STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017939	A. BUILDING: _____ B. WING _____	R-C 07/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COTTAGES AT LAKE PARK (THE)	2006 LAKE PARK DRIVE MARINETTE, WI 54143

(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 07/17/2023, with information gathered through 07/26/2023, Surveyors investigated one complaint, conducted a standard survey and verification visit. The complaint was substantiated and two (2) new deficiencies were identified. Two out of 2 deficiencies were repeat violations. See Statements of Deficiency (SOD) KBN11, dated 11/22/2021 and SOD GBP911, dated 03/30/2023. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census 27	{N 000}		
N 353	83.32(3)(i) Rights of Residents: Adequate treatment In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Prompt and adequate treatment. Receive prompt and adequate treatment that is appropriate to the resident ' s needs. This Rule is not met as evidenced by: The provider did not ensure Resident 1 received prompt and adequate treatment for an injury of unknown origin. This is a repeat deficiency, see Statement of Deficiency (SOD) KBN11, dated 11/22/2021. Findings Include: On 07/10/2023, the department received a complaint about an unwitnessed incident resulting in significant injury to a resident.	N 353		

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
	0017939	A. BUILDING: _____ B. WING _____	R-C 07/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COTTAGES AT LAKE PARK (THE)	2006 LAKE PARK DRIVE MARINETTE, WI 54143

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N 353	Continued From page 1 On 07/25/2023 at 6:00PM, Surveyor reviewed the Aurora BayCare Medical Center Admission documentation dated 06/16/2023. The emergency room physician assessed Resident 1 and noted the following: "Trauma alert called by myself [physician] after evaluation of patient which showed a shortened and externally rotated right leg." "Head: Normocephalic, with area of scalp ecchymosis [discoloration resulting from bleeding underneath the skin/bruise] to the R [right] parietal/occipital scalp." "Extremities: Right lower extremity is externally rotated and shortened. There is pain at both of the hips. There is ecchymosis to the left lateral hip ..." The medical documentation showed Resident 1 had a computerized tomography (CT) scan completed on 06/19/2023 at 8:17PM. The results of the CT scan resulted in a diagnoses of a right intertrochanteric hip fracture. Resident 1 was admitted to the hospital on 06/20/2023. Resident 1's leg was surgically repaired by cephalomedullary nailing. Further review of the Aurora BayCare Medical documentation dated 06/30/2023 noted the following diagnosis: Closed displaced intertrochanteric fracture of the right femur ..." On 07/17/2023 at 4:35PM, Surveyor reviewed Resident 1's observation notes for June 2023. The notes revealed the following information: 06/19/2023 at 5:45AM: "[S/he] slept all night in [his/her] bed. When giving [his/her] thyroid pill [s/he] told staff that [s/he] feels sick and to cover [him/her] up with the blankets to [his/her] neck."	N 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017939	A. BUILDING: _____ B. WING _____	R-C 07/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COTTAGES AT LAKE PARK (THE)	2006 LAKE PARK DRIVE MARINETTE, WI 54143

(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 353	Continued From page 2	N 353		

06/19/2023 at 1:15PM: "Resident has had a rough morning. [S/he] denies pain, but whenever you apply any pressure to [his/her] right side, [s/he] winces in pain. POA was notified. Resident spent all morning in [his/her] recliner sleeping. Please keep an eye on [him/her.] -thanks."
06/20/2023 at 9:00AM (nurse note): "There seems to be some charting missing on [Resident 1]? What happened? Why did [s/he] go to the hospital? Please put in notes when things like this happens, it needs to be documented."
06/20/82023 at 1:15PM: "[S/he] was sent out by ambulance at approximately 5:30 last night, due to not being able to stand or barely move around because of [his/her] right hip. [His/her] [family member] POA also found a very deep purple/black bruise on the back of [his/her] head also containing a lump. [S/he] was very irritated and not eating as much, most likely due to pain."

On 07/20/2023, at 5:39PM, Surveyor reviewed Resident 1's Task Administration Record (TAR) from 06/18/2023 to 06/20/2023. TAR and noted the following entries:

06/19/2023 at 11:26AM for Oral Care: Caregiver D documented, "refused by resident - [s/he] was in a lot of pain.
06/19/2023 at 11:26AM for Dressing (as needed): Caregiver D documented, "it was a 2 assist today."
06/19/2023 at 11:29AM for Walking Around Building: Caregiver D documented, "refused by resident - [s/he] was in a lot of pain."

On 07/17/2023 at 4:15PM, Surveyor reviewed Resident 1's Individual Service Plan (ISP) dated 06/03/2023. According to the ISP, Resident 1 required monitoring and assistance with dressing and ensuring the proper attire is selected.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017939	A. BUILDING: _____ B. WING _____	R-C 07/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COTTAGES AT LAKE PARK (THE)	2006 LAKE PARK DRIVE MARINETTE, WI 54143

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N 353	Continued From page 3	N 353		

Resident 1 only required assistance as needed for oral care and showering. The ISP noted Resident 1 ambulated independently with a walker. This ISP also identified Resident 1 was at risk for falls.
Note: On 06/19/2023, Resident 1 refused oral care because s/he was in pain and required assistance of two caregivers to get dressed.

On 07/17/2023 at 4:35PM, Surveyor reviewed Resident 1's observation notes from March 2023 through June 2023. The observation notes showed Resident 1 had a history unwitnessed fall.

The notes were as follows:
05/05/2023 at 2:06PM: Note was red flagged - "Incident Report (Found on Floor) ... "
05/10/2023 at 5:30AM - Note was red flagged - "Incident Report (Found on Floor) ... "
06/01/2023 at 11:26AM: Note was red flagged - "Incident Report (Fall - Unwitnessed) ..."
06/09/2023 at 1:38PM: Note was red flagged - "Incident Report (Fall - Unwitnessed) ..."
06/16/2023 at 4:00PM: Note from PRN Home Health PT - " ...Staff reported [s/he] had a recent fall and had some difficulty with ambulation earlier today ...."

Surveyor interviewed Caregiver B on 07/17/2022 at 9:45AM:
Caregiver B reported the morning of the incident, s/he was the medication passer. Caregiver B explained s/he went in a little after 7:00AM to pass medications. Caregiver B described positioning Resident 1 by pivoting his/her back and thigh to sit up on the bed. Caregiver B stated when s/he touched Resident 1's thigh area Resident 1 winced in pain. Caregiver B administered Tylenol for the pain. Caregiver B

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017939	A. BUILDING: _____ B. WING _____	R-C 07/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COTTAGES AT LAKE PARK (THE)	2006 LAKE PARK DRIVE MARINETTE, WI 54143

(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 353	Continued From page 4	N 353		

stated there were no reports of any falls from the previous shifts. After medications were passed, Caregiver C and Caregiver D assisted Resident 1 with a shower. Caregiver B reported Resident 1 was not able to walk to the shower, so the caregivers used a wheelchair and shower chair. Caregiver B reported Resident 1's head was not checked as they were asked not to wash Resident 1's hair. Resident 1's Power of Attorney/Health Care - E (POA-E) planned to take Resident 1 to a hair appointment later that day. Caregiver B confirmed Resident 1 could not stand up or bear weight. Caregiver B reported s/he notified the POA-E around 10:00AM and the nurse sometime after lunch. Caregiver B specified s/he told POA-E Resident 1 had pain on his/her right side, winced when touched and Resident 1 was given Tylenol for it. Surveyor inquired if POA-E and nurse was informed it took multiple caregivers to assist Resident 1 into the shower as s/he could not bear weight. Caregiver B reported s/he was not sure if s/he included this information.

Surveyor Interviewed Caregiver C on 07/17/2023 at 10:02AM:
Caregiver C explained s/he entered the room to assist Resident 1 with showering. Caregiver C described Resident 1 as, "appearing weak." Caregiver C reported sometimes it might require two caregivers to help Resident 1 up, but s/he always walked to the shower. This time, it took 2 caregivers to assist Resident 1 with the use of a wheelchair and shower chair. Caregiver C explained Resident 1 was not bearing weight the way s/he normally did.

Surveyor interviewed Caregiver D on 07/17/2023 at 10:15AM:
Caregiver D reported on 06/19/2023, s/he and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017939	A. BUILDING: _____ B. WING _____	R-C 07/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COTTAGES AT LAKE PARK (THE)	2006 LAKE PARK DRIVE MARINETTE, WI 54143

(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 353	Continued From page 5	N 353		

Caregiver C went to Resident 1's room to assist him/her with a shower. Caregiver D stated Resident 1 is usually a one person assist, but this time it almost took 3 caregivers to get Resident 1 from the bed to the bathroom. Resident 1 told the caregivers s/he was in pain and pointed at his/her right knee. Caregiver D reported they got the medication passer, Caregiver B, to help them. Caregiver D stated, "Took a med passer and two caregivers to get [him/her] in [the shower]." Caregiver D explained Caregiver B notified POA-E and the nurse. Caregiver D could not verify what information was shared with POA-E and the nurse. Caregiver D also reported Resident 1 would not be able to explain what happened due to his/her dementia diagnosis.

Surveyor interviewed Executive Director F (ED-F) on 07/17/2023 at 10:26AM:
ED-F confirmed there was not incident report completed for this incident. ED-F deferred to the self-report that was submitted to the department on 07/14/2023. ED-F explained through their investigation, the injury could have happened at night or right after the morning check. ED-F reported s/he felt Resident 1 could possibly independently get up after a fall.

Surveyor interviewed Registered Nurse A (RN-A) on 07/17/2023 at 12:14PM:
RN-A explained s/he was at the Cottages briefly but had to leave for a meeting at approximately 1:00PM. RN-A described being gone for 2 hours and then had to teach a class from 2:00PM to 4:00PM. RN-A reported s/he was informed by Caregiver B about Resident 1 as s/he was leaving for the meeting. Caregiver B relayed Resident 1 was in pain but had no bruising, but not the specific location of the pain. RN-A further stated Caregiver B informed him/her Resident 1 was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017939	A. BUILDING: _____ B. WING _____	R-C 07/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COTTAGES AT LAKE PARK (THE)	2006 LAKE PARK DRIVE MARINETTE, WI 54143

(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 353	Continued From page 6	N 353		

uncomfortable, but the caregivers got him/ her in the shower. RN-A reported s/he read the observation note stating Resident 1 was admitted to the hospital with a broken hip. RN-A reported s/he did not know Resident 1 needed substantial assistance to get in the shower and thought s/he walked. RN-A explained when Caregiver B spoke to POA-E, s/he offered to call 911 and have Resident 1 sent out at approximately 10:00AM-10:30AM, but POA-E said no as s/he would be in later.

Surveyor interviewed POA-E on 07/18/2023 at 2:02PM:
POA-E reported s/he received a phone call sometime between 9:00AM and 10:00PM from Caregiver B. POA-E stated Caregiver B said, "Wanted to let you know your [family member/Resident 1] was hard to wake up this morning." Caregiver B also reported Resident 1 was having right-side pain. POA-E explained it is not unusual for Resident 1 to be hard to wake up. POA-E then asked if Resident 1 had a fall and was informed they did not see anything reported from previous shifts. POA-E asked Caregiver B to have Resident 1 "checked out" and s/he would be in later that day. POA-E clarified "checked out" meant to have the nurse assess. POA-E explained Caregiver B told him/her they "managed" to get Resident 1 in the shower. POA-E assumed this meant Resident 1 was having some pain but was still able to walk into the shower. POA-A confirmed s/he was not informed Resident 1 could not bear weight or that it took multiple caregivers to assist him/her in the shower. POA-E stated if s/he knew this information, s/he would have been upset that Resident 1 was showered and would have requested transport to the emergency room for evaluation. POA-E reported when s/he entered

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	0017939	A. BUILDING: _____ B. WING _____	R-C 07/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COTTAGES AT LAKE PARK (THE)	2006 LAKE PARK DRIVE MARINETTE, WI 54143

(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 353	Continued From page 7	N 353		

Resident 1's room at approximately 4:30PM. POA-E observed Resident 1 sitting in his/her recliner, slumped over to the right. Resident 1 was resting his/her head on the right arm. POA-E stated, "Right away I thought this is not good, s/he does not look right to me." POA-E described having a difficult time waking Resident 1, and when Resident 1 did wake up, s/he was startled. POA-E assisted Resident 1 with sitting up straight, and his/her meal tray was brought to the room. Resident 1 ate a few bites but was not interested. After visiting a bit, POA-E asked Resident 1 if s/he would like to get up, and Resident 1 said yes as s/he needed to go to the bathroom. Resident 1 could not get up, so POA-E put both arms under Resident 1's armpits to help lift. POA-E reported, at that time, s/he looked down and saw Resident 1's right leg was turned outward. POA-E then looked Resident 1 over and found a large hematoma on the right back side of his/her head. POA-E stated, s/he thought Resident 1's hip was broken, so s/he directed a caregiver to call 911 around approximately 5:30PM.

On 07/18/2023 at 5:40PM, Surveyor reviewed the provider's undated policy titled, "Emergency Care/Fall and Incident Response Policy. The policy stated:

"If a resident is found after a fall or a fall is reported, or any other incident has occurred; the following steps are to be taken for a Responsive Resident: ... 8) Check the entire body for cuts, bruises, or deformities. Look for areas that may be indented or may be bulging ... 11) Obtain a set of vital signs including: blood pressure, pulse, O2, Temperature and respirations ... 13) Contact the physician of the resident; leaving a message if no one answers or it is after hours. Fall/incident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017939	A. BUILDING: _____ B. WING _____	R-C 07/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COTTAGES AT LAKE PARK (THE)	2006 LAKE PARK DRIVE MARINETTE, WI 54143

(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 353	Continued From page 8	N 353		

reports should be faxed to the physician's office as well once completed ... 15) Complete the incident or fall report in ECP as descriptively and factually as possible."

On 07/18/2023 at 5:50PM, Surveyor reviewed the provider's undated policy titled, "Emergency Care / Fall and Incident Response with head injury. The policy stated,

"For any resident with a head injury; the following procedure will take place. NOTE: Suspected head, neck or spinal cord injuries require outside care; so these individuals need to be sent to the emergency room for evaluation. There are two exceptions to this:
1) The resident is on hospice services; in this circumstance, hospice should be called first.
2) The resident does NOT have an activated POA/guardian in place and REFUSES treatment
OR
the resident POA/guardian REFUSES treatment. This MUST be documented and can be overruled by you, the team member. Even if the injured person or POA/guardian is refusing care; we do have the obligation to contact 911 if we feel in any way that this injury requires medical attention."

According to information found at the American Academy of Orthopedic Surgeons, if there is a break in the leg/hip area, it will cause immediate and severe pain. The person will not be able to bear weight and the injured leg may appear shorter and deformed. Information found at: https://orthoinfo.aaos.org/en/diseases--conditions/femur-shaft-fractures-broken-thighbone/
Date of Retrieval: 07/25/2023

At approximately 7:00AM, Caregiver B noted

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017939	A. BUILDING: _____ B. WING _____	R-C 07/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COTTAGES AT LAKE PARK (THE)	2006 LAKE PARK DRIVE MARINETTE, WI 54143

(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 353	Continued From page 9 Resident 1 was wincing in pain when hip and thigh area was touched. Sometime between 9:00am and 10:00AM, Caregiver C and Caregiver D assisted Resident 1 with a shower and noted s/he was in pain and could not bear weight. According to the ISP, Resident 1 ambulated with a walker and required assistance as needed for showers. On the morning of 06/19/2023, Resident 1 required assistance of multiple caregivers. Resident 1 could not bear weight and was transported from the bed to the shower using a wheelchair and showered using shower chair. During this time, POA-E was notified of Resident 1 being difficult to wake and experiencing right side pain. At 11:26AM, Resident 1 refused oral care and refused to walk around the building. The TAR noted Resident 1, "was in a lot of pain." Sometime between 12:00PM and 1:00PM, the nurse was notified of Resident 1's right side pain but did not know s/he could not bear weight. Resident 1 remained in his/her recliner until POA-E arrived at approximately 4:30PM. POA-E noticed Resident 1's right leg was turned outward, and s/he could not stand and was in pain. Finally, at approximately 5:30PM, emergency responders transported Resident 1 to the emergency room. The provider's policy stated when a fall or other incident occurs, caregivers should check the resident from head to toe and complete an incident report as well as notify the POA and management. In case of a head injury, the provider's policy stated even if a POA refuses treatment, the caregiver can override the decision and call 911. Resident 1 experienced a significant change in condition when s/he could no longer ambulate and had pain. Resident 1 was also at risk for falls and had a recent history of unwitnessed falls. The caregivers did not complete the head-to-toe assessment or incident report as verified during interviews. Additionally, it	N 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017939	A. BUILDING: _____ B. WING _____	R-C 07/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COTTAGES AT LAKE PARK (THE)	2006 LAKE PARK DRIVE MARINETTE, WI 54143

(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 353	Continued From page 10 was unclear what information was actually relayed to POA-E and the nurse regarding the change in condition. According to medical documentation, Resident 1 sustained a right intertrochanteric femur fracture that required surgical interventions. Cross Reference: N0389 DHS 83.35(3)(d) Service Plans Updated Annually Or On Changes	N 353		
{N 389}	83.35(3)(d) Service plans updated annually or on changes Individual service plan review. Annually or when there is a change in a resident ' s needs, abilities or physical or mental condition, the individual service plan shall be reviewed and revised based on the assessment under sub. (1). All reviews of the individual service plan shall include input from the resident or legal representative, case manager, resident care staff, and other service providers as appropriate. The resident or resident ' s legal representative shall sign the individual service plan, acknowledging their involvement in, understanding of and agreement with the individual service plan. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the Individual Support Plan (ISP) was updated when there was a change in a resident 's needs, abilities or physical or mental condition for Resident 1. This is a repeat deficiency, see Statement of Deficiency (SOD) GBP911, dated 03/30/2023.	{N 389}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017939	A. BUILDING: _____ B. WING _____	R-C 07/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COTTAGES AT LAKE PARK (THE)	2006 LAKE PARK DRIVE MARINETTE, WI 54143

(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 389}	Continued From page 11 Findings Include: On 07/10/2023, the department received a complaint about an unwitnessed incident resulting in significant injury to a resident. On 07/17/2023 at 4:15PM. Surveyor reviewed Resident 1's Individual Service Plan (ISP) dated 06/03/2023. The ISP noted Resident 1 had a diagnosis of unspecified dementia, and presence of a left artificial knee. The ISP further noted the following: TOILETING: "Independent. No assistance required." MOTION SENSOR: " ...to ensure that [Resident 1] is safe during the completion of [his/her] skills staff will be alerted of movement in [Resident 1's] room and staff at The Cottages will check on [Resident 1] to make sure they are safe and may/may not need assistance." ELEVATED FALL RISK: "[Resident 1] has been assessed and it has been determined s/he is at an elevated risk for falls. Because of this; motion detector is to be used during times the resident is sleeping or in their rooms or as specified." Updated on 06/19/2023 - ELEVATE LEGS WHEN IN RECLINER: "Per PT for edema management please encourage [Resident 1] to elevate [his/her] legs when [s/he] is in [his/her] recliner." On 07/17/2023 at 4:35PM, Surveyor reviewed Resident 1's observation notes from March 2023 through June 2023. The observation notes revealed Resident 1 was experiencing an increase in unwitnessed falls in May and June. The notes were as follows: 05/05/2023 at 2:06PM: Note was red flagged -	{N 389}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017939	A. BUILDING: _____ B. WING _____	R-C 07/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COTTAGES AT LAKE PARK (THE)	2006 LAKE PARK DRIVE MARINETTE, WI 54143

(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 389}	Continued From page 12 "Incident Report (Found on Floor) ... " 05/10/2023 at 5:30AM - Note was red flagged - "Incident Report (Found on Floor) ... " 06/01/2023 at 9:00AM: "[Resident 1] said [s/he] felt weak, [his/her] legs looked like they were gonna [sic] give out but they didnt [sic]. I was able to get [him/her] to [his/her] recliner safely and just brought [his/her] breakfast down to [him/her], please keep an eye on [him/her]." 06/01/2023 at 11:26AM: Note was red flagged - "Incident Report (Fall - Unwitnessed) ..." 06/09/2023 at 1:38PM: Note was red flagged - "Incident Report (Fall - Unwitnessed) ..." 06/11/2023: "When giving morning meds notice [sic] giant bruise on left hip." 06/16/2023 at 4:00PM: Note from PRN Home Health PT - " ...Staff reported s/he had a recent fall and had some difficulty with ambulation earlier today ...." On 07/18/2023 at 8:15AM, Surveyor reviewed Resident 1's Incident Reports regarding falls. The incident reports noted Resident 1 experiencing left knee pain, walking with a limp, and noting pain in the left knee. The incident reports revealed the following: 05/05/2023: "Resident was found on floor when staff entered [his/her] room. [S/he] was on [his/her] bottom, and [his/her] left knee was pulled in. [S/he] was between the bed and cupbord [sic]. ROM [range of motion] was performed. Resident stated [his/her] left knee hurt. No bruises noted and no redness on [his/her] back and denies hitting [his/her] head." 05/10/2023: "Resident appeared to be getting into or getting up from [his/her] chair when [s/he] fell or ended up on the floor between [his/her] bed and [his/her] chair. Resident left foot is significantly swollen and discolored a deep purple	{N 389}		

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{N 389}	Continued From page 13	{N 389}		

and reddish color around the ankle and toes. Right foot is also semi swollen but not to the extent the left foot is [sic]. Staff helped resident to [his/her] bed and got [him/her] tucked in, [s/he] didn't say [s/he] was in any pain at the time of the incident or post-incident ..."
NOTE: Observation note 05/10/2023 at 9:30AM - the RN assessed the left leg and noted swelling is from heart failure not injury.
06/01/2023: "[Resident 1's family member] called and said that [s/he] was on the phone with [Resident 1] and [s/he] was on the floor. Staff went in as [Resident 1's] alarm didn't go off and found [him/her] on the floor in front of [his/her] recliner. It appears the recliner slid back against [his/her] wall. [His/her] alarm did go off as staff entered [his/her] room. [Resident 1] is unsteady on [his/her] feet and seems to have a limp when walking."
06/09/2023: "[Resident 1] went back to [his/her] room after [s/he] was done eating lunch. [Resident 1] ended up falling in [his/her] bathroom. [S/he] did hit [his/her] head on the wall as [s/he] has a lump with a reed [sic] abrasion. It isn't bleeding. [Resident 1] is also complaining of [his/her] left leg hurting. [Resident 1] does seem to be out of it and very tired. Staff called POA right away and [s/he] said to monitor and if anything got worse [s/he] would come in."

On 07/25/2023 at 5:18PM, Surveyor reviewed Resident 1's medication administration records for May and June of 2023. Surveyor noted Resident 1 was prescribed acetaminophen 325mg scheduled at noon and as needed. Further review of the MAR revealed Resident 1 was only administered acetaminophen as needed once on 05/03/2023, and once on 06/19/2023.

Surveyor interviewed Power of Attorney/Health

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{N 389}	Continued From page 14 Care E (POA-E) on 07/18/2023 at 2:02PM: POA-E explained Resident 1 often has pain in the left knee due to an older knee replacement. POA-E reported the scheduled and as needed acetaminophen was for knee pain. Surveyor interviewed Caregiver C on 07/17/2023, at 10:02AM: Caregiver C reported some days, Resident 1 could walk better than others. Caregiver C described a time when s/he did not feel comfortable walking with Resident 1 by his/herself, but 20 minutes later, Resident 1 was ambulating just fine. Surveyor interviewed Caregiver D on 07/17/2023 at 10:15AM: Caregiver D reported Resident 1 was not independent and required a one person assist. Caregiver D confirmed Resident 1 was not someone that could provide self-care. Caregiver D explained s/he may need help pulling his/her pants up or down once in the bathroom. Surveyor interview Registered Nurse A (RN-A) on 07/17/2023 at 12:14PM: RN-A reported Resident 1 had no safety awareness. RN-A explained most falls involved Resident 1 would get up and slid down and seemed like s/he was found next to the bed after most falls. RN-A verified Resident 1 used a walker but preferred not to. Surveyor interviewed Executive Director F (ED-F) on 07/26/2023 at 2:30PM: ED-F explained the nurse or someone in management are the last people to see the incident reports. ED-F reported the provider will review the reports for trends and make updates to the ISP's when needed.	{N 389}		

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{N 389}	Continued From page 15 From 05/05/2023 to 06/16/2023, Resident 1 experienced 4 falls. According to incident reports, Resident 1 complained of left knee/leg pain at the time of the falls. The incident report contained caregiver observations that noted Resident 1 walked with a limp and verbalized left knee pain. Additionally, The ISP did not mention Resident 1's knee replacement and weakness to the knee/legs. The ISP only noted the use of a motion sensor and to elevate his/her legs to decrease edema. The ISP did not include information about the left knee pain possibly contributing to falls or identify the use of acetaminophen as needed. There were no further revisions made to the ISP to mitigate the risk of falls due to increased pain and weakness in the left leg/knee for Resident 1. Cross Reference: N0353 DHS 83.32(3)(i) Rights of Residents: Adequate Treatment	{N 389}		