility. Caregiver C told Surveyor Resident 1's pureed diet with thickened liquids was "deemed unnecessary at some point" although s/he was not sure when this change occurred. Caregiver C told Surveyor Resident 1 required constant supervision with meals, snacks, and any food items related to Resident 1's behavior of eating too fast and being at risk for choking. Caregiver C said s/he had seen Resident 1 struggle with swallowing after taking a bite of food before the incident on 11/26/2023 occurred. Caregiver B said s/he would have to tell Resident 1 to stop, give him/her a drink of water or give him/her a moment to try and swallow before asking Resident 1 to say "Ah" so s/he could look in Resident 1's mouth to check s/he had swallowed the food. Caregiver C told Surveyor Resident 1 would attempt to eat food from other resident's plates if within Resident 1's reach. Caregiver C told Surveyor Resident 1 would "wander" and get in to the home's refrigerator attempting to eat food without supervision.

On 07/18/2024 at 11:23 A.M., Surveyor conducted an interview with Caregiver B. Caregiver B told Surveyor Resident 1 experienced an incident of choking in August 2023, prior to Resident 1's incident on 11/26/2023. Caregiver B told Surveyor s/he was working while Resident 1 was eating the evening meal when Resident 1 choked on food served. Caregiver B said s/he performed the Heimlich maneuver on Resident 1 and "released" a bolus of food from Resident 1's mouth. Caregiver B said s/he called 911 when the choking incident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	390225	A. BUILDING: _____ B. WING _____	C 08/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ORCHARD VIEW ADULT FAMILY HOME	W6429 HWY 12 FORT ATKINSON, WI 53538

(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
M 450	Continued From page 20	M 450		

occurred, but Resident 1 had not lost consciousness and was no longer choking when the EMTs arrived. Caregiver B said the EMTs checked Resident 1 and left the facility. Caregiver B told Surveyor s/he could not remember what Resident 1 was served and eating during that incident but did recall the food was chopped on the plate and not pureed. Caregiver B told Surveyor Resident 1 exhibited a "raspy voice" for a couple days but was not hospitalized following this incident. Caregiver B told Surveyor s/he thought s/he contacted Licensee A right away after the incident and Caregiver B documented an incident report of this incident.

Licensee A provided Surveyor with a document titled, "Provider Incident Report Form." The form included Resident 1's name and was dated 08/13/2023. Caregiver B told Surveyor the documentation was written in his/her handwriting. The document did not include what time the incident occurred, who documented the form, and staff involved in the incident were not identified. The documentation included, "Choking" regarding the "type and extent of harm/injury experienced by [Resident 1] as a result of the incident." The documentation included, "EMS came to check on [Resident 1]" regarding the documented question "Did the member or others require medical attention?" The document did not include "where the incident took place." The documentation included, "Dinner, feeding [Resident 1]" regarding "describe what was occurring prior to the incident." The "incident summary" documentation included, "Feeding, began choking. [Caregiver B] asked [Resident 1] to spit food out. Provided Heimlich. Called 911 after [Resident 1] did not respond." The documentation did not include Resident 1's Legal Guardian D and Resident 1's managed care team were notified of the incident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	390225	A. BUILDING: _____ B. WING _____	C 08/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ORCHARD VIEW ADULT FAMILY HOME	W6429 HWY 12 FORT ATKINSON, WI 53538

(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
M 450	Continued From page 21 Licensee A told Surveyor s/he did not recall when s/he was made aware of this incident of choking on 08/13/2023. Licensee A said s/he did not recall being called by Caregiver B regarding this incident on 08/13/2023. Licensee A told Surveyor s/he would have picked up the documented incident report from a drawer in the kitchen, which s/he collected on a weekly basis, and it "slipped through the cracks." On 07/18/2024, Surveyor reviewed Resident 1's record, as provided by Licensee A. Resident 1 was admitted to the home on 03/10/2020 from another licensed assisted living facility located in a nearby community where Resident 1 resided for approximately 1 year. Resident 1's diagnoses included profound intellectual disabilities and Resident 1 was "nonverbal." Licensee A told Surveyor Resident 1 was supported by a managed care organization. Licensee A provided Resident 1's practitioner's notes and order dated 03/06/2020. The documentation included, "[Resident 1] is transferring to a different group home and needs an admission physical done..." The practitioner's orders included, "[Resident 1] must have pureed meals 3 times a day and pureed snacks and liquids thickened to nectar-thick consistency. [Resident 1] needs 1-on-1 supervision w/[with] hand-on-hand guidance from caregiver [at] meals. Cue [Resident 1] to slow down as [Resident 1] feeds [self] too quickly." On 07/24/2024 at 8:47 A.M., Surveyor conducted an interview with Resident 1's managed care Provider Quality Manager E including a request for records related to Resident 1's choking incidents at the home, including an incident on 08/13/2023. On 07/25/2024 at 3:46 P.M., Surveyor received	M 450		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	390225	A. BUILDING: _____ B. WING _____	C 08/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ORCHARD VIEW ADULT FAMILY HOME	W6429 HWY 12 FORT ATKINSON, WI 53538

(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
M 450	Continued From page 22	M 450		

an email from Provider Quality Manager E. The email included, "In review of the [08/13/2023] incident involving choking for [Resident 1]; [Resident 1's managed care organization] did not receive an incident report from the provider. This should have been reported even though they [caregivers] were able to remediate the situation. It would have then been reviewed to determine if it was DHS [Department of Health Services] reportable or not and afforded [Resident 1's managed care organization] the opportunity to partner/support the provider in ensuring [Resident 1's] care plan was clear and that training to staff around a pureed diet was understood. It is unfortunate that this occurred a second time with a negative outcome."

On 07/25/2024 at 12:43 P.M., Surveyor conducted an interview with Resident 1's Legal Guardian D. Legal Guardian D told Surveyor s/he visited Resident 1 at the home in June 2023 and observed a caregiver served Resident 1 a pot pie with gravy that was not pureed. Legal Guardian D said Resident 1 had to be cued to slow down while eating. Legal Guardian D said all of Resident 1's food was pureed at Resident 1's previous assisted living facility so s/he asked either Licensee A or one of the caregivers about Resident 1's food not being pureed at this home. Legal Guardian D said s/he was told by either Licensee A or one of the caregivers that Resident 1 did not need to have food pureed. Legal Guardian D said s/he let Licensee A or a caregiver know that Resident 1's previous assisted living facility pureed all of Resident 1's food. Legal Guardian D told Surveyor s/he was never informed of any changes to or a discontinuation of Resident 1's pureed diet order. Legal Guardian D told Surveyor s/he was not aware of any choking incidents experienced by

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	390225	A. BUILDING: _____ B. WING _____	C 08/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ORCHARD VIEW ADULT FAMILY HOME	W6429 HWY 12 FORT ATKINSON, WI 53538

(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
M 450	Continued From page 23 Resident 1 at this home in August 2023 or any other time before 11/26/2023. Legal Guardian D told Surveyor s/he immediately traveled to Wisconsin to be with Resident 1 at the hospital following notification of Resident 1's choking incident on 11/26/2023 and had to make the difficult decision to take Resident 1 off of life support. Summary: The provider did not ensure Resident 1's placing agency and legal guardian were notified of Resident 1's choking incident on 08/13/2023 that required the use of the Heimlich maneuver. Cross Reference: M0230 DHS 88.04(2)(f) Condition Which Represents Risk Or Harm	M 450		