STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0012367	A. BUILDING: _____ B. WING _____	C 01/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR PINES INC	540 W PRAIRIE WAUTOMA, WI 54982

(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 01/11/2024 with additional information gathered through 01/16/2024, Surveyor conducted a complaint investigation at Arbor Pines in Wautoma. As a result, 1 of 1 complaint was substantiated and 2 deficiencies were identified. Census: 7	N 000		
N 164	83.12(4)(b) Reporting when law enforcement is called. A CBRF shall send a written report to the department within 3 working days after any of the following occurs: Any time law enforcement personnel are called to the CBRF as a result of an incident that jeopardizes the health, safety, or welfare of residents or employees. The CBRF ' s report to the department shall provide a description of the circumstances requiring the law enforcement intervention. This reporting requirement does not apply to residents under the jurisdiction of government correctional agencies. This Rule is not met as evidenced by: Based on record review and interview, the provider did not send a written report to the department when law enforcement personnel were called to the CBRF as a result of an incident that jeopardized the health, safety, or welfare of residents or employees. On 10/15/2023, law enforcement personnel were called to the facility regarding a resident's (Resident 1's) lack of access to food. The department did not receive a report of this incident. Findings include:	N 164		

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

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N 164	Continued From page 1 On 01/08/2024, the department received a complaint related to law enforcement personnel being called out to the facility due to concerns related to health, safety and welfare of the residents and staff. On 01/11/2024 at 12:20 PM, Surveyor interviewed Caregiver A who confirmed law enforcement was at the facility sometime in October 2023 as there was a complaint Resident 1 was not getting enough to eat. Caregiver A stated s/he could confirm law enforcement had been called to the facility, however s/he did not have much information as s/he was not working at the time when law enforcement came onsite. On 01/11/2024 at 2:25 PM, Surveyor interviewed Caregiver B who also confirmed law enforcement came to the facility sometime in October 2023. Caregiver B reported Caregiver C worked the PM shift that day and s/he worked the night shift. Caregiver B stated when s/he came into work that day, Caregiver C told him/her the police came regarding Resident 1. Caregiver B reported s/he was not sure what it was all about, but knew the police officer spoke with Resident 1 and Caregiver C. On 01/11/2024 at approximately 2:45 PM, Surveyor interviewed Manager D who confirmed s/he received a phone call from Caregiver C on 10/15/2023 stating law enforcement was at the facility. Manager D stated Caregiver C told him/her the police were called because Family F called them saying Resident 1 was hungry. Manager D reported when s/he arrived at the facility, the police officer has been onsite and was already gone. Manager D stated s/he spoke with the police officer over the phone and was told the	N 164		

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N 164	Continued From page 2 police officer found "nothing criminal" occurring. Manager D stated s/he asked Administrator E to fill out the self-report as s/he was leaving on vacation. Manager D stated s/he was not sure if Administrator E submitted the self-report or not. On 01/12/2024, Surveyor reviewed the department's facility folder and did not locate a facility self-report regarding this incident. On 01/12/2024, Surveyor reviewed the police report, dated 10/15/2023 for the police involvement at the facility. Information from the report confirmed an officer was called to the facility on 10/15/2023 due to concerns Resident 1 was losing weight and a staff member was either not feeding him/her or was taking his/her food away. On 01/12/2024 at approximately 3:00 PM, Surveyor interviewed Administrator E via phone who verified s/he did not submit a self-report to the department regarding the police involvement at the facility on 10/15/2023. Administrator E stated s/he thought Manager D told him/her s/he spoke with the officer over the phone and did not know they were at the facility.	N 164		
N 388	83.35(3)(c) Implement, follow the individual service plan Implementation. The CBRF shall implement and follow the individual service plan as written. This Rule is not met as evidenced by: Based on record review and interviews, the provider did not follow one of one resident's Individual Service Plan (ISP) as written.	N 388		

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N 388	Continued From page 3 Resident 2 was not served a mechanical soft food as outlined in their ISP. Findings include: On 01/08/2024, the department received a complaint that alleged the provider was not offering diets specific to individual resident needs. On 01/11/2024 at approximately 11:00 AM, Surveyor interviewed Manager D who stated Caregiver G "made an error with [Resident 2]" on 12/24/2023 when s/he "indistinctively" gave him/her Chex Mix and went to the bathroom. Manager D confirmed Resident 2 was on a mechanical soft diet and should not have been given Chex Mix. Manager D reported when Caregiver G came out of the bathroom, Family H was patting Resident 2 on the back and stated s/he was choking. Manager D stated Caregiver G said Resident 2 was coughing and spit out a pretzel from the Chex Mix. Caregiver G reported Family H was upset at what happened and asked if s/he had another snack to give Resident 2. Manager D stated Caregiver G offered to give Resident 2 potato chips; however, Family H said no and asked if s/he had soft foods like pudding or Jello. Manager D confirmed s/he spoke with Caregiver G about the incident and reeducated him/her on the foods to avoid with Resident 2 as well as healthy alternatives to provide to him/her. Manager D also stated Caregiver G was given a verbal warning regarding the incident. On 01/11/2024 at approximately 3:30 PM, Surveyor reviewed Resident 2's record. Resident 2 was admitted to the facility on 08/10/2010 with the following diagnoses: developmentally disabled, mental retardation with possible dementia, partial symptomatic epilepsy,	N 388		

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N 388	Continued From page 4 cerebellar atrophy, anxiety, depression, hypothyroidism and deep venous thrombosis of the right leg. Resident 2's current ISP, signed 09/06/2023, stated: "Special diet: The resident has been ordered a mechanical soft diet. However, the staff needs to monitor the resident to see if the resident's food needs to be pureed instead ...Arbor Pines staff need to keep a close eye on the resident when [s/he] eats at all times which includes monitoring resident's eating habits and being alert for any possible food allergies or swallowing issues." Surveyor noted a physician's order, dated 08/24/2023 that identified Resident 2's ordered diet was mechanical soft. On 01/12/2024 at approximately 3:00 PM, Surveyor interviewed Administrator E who stated, "Our staff gave [Resident 2] the Chex Mix. I am going to be 100% honest with you. This was a mistake." Administrator E stated Manager D provided Caregiver G with a verbal warning and the menu had been adjusted to include alternatives for staff.	N 388		