STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0012186	A. BUILDING: _____ B. WING _____	C 02/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PORT HAVEN	334 S GARFIELD PORT WASHINGTON, WI 53074

(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 02/07/2024, Surveyor conducted a complaint investigation at Port Haven. Two deficiencies were identified. The complaint was unsubstantiated. Census: 5	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 within 3 working days after law enforcement personnel was called to the facility as a result of an incident that jeopardized the health, safety, or welfare of resident or employees. Police responded to the provider 4 times between October 2023-January 2024 due to Resident 1 calling for assistance. Findings include: On 01/26/2024, Surveyor reviewed Resident 1's record and identified the following:	N 164		

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

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N 164	Continued From page 1 Resident 1 was admitted to the facility on 05/06/2022 with diagnoses including anxiety, depression, Parkinson's, and mental health concerns. Resident 1 had an activated healthcare power of attorney that made decisions on his/her behalf. On 01/26/2024 at 9:45 AM, Surveyor interviewed Nurse B. Nurse B stated there were ongoing concerns with Resident 1 calling police for non-emergency issues. Nurse B stated the provider issued Resident 1 a 30-day notice for many reasons, but one reason was due to Resident 1 calling police for issues that could be handled by staff. Surveyor asked if the provider reported incidents to the Department when law enforcement personnel was called to the facility Nurse B stated, "No," s/he did not know this was a requirement. Nurse B noted multiple incidents occurred over the weekends when law enforcement responded. A review of police records documented: Port Washington Police Department incident 23-016167 dated 10/05/2023 documented: "I, [Police Officer C] was dispatched to the provider, where the reporting party [Resident 1] is a resident there, called 911 stating staff is refusing to give [him/her] prescribed medication. Upon arrival I [Police Officer C] spoke with [Caregiver D], who told me that [Resident 1] was prescribed diarrhea medication; however, staff was informed by [his/her] doctor that when [Resident 1] has diarrhea, [s/he] is to be given different kinds of food instead of this medication. [Police Officer C] told [Resident 1] to contact	N 164		

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N 164	Continued From page 2	N 164		

[his/her] doctor about this matter and if [s/he] is allowed to have the diarrhea medication, to have [his/her] doctor contact staff so that they can give it to [him/her]."

Port Washington Police Department incident 23-017476 dated 11/02/2023 documented:

"Police dispatched to the provider for a disorderly conduct complaint. The reporting party [Resident 1] claims that [Caregiver D] had made a threatening statement towards [him/her]. This statement was, "I put something special in your ice cream." Upon arrival on scene, made contact with [Resident 1] in [his/her] room. [S/he] advised that [s/he] and [Caregiver D] did not get along and that they have disagreements often."

Port Washington Police Department incident 24-000635 dated 01/12/2024 documented:

"[Resident 1] called and is having difficult breathing ....[Resident 1] is unhappy in the current facility and threatened [s/he] would walk away or harm [him/her] self if [s/he] had to stay. [S/he] was transported to hospital for [his/her] medical complaints."

Port Washington Police Department incident 24-001037 dated 01/19/2024 documented:

"Summary-Verbal argument. Responded to the provider's address for the report of disorderly conduct. Reporting party [Resident 1] states that [Caregiver E] has been harassing [him/her] ....In speaking with [Caregiver E] and [Resident 1] any disorderly conduct was unfounded ....[Resident 1] may being showing signs of cognitive decline."

On 01/26/2024, Surveyor reviewed Department

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N 164	Continued From page 3 records. There were no self-reports in the Department files regarding the above incidents. On 01/26/2024 at 12:35 PM, Surveyor interviewed Nurse B. Nurse B reiterated that s/he did not know when law enforcement personnel was called to the facility, but those incidents needed to be submitted to the Department. Nurse B stated Resident 1 signed a contract in October 2023 indicating s/he would stop calling 911 for non-emergency issues, but s/he did not follow through so a 30-day notice was issued. Nurse B stated Resident 1's mental health concerns have gotten worse over the last couple of months going beyond what the provider could support. Nurse B acknowledged in the future, anytime law enforcement would be called to the facility that jeopardized the safety/welfare of residents or staff, the provider would self-report.	N 164		
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.	N 389		

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N 389	Continued From page 4 This Rule is not met as evidenced by: Based on record review and interview, the individual service plan (ISP) was not updated for 1 of 1 resident reviewed (Resident 1) when there was a change in resident needs and abilities. Resident 1's ISP was not updated when s/he had documented incidents of suicidal ideations. Findings include: On 01/26/2024, Surveyor reviewed Resident 1's record and identified the following: Resident 1 was admitted to the facility on 05/06/2022 with diagnoses including anxiety, depression, Parkinson's, and mental health concerns. Resident 1 had an activated healthcare power of attorney that makes decisions on his/her behalf that was activated during most recent hospitalization. On 01/26/2024 at 9:45 AM, Surveyor interviewed Nurse B. Nurse B stated ongoing concerns with Resident 1's mental health. Nurse B stated Resident 1 continues to call the police for non-emergency issues that could be handled by staff. Nurse B stated Resident 1 was recently hospitalized for suicidal ideations. Surveyor asked Nurse B if the provider completed an assessment or updated Resident 1's ISP upon his/her return. Nurse B stated, "No," and s/he knew that was a requirement, but s/he had been busy with other things. Resident 1's ISP dated 06/06/2022 documented: "Emotional/Behavior: History of depression. Interventions-1) meds as ordered 2) goes to counseling 3) 1:1."	N 389		

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N 389	Continued From page 5 The ISP did not include any information regarding suicidal ideations. Resident 1's 30-day notice dated 12/29/2023 documented: "We have made every attempt to provide the care that [Resident 1] is now requiring. [Resident 1] has been educated several times and as proof of educational warnings done by the provider. [Resident 1] signed a document dated 10/9/2023, understanding the education and agreeing to adhere to the warning and house rules. [Resident 1] continues to make 911 calls for issues that could be dealt with by provider staff. [Resident 1] has been warned and educated by Ozaukee County Sheriff and paramedics on the cost and waste of resources for frequent non-emergency 911 calls. [Resident 1] continues to call 911. [Resident 1] has made several of "[his/her]" own MD appts. Seeing new doctors for various complaints that [s/he] does not inform staff of. [Resident 1] has also been prescribed new medications by these doctors and does not inform staff of these changes which makes it impossible to deliver safe and effective care by our CBRF staff. [Resident 1] continues to refuse to see the requested psychologist order by [his/her] primary, [Resident 1] also refused to have the ordered comprehensive psychological evaluation done in June of 2023, this was also order by [his/her] primary care physician." Resident 1's progress noted documented: "07/08/2023: Pt [sister/brother] called stating pt said [s/he] was suicidal. [Sister/brother] attempted to get [him/her] to explain why but pt said "goodbye" and hung-up phone. Pt started walking outside. Stated [s/he needed to go for a walk. Writer attempted to get pt to talk but [Resident 1] kept walking. Approximately 45 minutes later,	N 389		

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[Port Washington Police] called stating [s/he] was found laying under a tree and wouldn't talk. Police asked background and was informed [s/he] is [his/her] own person and is allowed to go for walks and explained the above situation. They had an ambulance on the way and were thinking [s/he] would be chaptered and would call later. 4:30 PM-Police here. Stated [s/he] was probably not going to be chaptered but wanted to go to hospital to be evaluated. Sent to hospital."

Resident 1's hospital discharge records dated 01/12/2024-01/17/2024 documented:
"Admission Diagnoses:
-Suicidal ideation
-Chronic pain disorder
-Parkinson's disease
Secondary Discharge Diagnoses:
-Major depressive disorder, recurrent episode, moderate
Identifying and Background Information:
...Pt resides in group home, and had locked [him/her] self in [his/her] room, was agitated, refusing meds and with suicidal ideations.
Psychiatric History:
....Had received inpatient psychiatric treatment multiple times in the past with last one 3 years ago after [s/he] tried to stop eating and taking [his/her] medications. Had overdosed on medications in 2002 following death of [his/her] [husband/wife] and 2nd time by overdose as [s/he] was tired of living.
Assessment And Plan:
Upon assessment, it appears that patient had been struggling with depression related to loneliness and has been having suicidal ideations which are chronic in nature.
Results of Clinical Interview:
When asked why [s/he] was admitted to the hospital, [Resident 1] stated, "They put me on

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N 389	Continued From page 7 suicide watch." [S/he] denied current suicidal ideation but endorsed past attempts. On 01/26/2024 at 12:35 PM, Surveyor interviewed Nurse B. Nurse B acknowledged Resident 1's ISP should have been updated after first hospitalization for suicidal ideations in July 2023. Nurse B confirmed s/he did not complete an assessment or update Resident 1's ISP after most recent hospitalization 01/12/2024-01/17/2024. Nurse B stated with everything going on with Resident 1's behaviors and 30-day notice, Resident 1's record was not updated. Nurse B noted s/he would update Resident 1's ISP in the near future. Resident 1's record did not contain an updated ISP when s/he had changes in needs after multiple documented incidents of suicidal ideations.	N 389		