STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0012701	A. BUILDING: _____ B. WING _____	C 06/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUMMINGBIRD ADULT HOME LLC	5355 CLASSIC LANE PLATTEVILLE, WI 53818

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M 000	INITIAL COMMENTS On 06/26/2024, the Bureau of Assisted Living, Southern Regional Office conducted a standard survey and complaint investigation at Hummingbird Adult Family Home, an AFH located in Platteville, WI. As a result of the investigation, 3 violations of Chapter DHS 88 were issued. Complaint was substantiated Census: 0	M 000		
M 244	88.04(5)(a) TRAINING-15 HOURS WITHIN 6 MONTHS The licensee and each service provider shall complete 15 hours of training approved by the licensing agency related to health, safety and welfare of residents, resident rights and treatment appropriate to residents served prior to or within 6 months after starting to provide care. This training shall include training in fire safety and first aid. This Rule is not met as evidenced by: Based on record review and interview, the provider shall complete 15 hours of training approved by the licensing agency related to health, safety and welfare of residents, resident rights and treatment appropriate to residents served prior to or within 6 months after starting to provide care. This training shall include training in fire safety and first aid.	M 244		

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

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M 244	Continued From page 1 FINDINGS INCLUDE: On 06/26/2024, Surveyors arrived at facility for a standard survey. On 06/26/2024, Surveyor reviewed the facility staff roster. The 2 staff listed were Licensee A and Caregiver B. Licensee A verified Surveyor had the complete staff roster. Caregiver B was hired on 11/04/2020. On 06/26/2024, Surveyor reviewed Caregiver B's staff record. Caregiver B had 8 hours of training completed within 6 months after starting to provide care. Caregiver B had not completed training in resident rights and fire safety. On 06/26/2024 at 12:30 PM, Surveyor discussed the above concern with Licensee A. Licensee A acknowledged Caregiver B's staff record contained 8 hours of documented training within 6 months of hire and the training did not include fire safety or resident rights training.	M 244		
M 570	88.10(3)(l) Safe Physical Environment Individuals, except for correctional residents, have basic rights which they do not lose when they enter an adult family home. A resident shall have a safe environment in which to live. The adult family home shall safeguard residents who cannot fully guard themselves from environmental hazards to which they are likely to be exposed, including conditions which would be hazardous to anyone and conditions which would be or are hazardous to a particular resident because of the resident's condition or disability.	M 570		

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M 570	Continued From page 2	M 570		

This Rule is not met as evidenced by:
Based on observation and interview the provider did not ensure the residents were safeguarded from environmental hazards in which they were likely exposed including conditions that would be hazardous to anyone. The provider did not ensure safe water temperatures or a floor that was even to prevent tripping and easy access to exits in the event of an emergency.

Findings include:

This provider is licensed to serve the following client groups: Advanced aged, traumatic brain injury, developmentally disabled, irreversible Alzheimer's and dementia and emotionally disturbed/mental illness.

Example 1: Water Temperatures

On 06/26/2024 at approximately 11:40 AM, Surveyor took the water temperature at the faucet in the bathroom sink used by all the residents of the facility. The hot water temperature was 133.2 degrees Fahrenheit.

Second and third-degree hot water burns can occur at the following rates at the following temperatures:

110 degrees F. 13 minutes
120 degrees F. 10 minutes
127 degrees F. 1 minute
130 degrees F. 30 seconds
140 degrees F. 6 seconds
158 degrees F. 1 second

"Exposure to hot water is a potential

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environmental danger for residents. Elderly residents and residents with mental and physical disabilities may have neurological conditions that prevent instant recoil from hot water. Because these individuals do not instantly react to dangerous temperature levels, they are at particular risk for injury. Hot water can cause scalding; e.g., second and third degree burns in which the skin blisters and swells. In such instances, skin does not return to normal and forms scar tissue upon healing. These burns may lead to permanent disability." (Source: Publication DHS P-01942 - 08/2017).

On 02/06/2024 at approximately 2:00 PM, Surveyor shared findings with Licensee A who confirmed their understanding of the regulation regarding water temperatures and safety for residents. Licensee A stated they didn't know that the water had become so hot.

Example 2: Uneven Walking Surfaces and Wall Damage

On 06/26/2024 at approximately 11:40 AM, Surveyor toured the facility and observed many uneven surfaces throughout the floors of the home as well as other structural issues throughout the home that could potentially compromise the livability of the home.

1. There were floorboards that were warped directly in front of the front door (Photo #1).
2. There was a broken piece of drywall hanging down from a hole in the bathroom directly in front of the bathroom window. Licensee A stated that there was a venting unit beyond it (Photo #2).
3. In Resident 2's room there was a 6-inch vertical crack in the wall (Photo #3).
4. There were buckling floorboards in the

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M 570	Continued From page 4 hallway between Resident 2's room and the bathroom (Photo #4). 5. The second exit of the home which was to be used in the event of an emergency requiring evacuation was through a door that contained a sign that instructed no residents to enter. The path to the second emergency exit contained many obstacles including items in the path of exit and uneven flooring difficult for Surveyor to navigate. On 02/06/2024 at approximately 2:00 PM, Surveyor shared findings with Licensee A who acknowledged that many of the floorboards in the facility, including those in Resident 2's bedroom, were warped due to Resident 2 frequently urinating on the floor. Licensee stated that the path to the second emergency exit was cluttered because they were reorganizing the back room but, "somebody would always be with a resident to guide them out." CROSS REFERENCE M0580 DHS Chapter 88.10(3)(p) Prompt And Adequate Treatment	M 570		
M 580	88.10(3)(p) Prompt and Adequate Treatment Prompt and adequate treatment. To receive prompt and adequate treatment and services appropriate to the resident's needs. This Rule is not met as evidenced by: Based on record review and interview, the provider did not provide prompt and adequate treatment to meet Resident 1's needs. Resident 1 suffered a traumatic brain injury (TBI)	M 580		

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in 2020 which left him/her nearly non-verbal. Resident 1 relied on Licensee A and Caregiver B for all personal cares including but not limited to administering prompt emergency care.

On 05/31/2024, Licensee A brought Resident 1 to an emergency room. Licensee A reported to emergency room personnel s/he had observed bruising on Resident 1's right arm that day. Licensee A reported an incident from 05/27/2024 may have been the cause of the injury to Resident 1's right arm. Emergency room personnel assessed Resident 1 to have the following injuries, a clean break to the right arm, bruising on left arm, bruising on both legs, a subdural hematoma (brain bleed). Emergency room personnel notified the local police department and social services of Resident 1's injuries.

On 06/26/2024 at 2:00 PM, Surveyor asked Licensee A why Resident 1 had not been administered emergency treatment on 05/27/2024. Licensee A maintained s/he did not observe any bruising or swelling on Resident 1's right arm until 05/31/2024. Licensee A acknowledged facility was responsible for dressing, bathing, and toileting Resident 1. Licensee A did not have an explanation as to why bruising and/or swelling hadn't been observed by facility until 05/31/2024. Licensee A acknowledged from 05/27/2024 to 05/31/2024, Resident 1 had been verbalizing 'ouch' when his/her right arm was moved. Licensee A reported s/he had been administering cold compresses and Tylenol for treatment of Resident 1's right arm pain

FINDINGS INCLUDE:

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The facility provides care to the following client groups: developmentally disabled, emotionally disturbed, mental illness, irreversible dementia, Alzheimer's, advanced aged & traumatic brain injury.

On 06/10/2024, The Department received a complaint alleging mistreatment of a resident had occurred at facility.

On 06/24/2024, Surveyors arrived at facility for a complaint investigation.

RECORD REVIEW:

On 06/26/2024, Surveyor reviewed Resident 1's facility facesheet. Resident 1 was admitted to the facility on 11/04/2020.

On 06/26/2024, Surveyor reviewed Resident 1's individualized service plan (ISP) dated 05/22/2024. Documented on the first page, "[Resident 1] ... had a fall in January 2020 which resulted in traumatic brain injury (Subdural Hematoma) which affected [his/her] speech, motor skills, [his/her] ability to communicate and [his/her] cognitive skills...". According to the ISP Resident 1 required full assistance with bathing, grooming and dressing.

On 06/26/2024, Surveyor reviewed police report dated 05/31/2024. Deputy C arrived at emergency room to investigate allegations of abuse. Deputy C documented the following, "Hospital staff stated the mentally disabled patient had broken bones and significant bruising from an incident that was reported to have occurred on Monday 05/27/2024... I made contact with [Nurse G] that had seen the injured patient. The following is a summary of my contact: The patient,

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[Resident 1], presented to the ER with [his/her] caretaker [Licensee A] ... [Nurse G] advised [Resident 1] has an injury to [his/her] right upper arm. This injury allegedly happened on Monday. [Nurse G] stated the arm was visibly broken; the arm was swollen, bruised, and hard. [Resident 1] also had bruising on [his/her] left arm, and both of [his/her] legs. [Resident 1] suffered a traumatic brain injury in 2020, which left [him/her] non-verbal... [Resident 1] can say small phrases like "ow". [Nurse G] stated given all the circumstances, [s/he] felt the injuries needed to be reported...I confirmed [Resident 1's] injuries with [Nurse G]. [Nurse G] stated the break in the arm was a clean break, and [s/he] could not believe they did not bring [Resident 1] in for treatment sooner. I asked if [Resident 1] would be in considerable pain due to the injury. [Nurse G] stated [Resident 1] would be in pain ... [Nurse G] stated [s/he] was concerned that it took 5 days for [Resident 1] to be brought in for treatment."

On 06/28/2024, Surveyor reviewed Resident 1's hospital record dated 05/31/2024. On 5/31/2024 at 6:55 PM, Nurse Practitioner H documented the following, " History Provided by: Patient's caregiver present at the time of examination. [Resident 1] who is brought in by [his/her] caregiver with a swollen right arm that was noticed by staff on Monday 5/27. [Licensee A] who is present with patient stated in triage that another caregiver tried to pull the patient up by [his/her] right arm on Monday to help [him/her] get up for dinner and ever since then the right arm has been painful and swollen. While examining patient was discussing with [Licensee A] of the injury occurred, [Licensee A] stated that resident pulled on patient's arm trying to get [him/her] up for dinner which was different than what was told in triage. The patient does have a

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history of a traumatic brain injury (TBI) which occurred in 2020 and major neurocognitive disorder related to the TBI and is mostly nonverbal at baseline. Patient currently resides in assisted living ... During examination patient is able to verbalize "ouch" with movement to the right arm along with palpation to the upper right arm, lower right arm. Significant amount of swelling located in the middle of the upper right arm, swelling also noted in the lower right arm, swelling and ecchymosis (bruising) noted on the top of right hand. Point tenderness noted on exam to upper right upper arm. No tenderness noted on exam to right hand. Patient does have multiple old bruises noted on lower extremities ... Medical Decision Making Right extremity x-rays did show displaced fracture of the right humerus. Patient does have multiple areas of bruising that caregiver states have happened when patient is up walking around and bumping into furniture. Patient does have history of severe protein malnutrition which could make [him/her] more prone to bruising with delayed healing. Patient was placed in sling for immobilization will need to follow-up with orthopedics for further management of fracture." On 05/31/2024 at 7:35 PM, Nurse G administered 30 mg of IV Ketorolac for pain management.

On 06/28/2024, Surveyor reviewed Resident 1's May 2024 medication administration record (MAR). The one PRN (as needed) medication listed on the MAR for pain is acetaminophen (Tylenol) 650 mg every 6 hours. From 05/27/2024 to 05/31/2024, zero doses of Acetaminophen were documented as administered to Resident 1 for pain.

INTERVIEWS:

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On 06/21/2024 at 11:39 PM, Surveyor spoke with APS Worker F. APS Worker F stated s/he was on call the evening of 05/31/2024. APS Worker F stated arrangements for Resident 1 to stay at hospital were arranged until safe housing could be secured.

On 06/21/2024 at 2:26 PM, Surveyor spoke with Deputy C. Deputy C stated s/he was the responding officer to the emergency room on 05/31/2024. Deputy C stated Licensee A did not provide a consistent account of how Resident 1's injuries had developed. Deputy C stated Licensee A had reported that s/he had given Resident 1 cold compresses and Tylenol from 05/27/2024 to 05/31/2024.

On 06/26/2024 at 2:00 PM, Surveyor discussed the above concerns with Licensee A. Licensee A stated s/he did not witness the 05/27/2024 incident between Resident 1 and Resident 2. Licensee A stated Caregiver B had witnessed and reported the incident to Licensee A on 05/27/2024. Licensee A stated Caregiver B reported s/he was standing behind the island in the kitchen facing the living room and then Caregiver B notified both residents that their meal was ready. Caregiver B allegedly witnessed Resident 2 stand up next to Resident 1's right side, grab Resident 1's lower right extremity with both hands, and then pull aggressively on Resident 1's right arm. Caregiver B reported to Licensee A that s/he had to separate Resident 1 from Resident 2. Licensee A reported to Surveyor that s/he noticed Resident 1 saying 'owe' when his/her right arm was moved after Caregiver B reported this incident. Licensee A stated s/he provided Resident 1 with cold compresses and ibuprofen from 05/27/2024 to 05/31/2024 for treatment of right arm pain. Licensee A stated

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M 580	Continued From page 10 s/he did not feel Resident 1 required emergency assessment or nurse assessment on 05/27/2024. Licensee A stated s/he did not report any concerns related to Resident 1's arm until 05/31/2024 when s/he took Resident 1 to the ER. Licensee A stated s/he did not observe any bruising or swelling on Resident 1's right arm until 05/31/2024. Licensee A acknowledged Resident 1 requires full staff assistance for dressing, bathing and toileting. Licensee A acknowledged s/he did not have documentation related to the 05/27/2024 incident or Resident 1's physical condition from 05/27/2024 to 05/31/2024. Licensee A acknowledged Resident 1 relied on facility staff to communicate emergency needs to medical providers. Licensee A acknowledged Resident 1 was not provided adequate treatment for his/her right arm break from 05/27/2024 to 05/31/2024. Licensee A stated Resident 1 has a history of bruising easily when asked about bruising on the left arm and bilateral lower extremity. CROSS REFERENCE M0570 DHS Chapter 88.10(3)(1) Safe Physical Environment	M 580		