STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016841	A. BUILDING: _____ B. WING _____	C 09/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESTON II	3008 MAY ST EAU CLAIRE, WI 54701

(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 08/03/2023, Surveyor conducted a licensure survey and complaint investigation at Preston II. Data collection continued through 09/13/2023. The complaint was substantiated. Two deficiencies were identified. Census: 4	M 000		
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. 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. Findings include: On 08/17/2023 at 10:17 AM, Surveyor conducted an environmental tour of the facility. Surveyor observed the following:	M 570		

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

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M 570	Continued From page 1 1. In the laundry room, the dryer plug-in to the outlet on the back wall had frayed wires exposed. 2. In the laundry room there were multiple ceiling tiles missing, with stained ceiling tiles around the missing ones, and some tiles peeling paint. 3. In the kitchen, there was a phone jack protruding with exposed wires out of the wall. At 11:23 AM, Surveyor interviewed Assistant Program Manager (APM) A. APM A stated the laundry room ceiling tiles had been that way since s/he started in June 2023. APM A stated s/he was not sure what happened. On 09/13/2023 at 10:00 AM, Surveyor interviewed Regional Director (RD) B. RD B stated that at least a year ago, the upstairs bathroom tub was not draining and maintenance had to access a pipe through the laundry room ceiling. RD B stated the laundry room ceiling was on the maintenance list to fix.	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 Resident 1 with prompt and adequate treatment. Resident 1 was left on the floor for over 9 hours until Program Manager (PM) E noticed something was not right with Resident 1 and called 911.	M 580		

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Findings include:

On 05/24/2023, the department received a complaint alleging staff had left a resident lying on the floor all night.

The provider is licensed to serve up to 4 ambulatory residents within the client groups of developmentally disabled and emotionally disturbed/mental illness.

RECORD REVIEW

On 08/17/2023, Surveyor requested Resident 1's record for review. Assistant Program Manager (APM) A stated their regional office had the record. Surveyor requested the regional office send Resident 1's record.

On 08/31/2023, Surveyor reviewed Resident 1's record sent by the regional office on 08/21/2023. Resident 1's face sheet indicated s/he was admitted to the facility on 04/01/2013. Resident 1 had a guardian and managed care organization (MCO) as part of his/her care team. Resident 1 had diagnoses that included type 2 diabetes, history of alcohol dependence, history of psychoactive substance abuse, herpes viral infection, schizoaffective disorder, post-traumatic stress disorder, chronic obstructive pulmonary disease (COPD) and chronic hepatitis C.

Resident 1's individual service plan (ISP), dated 05/16/2023, indicated Resident 1 was independent with personal cares and needed prompts or reminders at times. The ISP indicated Resident 1 had recently relapsed with drug and/or alcohol use and was hospitalized. The ISP indicated Resident 1 was not able to self-supervise at the facility due to a recent

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elopement and getting into the medication cabinet leading to an overdose. Resident 1 was required to ride along on all transports. The ISP indicated Resident 1 had a history of arguing, slamming doors, and threatening behavior. The ISP indicated Resident 1 would experience auditory and visual hallucinations, anxiety, agitation, and had a history of suicidal threats and attempts. The ISP indicated the facility was staffed with 24/7 awake staff. The ISP did not indicate Resident 1 lying down on the floor was a normal exhibited behavior.

On 05/21/2023, between 7:00 PM to 7:00 AM, Caregiver C wrote in Resident 1's T-Log, "[Resident 1] called to this staff that [s/he] slid [sic] [his/her] water and staff got [him/her] more water. When staff had left [his/her] room [s/he] fell out of [his/her] bed to the floor at 9:45 PM. [Resident 1] try [sic] to get back up with staff helping [him/her] for about 15 to 20 minutes and back up [sic] was called. [Resident 1] was sleep [sic] on the floor at 11PM [sic]. [Resident 1] slept on the floor all night. [Resident 1] remains on the floor asleep at this time. [Resident 1] will not wake up for [his/her] 6AM medication."

On 09/07/2023, Surveyor received an internal investigation conducted by Regional Director (RD) B, dated 05/22/2023 to 05/24/2023, which stated, "On May 22, 2023 [Resident 1] passed away in [his/her] bedroom at [the facility]. 911 was called when [Program Manager (PM) E], checked on [Resident 1] and found [him/her] unresponsive on [his/her] bedroom floor. [PM E] directed the staff to call 911 and [s/he] began CPR (cardiopulmonary resuscitation) on [Resident 1]. Police arrived as the first responders and then paramedics. [Resident 1] was pronounced dead, and the medical examiner was notified."

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M 580	Continued From page 4 The investigation had an interview with Caregiver C explaining, "[Resident 1] was in [his/her] room when I got to work at 7pm [sic]. [Resident 1] called out to me a few minutes later and said [s/he] wasn't going to take [his/her] meds (medications) and I asked [him/her] why and [s/he] wouldn't answer me. At 8pm [sic] [Resident 1] refused to take [his/her] meds. [Resident 1] said [s/he] felt over-medicated with lithium. I called back-up and [APM D] came to the house and talked to [Resident 1]. Then [Resident 1] agreed to take [his/her] meds and did [his/her] nebulizer treatment after [APM D] came. [Resident 1] was walking around slowly. [Resident 1] checked [his/her] blood sugar and then went back to [his/her] bedroom. [Resident 1] was laying [sic] in bed watching tv [sic]. At about 9:30pm [sic] [Resident 1] tipped over [his/her] ice water. I cleaned it up and gave [him/her] a fresh cup with a lid. [Resident 1] took the lid off and spilled it again right away. [Resident 1] was upset and said that I put the lid on too tight. [Resident 1] was sitting on [his/her] bed. I grabbed a towel from the laundry room and walked back in [his/her] room and [s/he] was laying [sic] on the floor on [his/her] stomach. I asked [him/her] what happened, and [s/he] said [s/he] slid out of bed. I asked [him/her] if [s/he] needed help up and [Resident 1] said, 'I'm out of air.' I checked to make sure [his/her] oxygen machine was on, and it was and [s/he] had it in [his/her] nose. I tried to help [him/her] up but [Resident 1] got upset and said [sic] 'screw it, leave me here.' I continued to try to help [him/her] get in bed but [s/he] was not helping to try. At about 10:45 - 11 pm [sic] [Resident 1] was snoring. I gave [him/her] a pillow and sheet to cover up." Caregiver C indicated that at 6:00 AM, s/he attempted to give Resident 1 his/her medications and Resident 1 would not	M 580		

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respond.

The investigation had an interview with APM D, which explained what happened from his/her perspective. APM D stated, "[Resident 1] wasn't feeling well on Wednesday and Thursday, and [s/he] had the same symptoms as other house mates and staff. [Resident 1] was achy and had a sore throat. I let [registered nurse (RN], know and [s/he] said to monitor [Resident 1's] vitals and take [him/her] in if anything changed or [s/he] felt worse. On Friday [s/he] said [s/he] felt fine, and [his/her] throat did not hurt anymore. [Resident 1] was acting as [s/he] normally did. Saturday and Sunday I went in because [s/he] was refusing meds and [s/he] fell out of [his/her] bed. [Resident 1] was able to get up and did not hit [his/her] head. I told [him/her] we had to lock [his/her] smokes (cigarettes) up because if [s/he] was falling then [s/he] needed someone to watch [him/her] go out to smoke. [Resident 1] got mad at me and was yelling at me."

RD B asked APM D if staff called him/her on Saturday night on the overnight shift about Resident 1. APM D indicated s/he did not think staff contacted him/her but was not sure due to being groggy from taking cold medicine. The investigator asked APM D if s/he had notified management about Resident 1's fall and that his/her cigarettes were locked up. APM D stated s/he had not and was going to let them know on Monday. The investigator asked APM D what happened when s/he arrived for his/her shift on Monday, 05/22/2023. APM D stated, "[Caregiver C] said [Resident 1] wouldn't wake up to take his/her meds and that [s/he] was still sleeping on the floor ...I kept going in there and trying to wake [him/her]. At one point [s/he] had [his/her] hand in a fist. I tried to get vitals and couldn't because of

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how [s/he] was lying."

RD B asked APM D if s/he questioned why Resident 1 was still lying in the same position. APM D indicated Resident 1 did not feel cold and s/he could see Resident 1 was breathing. APM D indicated s/he thought Resident 1 was mad at him/her and Resident 1 would have behaviors like that. The investigator asked APM D if Resident 1 refusing medications and meals during the weekend was unusual behavior for him/her and if at any time APM D thought this was a medical issue. APM D indicated s/he did not think so because Resident 1's vital signs were fine. APM D stated that when Resident 1 would get upset at APM D, Resident 1 would ignore him/her and not cooperate. APM D did not contact a nurse or physician at any time over the weekend.

The Assess and Prevent Falls policy and procedure, dated February 2013, stated if a resident had a fall, "If resident appears in serious distress (i.e. altered consciousness, severe pain, or is unable to get self up [sic] without assist or without usual assist). a. staff will call 911." The policy also indicated staff should have notified management and if the resident had a history of feigning falls for attention, staff were to refer to the resident's ISP for specific interventions for that resident.

The Notification of Physician and Guardian of Injury/Significant Change in Client, dated February 2012, indicated if a resident had an injury or significant adverse change in physical or mental condition, staff should check the resident over for multiple listed signs and symptoms. One of the signs and symptoms listed was unexplainable confusion or drowsiness. The policy stated, "If any of these signs or symptoms

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are evident, staff will immediately call 911 and make the resident comfortable, apply necessary first aid, and keep as safe as possible." The policy indicated staff would also notify management. The policy stated, "WHEN IN DOUBT, INFORM MANAGEMENT AND PROCEED TO TAKE RESIDENT IN FOR MEDICAL ATTENTION."

The Death Investigation Report indicated Resident 1's time of estimated death was at 3:00 AM caused by cardiopulmonary arrest due to probable complications of COPD. The report stated, "Upon EMS arrival, [Resident 1] was cool to the touch and obviously deceased. No lifesaving efforts were made. [Police] reported [Resident 1] was seen around 10:00 PM the previous night, staff reported that [s/he] was lying on [his/her] floor and refused to get back in bed. Staff stated that they again checked on [him/her] around 7:00 AM, [s/he] was still on the floor and they saw movement that was consistent with breathing. [S/he] was not disturbed until the time of discovery ...I was then directed to a lower level [sic] bedroom, where I observed an obese [person], identified as [Resident 1], lying supine on the floor. [Resident 1] was not exhibiting any signs of life, dark lividly was observed in [his/her] facial area, along with purge coming from [his/her] mouth and nose, along with a nasal cannula oxygen line in place." The death report indicated they were called at 10:56 AM.

INTERVIEW

On 08/17/2023 at 12:02 PM, Surveyor interviewed APM A. APM A stated s/he started working at the facility after Resident 1's death. APM A stated their current fall policy and procedure would be for staff to thoroughly assess

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the resident and help the resident get off the floor. APM A stated if staff could not get the resident off the floor with assistance, then they would call emergency medical services (EMS) to assist and not leave the resident on the floor.

On 09/01/2023 at 2:13 PM, Surveyor interviewed Caregiver C. Caregiver C confirmed s/he worked the overnight shift when Resident 1 was left on the floor all night and started at 7:00 PM on 05/21/2023. Surveyor asked Caregiver C to explain what happened. Caregiver C stated at 7:30 PM, Resident 1 refused to take his/her medications. Caregiver C stated s/he called APM D who came in and got Resident 1 to take his/her medications. Caregiver C stated around 10:00 PM Resident 1 kept knocking his/her water cup on the floor. Caregiver C stated s/he went downstairs to refill Resident 1's glass of water and when s/he came back s/he found Resident 1 sitting on the floor with his/her back towards the bed. Caregiver C stated Resident 1 stated s/he was tired and proceeded to lay down on the floor on his/her stomach. Caregiver C stated s/he tried for 30 minutes to get Resident 1 up off the floor. Caregiver C stated s/he then called APM D, whom was on-call that night, and asked for help. Caregiver C stated APM D told him/her s/he was not coming in and to monitor Resident 1. Caregiver C stated s/he monitored Resident 1 hourly all night. Surveyor asked Caregiver C why s/he did not call 911. Caregiver C stated his/her brain was not working well that night due to the stress and s/he would check on Resident 1 by calling his/her name and hear a grunt in response. Caregiver C also stated s/he did not know who else to call for help within the company that night. Caregiver C stated s/he did not get support from management and kept beating him/herself up over the situation. Surveyor asked

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Caregiver C what his/her hourly checks consisted of. Caregiver C stated s/he would look into Resident 1's room and it appeared s/he was breathing. Caregiver C stated Resident 1 did not wake up at any point in the night. Caregiver C stated s/he last checked on Resident 1 at 6:00 AM when s/he refused his/her morning medications, and it appeared Resident 1 was still breathing at that time but still had not moved from the same position s/he was in at 10:00 PM on the floor.

On 09/01/2023 at 2:55 PM, Surveyor interviewed RD B. RD B stated APM D did not contact management over the weekend of the incident with Resident 1. RD B stated Caregiver C tried helping Resident 1 up until 11:00 PM. RD B stated Resident 1 had laid on the floor in the past when s/he was mad, but s/he would always eventually get back up. RD B stated Caregiver C told him/her s/he checked on Resident 1 through the night and thought s/he heard Resident 1 snoring, but the fan and oxygen machine were loud. RD A stated Caregiver C waited until APM D came on shift at 7:00 AM the next morning to update about Resident 1 refusing his/her morning medications. APM D notified PM E around 7:30 AM that Resident 1 was still having behaviors of refusing medications and lying on the bedroom floor. RD B stated s/he spoke to APM D around 8:00 AM and APM D did not relay the extent of Resident 1's change in condition, so RD B asked APM D to take Resident 1's vital signs and encourage him/her to eat. RD B called PM E around 8:30 AM and asked him/her to go over to the facility to check on Resident 1. RD B stated when PM E arrived s/he right away could tell something was not right with Resident 1 and had staff call 911 right away while starting CPR. RD B stated when EMS showed up Resident 1 was

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already dead. RD B stated staff should have called 911 immediately in this situation. RD B stated they already had training for all staff on the policy and procedures to follow, how to assess a resident to make sure they are alive, etc. RD B stated Caregiver C attended the all staff training and had a written coaching plan.

On 09/07/2023 at 4:22 PM, Surveyor interviewed Provider Quality Manager (PQM) G with the managed care organization (MCO). PQM G stated the MCO was notified of Resident 1's death on 05/22/2023 and was surprised to learn Resident 1 had not been doing well since 05/19/2023. PQM G confirmed Resident 1 lying on the floor was an abnormal behavior.

On 09/13/2023 at 10:00 AM, Surveyor interviewed RD B again in an exit conference. RD B confirmed Caregiver C did not chart his/her hourly checks on Resident 1 thoroughly. RD B stated s/he felt Caregiver C did do his/her hourly checks on Resident 1, but truly did not realize the extent of Resident 1's change in condition and thought it was a behavioral issue. RD B stated APM D no longer worked for the company.

SUMMARY

The provider did not provide Resident 1 with prompt and adequate treatment after a change in condition starting around 10:00 PM on 05/21/2023. Resident 1 had an unwitnessed fall from his/her bed to the floor and staff could not get him/her up. Resident 1 was left on the floor overnight from approximately 10:00 PM to 7:00 AM. Resident 1 was left on the floor for over 9 hours until Program Manager (PM) E noticed something was not right with Resident 1 and called 911. Per the death report, Resident 1 had

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M 580	Continued From page 11 already passed away by 3:00 AM that morning due to natural causes. Caregiver C did not provide prompt and adequate treatment for Resident 1 by failing to get medical care promptly when s/he had a change in condition.	M 580		