STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018318	A. BUILDING: _____ B. WING _____	C 09/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELENS HOUSE GRAND CHUTE BLUE	4210 N SHADY WOOD CT APPLETON, WI 54913

(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 09/06/2023 with additional information gathered through 09/08/2023, Surveyor conducted a complaint investigation at Helen's House Grand Chute Blue in Appleton. As a result, 1 deficiency was identified. Census: 4	M 000		
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 Resident 1 with prompt and adequate treatment after a fall that resulted in a fractured nose and a brain bleed. Findings include: The department received a complaint on 08/31/2023 alleging Resident 1 had two falls and was admitted to the hospital for a broken nose and brain bleed. On 09/06/2023, Surveyor conducted a complaint investigation. At 9:50 AM, Surveyor observed Resident 1's room with House Manager A. Surveyor observed a bed alarm on Resident 1's bed along with a fall mat underneath his/her bed and a carpeted floor. House Manager A confirmed due to Resident 1's history of falls, staff are to pull out the fall mat when Resident 1 goes to sleep at night. House Manager A also reported Resident 1 is to be toileted 2 to 3 times throughout the night.	M 580		

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

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M 580	Continued From page 1 On 09/06/2023 at 9:55 AM, Surveyor interviewed Licensee B about Resident 1's recent falls. Licensee B reported Resident 1 fell on 08/30/2023 around 11:30 PM and again at approximately 6:00 AM on 08/31/2023. Licensee B confirmed when Resident 1 fell out of bed on 08/30/2023 there was no fall mat on the floor. Licensee B reported when Resident 1 fell, s/he landed on his/her face on the carpeted floor which caused a rug burn on his/her nose and some slight bleeding. Licensee B confirmed when Resident 1 fell the second time, the morning of 08/31/2023, the fall mat was pulled out and there were no noticeable injuries. Licensee B confirmed Caregiver C was working night shift on 08/30/2023 and completed the fall reports. On 09/06/2023, Surveyor reviewed the fall report, dated 08/30/2023 at 11:30 PM. The fall report completed by Caregiver C stated, "[Resident 1] rolled out of [his/her] bed and because PM shift did not have the protection mat pulled out from under [his/her] bed [s/he] landed on [his/her] face." The report indicated Caregiver C assessed Resident 1 by answering "Yes" to all of the following questions: "Is resident able to move all extremities on command? Is there any evidence that the resident hit their head? Is there any apparent injury?" Surveyor observed that following all of the questions on the form there was a statement that indicated, "and call Nurse." Caregiver C noted Resident 1 had a rug burn on his/her nose with slight bleeding. The report stated once Caregiver C assessed Resident 1, s/he pulled the fall mat out from under Resident 1's bed, picked him/her up and put him/her further into the middle of the bed. On 09/07/2023, Surveyor reviewed the fall report,	M 580		

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M 580	Continued From page 2	M 580		

dated 08/31/2023 at 5:30 AM. The fall report completed by Caregiver C indicated Resident 1 rolled out of bed onto the floor. The form indicated Caregiver C found Resident 1 on his/her back and there were no noticeable injuries. Caregiver C noted there was no evidence during this fall Resident 1 hit his/her head or had any apparent injury.

On 09/07/2023, Surveyor reviewed Resident 1's record including his/her ISP, Reference Sheet and Plan of Care Kardex. Resident 1 was admitted to the facility on 12/18/2020 with diagnoses including insomnia, arthritis, difficulty walking, muscle weakness, unsteadiness on feet and history of falls. Resident 1's current ISP, dated 03/25/2023, documented full cares for all activities of daily living including bathing; hair, nail, skin, teeth care; dressing; glasses and hearing aids. For mobility, Resident 1's ISP, reflected s/he needs assistance with transferring and uses a wheelchair. S/he is also identified as a medium/high risk for falls, is on 2-hour bed checks and needs assistance full time. In addition, Resident 1's "Plan of Care Kardex," dated 03/25/2023, reflected Resident 1 needed a fall mat, motion sensor, pressure mat and pull tab. Surveyor did not observe any documentation regarding Resident 1's fall mat on his/her ISP and there were no updates to the ISP since 03/25/2023.

On 09/07/2023 at 9:40 AM, Surveyor interviewed Caregiver C who confirmed s/he came into work for night shift on 08/30/2023 to replace Caregiver E who was working the PM shift. Caregiver C reported it was Caregiver E's first time working alone and s/he forgot to pull the fall mat out for Resident 1 when s/he put him/her to bed that night. Caregiver C stated s/he heard Resident 1

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M 580	Continued From page 3	M 580		

fall in his/her room around 11:30 PM and when s/he ran into his/her room, Resident 1 was laying face down on the floor with no fall mat. Caregiver C reported, "[Resident 1] wasn't moving or saying anything. [S/he] squeezed my hand and I saw a little blood on [his/her] face and a rug burn. [S/he] seemed ok, so I got [him/her] back into bed. I wiped [him/her] down and got [him/her] into the middle of the bed. [His/her] eyes and nose were already swollen. I saw bruising already around [his/her] eyes. I monitored [him/her] for the rest of the night. I was so scared." Caregiver C confirmed s/he did not call anyone as it was the middle of the night and s/he was hesitant to call 911 because "I didn't feel [s/he] was injured enough." Caregiver C stated, "When I turned [him/her] over, I could tell [s/he] was ok. I made my best judgment. [S/he] was moving [his/her] arms, legs and head. I was thinking concussion, so I kept checking in on [him/her]." Caregiver C stated Resident 1 fell out of bed again on 08/31/2023 at 5:30 AM. Caregiver C stated Resident 1 landed on his/her back on the fall mat. Caregiver C reported s/he assessed Resident 1 for any injuries and then picked him/her up and put him/her back to bed. S/he stated, "[His/her] face looked the same. It was swollen and bruised." Caregiver C reported s/he forgot to call everyone that morning when his/her shift ended, so the AM shift notified the family and nurse.

On 09/07/2023, Surveyor reviewed the provider's fall procedure and observed the following steps:

1) Assess the resident for any injuries.
2) Follow the protocol on the Fall Report form in regard to calling the Director of Care, assisting the resident off the floor, and faxing form to the Director of Care.
3) Assess the area the resident fell in. Take note

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M 580	Continued From page 4	M 580		

in the position the resident is on the floor. Also take note of any furniture that may have contributed to the fall.
4) Determine what may have contributed to the fall.
5) Ensure that safety measures have been taken to reduce the risk of future falls.
6) Update the next shift. Ensure that any change in safety measures are relayed with all staff via an email placed in the Helen's House staff email.
7) Fill out a Fall Report and Fax to Director of Care at 920-202-8086
8) Update POA, Community Care/Lakeland Care, Hospice (if resident is on Community Care, Lakeland Care and/or Hospice), sign and date that they have been notified.

On 09/07/2023 at 2:25 PM, Surveyor reviewed an incident report received from Licensee B via email who reported Caregiver F came in for his/her AM shift on 08/31/2023. When Caregiver F started to get Resident 1 up for the day, s/he noticed the bruising on his/her face and called the nurse. The report indicated Family D called at 9:30 AM and requested that Resident 1 go to the hospital. Resident 1 was transported to the hospital around 12:15 PM.

On 09/07/2023 at approximately 3:00 PM, Surveyor reviewed the hospital discharge report stating Resident 1 was admitted on 08/31/2023 and discharged on 09/07/2023. The hospital discharge report states Resident 1 was admitted for a fall and diagnosed with a traumatic subdural hematoma and a fracture of nasal bones.

On 09/07/2023 at 3:20 PM, Surveyor interviewed Licensee B who confirmed Caregiver C did not follow the provider's fall protocol when Resident 1 fell on 08/30/2023 at 11:30 PM. Licensee B

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M 580	Continued From page 5 reported Caregiver C should have contacted the nurse right away. Licensee B also acknowledged the "Plan of Care Kardex" was a supplement of the ISP; however, both the ISP and Kardex should be updated at the same time. Licensee B confirmed the fall mat was implemented for Resident 1 on 08/17/2023 and his/her ISP was not updated to reflect this change. In summary, the provider did not update Resident 1's ISP when his/her needs changed. The provider also did not provide prompt and adequate treatment when Resident 1 fell on 08/30/2023 which resulted in a fractured nose and a brain bleed. As a result of the fall, Resident 1 was hospitalized from 08/31/2023 to 09/07/2023.	M 580		