| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0013474 | A. BUILDING: _____ B. WING _____ | R-C 07/27/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MILL POND TWO | 515 MARKET ST WESTFIELD, WI 53964 |

| (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 |
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| {N 000} | Initial Comments<br><br>On 07/27/2023, Surveyor completed 2 complaint investigations and verification visit at Mill Pond Two, a CBRF in Westfield.<br><br>Three deficiencies were identified. Statement of Deficiency (SOD) JPMD11, dated 10/27/2022, was corrected.<br><br>The complaints were substantiated.<br><br>Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed.<br><br>Census: 8 | {N 000} | | |
| N 326 | 83.31(4)(a) Notice of facility initiated discharges<br><br>Discharge or transfer initiated by CBRF. Notice and discharge requirements. 1. Before a CBRF involuntarily discharges a resident, the licensee shall give the resident or legal representative a 30 day written advance notice. The notice shall explain to the resident or legal representative the need for and possible alternatives to the discharge. Termination of placement initiated by a government correctional agency does not constitute a discharge under this section. 2. The CBRF shall provide assistance in relocating the resident and shall ensure that a living arrangement suitable to meet the needs of the resident is available before discharging the resident.<br><br>This Rule is not met as evidenced by:<br>Based on interview and record review, the provider did not issue a 30-day written advanced notice prior to the involuntary discharge of Resident 9. | N 326 | | |

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

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| N 326 | Continued From page 1<br><br>Findings include:<br><br>On 07/25/2023, Surveyor conducted a complaint investigation alleging the facility declined a resident's return to the facility following an emergency room visit.<br><br>On 07/25/2023 at approximately 10:00 a.m., Surveyor reviewed Resident 9's record. Resident 9 was admitted to the provider's facility with diagnosis of traumatic brain injury. Resident 9's record documented the following progress notes:<br><br>04/14/2023 NOC: " ...Continuously complaining of pain ... 911 was contacted and EMS dispatched to residence ... Emergency room RN stated patient was ready for discharge and needed pick up ... ER RN stated that EMS wouldn't transport back due to not meeting criteria for ambulance transport ... Manager informed that the facility doesn't have capability to transfer resident once back to facility and also (has) improper equipment to transfer facility van ... Manager tried to talk to physician to let know about [Resident 9] decline in general health ... [Manager] informed physician [s/he] wouldn't be able to pick [him/her] up due to transfer ability being beyond what resident room is equipped for ... EMS had to physically lift resident and carry to stretcher ... 2 staff to boost and reposition resident."<br><br>04/17/2023: "I explained to ER RN that due to [his/her] lack of mobility, the facility had no means to transfer [him/her]. ER RN stated that the physician could write an order for a hoyer lift. Writer explained to RN that resident's room and home could not accommodate a hoyer lift ... Writer tried to explain to the ER physician that | N 326 | | |

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| MILL POND TWO | 515 MARKET ST WESTFIELD, WI 53964 |

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| N 326 | Continued From page 2 | N 326 | | |

there was not a safe way to transfer resident back to the facility due to [his/her] decrease in mobility and the fact that resident cannot transfer to a vehicle ... [S/he] is exceeding the care level of the facility."

04/18/2023: "Remains admitted at [hospital]. Referrals sent to skilled nursing facilities."

05/08/2023: "Guardian picked up belongings."

On 07/25/2023 at approximately 10:30 a.m., Surveyor interviewed Administrator A regarding the facility's denial of Resident 9 returning to the facility. Administrator A stated Resident 9 had become less mobile and more behavioral over the past several weeks to a few months and the facility was no longer able to care for him/her. Surveyor asked Administrator A if the facility issued Resident 9 a 30-day notice. Administrator A stated s/he had issued a 30-day notice in the past, but rescinded it because alternate placement would never be found. Surveyor asked Administrator A if s/he had completed a new assessment related to mobility and behavioral concerns due to the change in Resident 9's condition. Administrator A replied, "No. Just documented notes." Surveyor noted there were 2 current residents that required a hoyer lift in the facility and asked Administrator A why the facility could not assist Resident 9 with a hoyer. Administrator A stated Resident 9's room was too small; "Only 10 feet by 12 feet." Surveyor shared that 10 feet by 12 feet would be adequate space to accommodate a hoyer. Administrator A stated that Resident 9 had too many belongings in his/her room. When asked if the provider attempted to declutter Resident 9's room to make space for a hoyer, Administrator A replied, "No. Because behaviors."

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| N 326 | Continued From page 3<br><br>The facility declined Resident 9's return to the facility when s/he was sent to the hospital and medically cleared to return to the facility. Resident 9 was not issued a 30-day notice when involuntarily discharged.<br><br>Cross Reference: N0381 DHS 83.35(1)(a) Pre-Admission And Ongoing Assessments | N 326 | | |
| N 381 | 83.35(1)(a) Pre-admission and ongoing assessments.<br><br>Scope. The CBRF shall assess each resident ' s needs, abilities, and physical and mental condition before admitting the person to the CBRF, when there is a change in needs, abilities or condition, and at least annually. The assessment shall include all areas listed under par. (c). This requirement includes individuals receiving respite care in the CBRF. For emergency admissions the CBRF shall conduct the assessment within 5 days after admission.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the provider did not ensure an assessment was completed when there was a change in Resident 9's needs.<br><br>Findings include:<br><br>On 07/25/2023, Surveyor conducted a complaint investigation alleging the facility declined a resident's return to the facility following an emergency room visit. | N 381 | | |

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| MILL POND TWO | 515 MARKET ST WESTFIELD, WI 53964 |

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| N 381 | Continued From page 4<br><br>On 07/25/2023 at approximately 10:00 a.m., Surveyor reviewed Resident 9's record. Resident 9 was admitted to the provider's facility with diagnosis of traumatic brain injury. Resident 9's record documented the following progress notes:<br><br>04/14/2023 11:15 a.m.: "Resident yet in bed. Compalins of leg pain. Primary care called to get a prescription of pain medication. Resident has been sliding out of wheelchair daily. Mainly on 3:00 p.m. to 11:00 p.m. shift. Resident does not slide out of wheelchair at work. Resident will not assist to reposition [him/herself] and at this time sitting in urine soaked [pad] ... Exhibiting decrease in mobility while at home."<br><br>04/14/2023 7:00 a.m. - 3:00 p.m. : "Resident is home today. Was up complaining of pain. Staff went in before lunch to get resident up out of bed and resident was unable to provide any assistance with mobility at that time. Staff needed to get another staff member from next door to help get resident up and dressed and in [his/her[ chair."<br><br>04/14/2023 3:00 p.m. - 11:00 p.m.: "Resident was found on floor at 3:15 p.m .. Said [s/he] was in pain and couldn't get up. Staff and I tried to assist but still nothing ... Called EMS ... Patient not transferred per [his/her] request."<br><br>04/14/2023 3:50 p.m.: "Resident declined pain while EMS was present."<br><br>04/14/2023 3:00 p.m. - 11:00 p.m.: "Resident continued to say [his/her] leg hurt. [S/he] was passing out in [his/her] wheelchair multiple times today ... Used bedroom bathroom just fine. While getting up back in [his/her] chair [s/he] would | N 381 | | |

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| N 381 | Continued From page 5 | N 381 | | |

complaint about leg pain. At the end of the night resident had a very hard time getting into bed."

04/14/2023 NOC: " ...Continuously complaining of pain ... 911 was contacted and EMS dispatched to residence ... Emergency room RN stated patient was ready for discharge and needed pick up ... ER RN stated that EMS wouldn't transport back due to not meeting criteria for ambulance transport ... Manager informed that the facility doesn't have capability to transfer resident once back to facility and also improper equipment to transfer facility van ... Manager tried to talk to physician to let know about [Resident 9] decline in general health ... [Manager] informed physician [s/he] wouldn't be able to pick [him/her] up due to transfer ability being beyond what resident room is equipped for ... EMS had to physically lift resident and carry to stretcher ... 2 staff to boost and reposition resident."

04/17/2023: "I explained to ER RN that due to [his/her] lack of mobility, the facility had no means to transfer [him/her]. ER RN stated that the physician could write an order for a hoyer lift. Writer explained to RN that resident's room and home could not accommodate a hoyer lift ... Writer tried to explain that there was not a safe way to transfer resident back to the facility due to [his/her] decrease in mobility and the fact that resident cannot transfer to a vehicle ... [S/he] is exceeding the care level of the facility."

On 07/25/2023 at approximately 10:30 a.m., Surveyor interviewed Administrator A regarding the facility's denial of Resident 9 returning to the facility. Administrator A stated Resident 9 had become less mobile and more behavioral over the past several weeks to a few months and the facility was no longer able to care for him/her.

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| N 381 | Continued From page 6<br>Surveyor asked Administrator A if s/he had completed a new assessment related to mobility and behaviors due to the change in Resident 9's condition. Administrator A replied, "No. Just documented notes."<br><br>Cross Reference: N0326 DHS 83.31(4)(a)1. Notice Of Facility Initiated Discharge | N 381 | | |
| N 426 | 83.38(1)(b) Supervision.<br><br>As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident's highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Supervision. The CBRF shall provide supervision appropriate to the resident's needs.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the provider did not ensure supervision appropriate to the needs of residents was provided. The provider's staff would leave the facility unattended to provide assistance next door.<br><br>Findings include:<br><br>On 07/25/2023, Surveyor conducted a complaint investigation alleging that caregivers would leave the facility unattended to assist with cares at the affiliated facility next door. The facility is licensed to serve up to 8 residents with diagnoses | N 426 | | |

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| N 426 | Continued From page 7<br>including physically disabled, alcohol/drug dependent, emotionally disturbed/mental illness, developmentally disabled and traumatic brain injury.<br><br>On 07/25/2023 at approximately 8:45 a.m., Surveyor interviewed Administrator A regarding the facility's staffing patterns and reviewed the facility's schedule, dated 06/18/2023 to 07/29/2023. Administrator A stated there was 1 staff present and 1 staff member "floating" between the facility and the facility next door on weekdays for all 3 shifts (day, evening, night). Administrator A added that s/he and the director were also present during weekday day shifts. Administrator A stated 1 staff member was present at each facility for each shift on weekends. Surveyor reviewed the provider's schedule, which documented 1 staff member for each facility on weekends and only 1 staff member for each facility on weekday overnights at times. Surveyor asked Administrator A how staff manage cares for the hoyer lift residents in the facility next door. Administrator A stated hoyer lifts require 2 staff, so if a resident next door needed assistance when there was only 1 staff member present next door, the staff member would temporarily leave and go next door to provide assistance. Administrator A confirmed during these occurrences the facility was left with no staff.<br><br>On 07/25/2023 at approximately 12:00 p.m., Surveyor interviewed Caregiver C. Caregiver C was familiar with both facilities located side by side. Caregiver C confirmed the affiliated facility had 2 residents that required a hoyer lift, so when only 1 staff member was present in each facility, the caregiver would leave the facility unattended to provide assistance at the affiliated facility next | N 426 | | |

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| N 426 | Continued From page 8 | N 426 | | |

door. Caregiver C stated the hoyer lift transfers usually took place around 9:00 a.m. on weekends. Caregiver C stated the facility was probably left unattended 1 time every day shift on weekends, unless there was a fall or behaviors that the caregiver needed to go over to provide assistance with.

On 07/25/2023 at approximately 12:15 p.m., Surveyor reviewed concern with Administrator A that the facility was left unsupervised for staff to assist with cares next door. Administrator A acknowledged concern and stated s/he would need to somehow change the staffing patterns.

On 07/27/2023 at approximately 4:30 p.m., Surveyor reviewed documentation from Administrator A that documented the needs of the facility's residents as follows:

- Resident 1 required 24-hour care.
- Resident 2 required 24-hour care.
- Resident 3 required 24-hour care.
- Resident 4 required 24-hour care, including assistance of 1 for cares.
- Resident 5 required 24-hour care.
- Resident 6 required 24-hour care.
- Resident 7 required 24-hour care, including assistance of 1 for cares and mobility.
- Resident 8 required 24-hour care, including assistance of 1 if using his/her walker.

The provider did not provide the 24-hour supervision and care needed for 8 out of 8 residents.