STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017490	A. BUILDING: _____ B. WING _____	C 08/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SONGBIRD POND ASSISTED LIVING	1900 ARBOR VIEW DR PLYMOUTH, WI 53073

(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 07/28/2023, with information gathered through 08/09/2023, Surveyor conducted a complaint investigation at Songbird Pond Assisted Living. One deficiency was identified. Complaint was unsubstantiated. Census: 37	N 000		
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 1 of 1 resident's Individual Service Plan (ISP) was reviewed when s/he experienced a change of condition. Resident 1's ISP was not updated to include behaviors regarding activities of daily living (ADLs). Findings include:	N 389		

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

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N 389	Continued From page 1 The provider is licensed to care for a maximum of 44 residents from client group advanced aged, irreversible dementia/Alzheimer's, physically disabled, and terminally ill. On 07/28/2023, at approximately 10:40 AM, Surveyor interviewed House Manager (HM) B and Manager C. HM B and Manager C explained to Surveyor that Resident 1 had a habit of "scooting out" of his/her wheelchair and if s/he stated s/he wanted to walk to a destination with his/her walker, s/he would take a couple of steps and decide s/he did not want to. HM B stated, "[S/he] would deliberately sit down right where [s/he] was at." Manager C stated, "[Resident 1] was not ambitious, [s/he] would prefer staff to complete all tasks." HM B and Manager C stated Resident 1 could be an "attention seeker," so at times it would be difficult to determine if s/he actually was in pain or did not feel well. HM B stated, "[Resident 1] was legally blind and [s/he] would tell staff that [his/her] needs come first, because [s/he] is blind." On 07/28/2023, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the facility on 09/27/2021, with diagnoses including blindness, hypertensive heart and chronic kidney disease with heart failure, acute on chronic combined systolic (congestive) and diastolic (congestive) heart failure, anxiety disorder, Type 2 diabetes, and major depressive disorder. Resident 1's "Observations," dated 12/02/2022 to 01/24/2023, documented: "12/02/2022 - Resident is hallucinating today ..." "12/03/2022 - Was hallucinating about [wo/men]	N 389		

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N 389	Continued From page 2	N 389		

in [his/her] room and wanting to go to bed with [her/him]."
"12/05/2022 - Used call light a lot today before [spouse] came."
"12/14/2022 - Resident was confused this AM. Thinking [s/he] still had food in front of [her/him] after [s/he] told staff to take it. Resident refused shower ... Was out of it today. ... Resident did fall back into [his/her] wheelchair during transferring ... Resident refused changing and cares."
"12/15/2022 - Resident hasn't been using [his/her] pendent for help [s/he] has been yelling out"
"12/16/2022 - Resident had a fall this evening around 6:00. Non emergent ambulance was called for lift assist and assessment. Resident sustained an injury to the back of [his/her] head. [S/he] was taken by ambulance to the hospital ... [spouse] was here and witnessed the fall."
"12/29/2022 - Resident returned from the hospital today."
"12/30/2022 - Resident took a half hr (hour) to stand from the toilet, almost had to use a hoyer ... resident told staff this morning [s/he] had to be fed because [s/he] is blind. Nurse let resident know that [s/he] feeds [her/himself] here."
"12/31/2022 - ... ambulate to the bathroom but used [his/her] wheelchair to get back. ... Was on call light every 10 minutes or so tonight."
"01/02/2023 - Resident had slid out of [his/her] recliner at around 8 am."
"01/09/2023 - Was lowered to the floor at 10:30 am. No injury. Was transferring to [his/her] recliner and decided to sit down with no warning ..."
"01/10/2023 - Resident is not standing well when staff tried to get [him/her] up to change [him/her] [s/he] leaned forward as if [s/he] was gonna fall then threw [him/herself] back into chair says

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N 389	Continued From page 3	N 389		

[his/her] legs are hurting ..."
"01/16/2023 - ... sliding out of [his/her] wheelchair 2 times staff had to boost [him/her] up ..."
"01/19/2023 - Was in an okay mood today. Was still yelling and hollering throughout the shift periodically. Especially when doing cares. ..."
"01/21/2023 - Rang several times throughout the night. ... was awake most of the night ..."
"01/24/2023 - Got sent out today via ambulance ..."

Resident 1's ISP, dated 09/16/2022, documented:
"Behavior Patterns: Not Applicable"
"Mental Health: Attitude - Not Applicable, Interaction - Not Applicable, Maturation - Not Applicable, Mental Illness - Not Applicable, Self-Concepts - Not Applicable, Verbal - Not Applicable"

On 08/09/2023, at approximately 3:40 PM, Surveyor interviewed Administrator A. Administrator A stated Resident 1 would go in phases of not wanting to complete basic activities of daily living, such as feeding him/herself, picking up the Kleenex box that was sitting next to her/him. Resident 1 would refuse to stand so staff would have to utilize a sit-to-stand lift. Administrator A and Surveyor reviewed Resident 1's ISP. Administrator A stated the behaviors identified by his/her staff and him/herself were not reflected in Resident 1's ISP. Administrator A stated s/he would review all resident ISPs to ensure individualization.