| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0019662 | A. BUILDING: _____ B. WING _____ | C 03/01/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ELLENS HOME OF GERMANTOWN | N113 W16358 SYLVAN CIRCLE GERMANTOWN, WI 53022 |

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| N 000 | Initial Comments<br><br>On 03/01/2024, Surveyor conducted a complaint investigation and probationary survey at Ellen's Home of Germantown.<br><br>Two deficiencies were identified.<br><br>The complaint was unsubstantiated.<br><br>Census: 15 | N 000 | | |
| N 352 | 83.32(3)(h) Rights of Residents: Receive medication<br><br>In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Receive medication. Receive all prescribed medications in the dosage and at intervals prescribed by a practitioner. The resident has the right to refuse medication unless the medication is court ordered.<br><br>This Rule is not met as evidenced by:<br>Based on interview and record review, the provider did not ensure Resident 2 received prescribed medications in the dosage and intervals prescribed by a practitioner.<br><br>Resident 2 was given his/her Midodrine when parameters indicated to hold this medication on 11 occasions from 12/01/2023-02/28/2024.<br><br>Findings include:<br><br>On 03/01/2024, Surveyor reviewed Resident 2's file, which indicated Resident 2 was admitted to the facility on 08/01/2023 with diagnosis including syncope and atrial fibrillation. Resident 2 was their own legal decision maker. Resident 2's individual service plan (ISP) dated 02/10/2024 | N 352 | | |

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

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| N 352 | Continued From page 1<br>documented that s/he was dependent on staff to administer medications. Within Resident 2's list of prescribed medications, Surveyor observed the following:<br><br>-"Midodrine 5mg tab, take 1 tablet by mouth 4x/day, hold if sbp [systolic blood pressure] greater than 160," with a start date of 01/20/2022.<br><br>Surveyor reviewed Resident 2's medication administration record (MAR) from 12/01/2023-02/28/2024 and observed the following discrepancies:<br><br>-12/09/2023 (4:00 PM) Blood pressure documented as 170/96, Midodrine marked as given with staff initials.<br><br>-12/30/2023 (4:00 PM) Blood pressure documented as 180/83, Midodrine marked as given with staff initials.<br><br>-01/01/2024 (12:00 PM) Blood pressure documented as 167/96, Midodrine marked as given with staff initials.<br><br>-01/25/2024 (12:00 PM) Blood pressure documented as 164/80, Midodrine marked as given with staff initials.<br><br>-01/01/2024 (4:00 PM) Blood pressure documented as 172/99, Midodrine marked as given with staff initials.<br><br>-01/16/2024 (4:00 PM) Blood pressure documented as 179/101, Midodrine marked as given with staff initials.<br><br>-02/06/2024 (8:00 AM) Blood pressure documented as 181/94, Midodrine marked as | N 352 | | |

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| N 352 | Continued From page 2<br>given with staff initials.<br><br>-02/25/2024 (8:00 AM) Blood pressure documented as 191/70, Midodrine marked as given with staff initials.<br><br>-02/15/2024 (12:00 PM) Blood pressure documented as 161/56, Midodrine marked as given with staff initials.<br><br>-02/13/2024 (4:00 PM) Blood pressure documented as 188/70, Midodrine marked as given with staff initials.<br><br>-02/28/2024 (4:00 PM) Blood pressure documented as 187/97, Midodrine marked as given with staff initials.<br><br>On 03/01/2024 at 12:00 PM, Surveyor observed Caregiver D administer Resident 2's medications. Surveyor observed Caregiver D measure Resident 2's blood pressure. Caregiver D stated Resident 2's blood pressure was recorded at 162/77. Caregiver D stated since Resident 2's blood pressure was over 160, staff would hold his/her 12:00 PM Midodrine. Caregiver D stated if staff hold Resident 2's medication, staff are supposed to initial with an "H" on the MAR.<br><br>On 03/01/2024 at 3:00 PM, Surveyor interviewed Director A, Administrator B, and Director of Operations C. Director A and Administrator B acknowledged staff should have held Resident 2's Midodrine when vitals were over administration parameters. Director A stated staff check Resident 2's medications 4x/day and use a wrist blood pressure monitor provided by Resident 2. Director A did not comment further. | N 352 | | |

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| N 381 | Continued From page 3 | N 381 | | |
| N 381 | 83.35(1)(a) Pre-admission and ongoing assessments.<br><br>Scope. The CBRF shall assess each resident ' s needs, abilities, and physical and mental condition before admitting the person to the CBRF, when there is a change in needs, abilities or condition, and at least annually. The assessment shall include all areas listed under par. (c). This requirement includes individuals receiving respite care in the CBRF. For emergency admissions the CBRF shall conduct the assessment within 5 days after admission.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the provider did not ensure an assessment of Resident 1's physical and mental condition was completed when there was a change in needs.<br><br>Resident 1 was not re-assessed when s/he experienced a left avulsion fracture on 02/17/2024.<br><br>Findings include:<br><br>On 03/01/2024, Surveyor reviewed Resident 1's record and identified the following:<br><br>Resident 1 was admitted on 08/01/2023 with a diagnosis of dementia. Resident 1 had an activated healthcare power of attorney that made decisions on his/her behalf.<br><br>Resident 1's incident report dated 02/17/2024 documented:<br>"Type /Nature of Incident: Fall with or without | N 381 | | |

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| N 381 | Continued From page 4 | N 381 | | |

injury.
Resident found by staff when doing rounds. [S/he] was laying on the floor in bedroom.
Actions Taken: Cleaned/bandaged right elbow has scrape to right elbow. Also has scrape to right elbow. Also scrape to scalp.
Intervention: Sent to hospital.
Predisposing Situation Factors: Using walker."

Resident 1's hospital discharge summary dated 02/17/2024 documented:
"Reason for visit: Fall
Diagnoses: Avulsion fracture, closed nondisplaced avulsion fracture of left talus
Imaging tests: CT C-spine, CT Trauma head, DX Elbow Rt 3V, DX Foot Lt 3V."

Resident 1's progress notes documented:
"02/17/2024: Resident had fall in room, sent to ED for eval. Resident returned from ED.
02/19/2024: Optum RN follow up visit post fall."

Resident 1's home health notes dated 02/19/2024 documented:
"[Resident 1] seen for post ED follow up. [S/he] was sent to the ED on 02/17/2024 after being found on the floor in [his/her] room after unwitnessed fall. Workup in the ED revealed a left talus nondisplaced avulsion fracture, [s/he] was given a tall walking boot and returned to the facility with recommendation to follow-up with orthopedics. Today on exam [s/he] is sitting in the dining area in a wheelchair, boot is on [his/her] left foot. Denies pain or other concerns. Staff do not want [him/her] up walking with [his/her] walker as they are concerned [s/he] will fall because [s/he] is not used to walking with the boot. Facility staff with no further concerns, is complaint with medications which the facility manages.
Plan: ...May not ambulate independently, continue

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| N 381 | Continued From page 5 | N 381 | | |

to use wheelchair until okayed by Ortho. Walking boot in place. Monitor for falls, fall precautions, due to dementia will need reminders that [s/he] is not able to ambulate with [his/her] walker on [his/her] own. Follow ortho recommendations for weightbearing status and length of time boot is required."

Resident 1's individual service plan (ISP) dated 10/19/2023 documented:
"Resident at times goes outside by [him/herself]. Wander guard placed on walker to prevent elopement." The ISP did not document Resident 1 as a fall risk or include any interventions to mitigate this risk.

Resident 1's record did not contain a change of condition assessment after Resident 1 sustained a left avulsion fracture and had a change in his/her mobility status from using a walker to using a wheelchair.

On 03/01/2024 at 2:00 PM, Surveyor requested an updated assessment from Director A related to Resident 1's left avulsion fracture.

On 03/01/2024 at 3:00 PM, Surveyor interviewed Director A, Administrator B, and Director of Operations C. Director A stated s/he was not able to find a change of condition assessment related to Resident 1's left avulsion fracture. Director A confirmed a change of condition assessment was not completed. Surveyor shared concern that Resident 1 experienced a change in mobility status going from using a walker to using a wheelchair after his/her avulsion fracture and the provider had not completed an assessment when they observed a change in needs. Director A and Administrator B acknowledged the concern. Director of Operations C stated the provider will

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| N 381 | Continued From page 6<br>soon be going to an electronic health records system which will include built in assessments so staff can complete after incidents like Resident 1's. | N 381 | | |