STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009149	A. BUILDING: _____ B. WING _____	R 10/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN HOMESTEAD	1001 W BROWN ST WAUPUN, WI 53963

(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 10/17/2023, with information obtained through 10/18/2023, the Bureau of Assisted Living, Southern Regional Office, conducted a verification visit at Christian Homestead, a community-based residential facility (CBRF) located in Waupun, WI. As a result of the survey, 3 deficiencies were identified. One deficiency is a repeat deficiency. See Statement of Deficiency (SOD) 678Y12, dated 07/20/2021. Under statutory provisions of Wis. Stat. Chapter 50, a $200 revisit fee is being assessed. Census: 29	N 000		
N 161	83.12(3)(a) Investigate injuries of unknown source. Investigating injuries of unknown source. A CBRF shall investigate any of the following: 1. An injury that was not observed by any person. 2. The source of an injury to a resident that cannot be adequately explained by the resident. 3. An injury to a resident that appears suspicious because of the extent of the injury or the location of the injury on the resident. This Rule is not met as evidenced by: Based on record review and interview, the provider did not investigate injuries of unknown sources for 2 residents. Resident 2 was discovered to have a right buttocks wound on 09/02/2023 with no further investigation or information about the wound.	N 161		

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

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N 161	Continued From page 1 Resident 3 was discovered to have a left cheek bruise on 09/04/2023 and a skin tear on his/her right elbow on 09/16/2023 with no further investigation or documented information about either injuries. Findings include: Example 1: Resident 2 On 10/17/2023, Surveyor reviewed Resident 2's record. Resident 2 was admitted to the provider on 06/09/2016 with diagnoses including unspecified dementia. Resident 2 was documented as having an activated power of attorney for healthcare. Resident 2 was documented as receiving hospice services. Surveyor reviewed Resident 2's observation notes from 09/01/2023 - 10/17/2023 and observed the following entry on 09/02/2023 at 1:56 a.m.: "at 1am we change[sic] [Resident 2] dirty brief and found a wound on [his/her] right butt cheek and apply barrier cream." There was nothing else further documented in the observation notes about this wound. At approximately 4:00 p.m., Surveyor interviewed Administrator A and Wellness Director B. Wellness Director B confirmed s/he wasn't able to find any additional information in Resident 2's record about the discovered buttocks wound. Wellness Director B reported that s/he reached out to Resident 2's hospice team to see if any information about the wound was reported to them but it seemed like it had not been. Surveyor asked if it was possible this could be a pressure wound based on its documented location. Wellness Director B replied that s/he wasn't sure because Resident 2 also demonstrated	N 161		

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N 161	Continued From page 2	N 161		

scratching behaviors where s/he would scratch him/herself. Administrator A and Wellness Director B reported that staff should have completed a skin assessment and incident report upon discovering Resident 2's wound as well as notifying the on-call nurse.

Example 2: Resident 3

On 10/17/2023, Surveyor reviewed Resident 3's record. Resident 3 was admitted to the provider on 06/27/2023 with diagnoses including unsteadiness of feet. Resident 3 was his/her own legal decision maker. Surveyor reviewed Resident 3's observation notes from 09/01/2023 - 10/17/2023 and observed the following:

- 09/04/2023 (12:46 p.m.): "small quarter size bruise of left bottom cheek. not causing any pain."

- 09/16/2023 (time cut off in text): "Writer went into residents[sic] room to toilet at 2330 and noticed a dime sized skin tear on residents[sic] right elbow. Writer asked what happened and resident stated, 'they used that machine [sit to stand] on me and I think its[sic] from that.' Writer cleaned wound and applied [text cut off]...aid. Resident stated [s/he] barely noticed it and that it didn't hurt at this time."

At approximately 2:00 p.m., Surveyor interviewed Administrator A and Wellness Director B about the above 2 entries. Surveyor asked if there was any additional information about either Resident 3's bruise or skin tear in his/her record. Wellness Director B reported s/he was unable to find any. Surveyor asked if they thought the sit-to-stand lift related to Resident 3's skin tear as s/he reported it had. Wellness Director B replied that the tear

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N 161	Continued From page 3 couldn't have been related to the lift because no portion of the lift or sling would've contacted Resident 3 in that location (right elbow). Wellness Director B reported that Resident 3 hated to transfer using the sit-to-stand lift and so it wouldn't be surprising for him/her to blame the lift for his/her skin tear even though the injury didn't seem consistent with transferring with the lift. Surveyor asked if there was any other information or investigation completed to see where the skin tear came from. Administrator A reported s/he recalled talking to Resident 3 and that s/he blamed it on bumping his/her arm in the bathroom, but confirmed this was not documented anywhere. Wellness Director B reported that for both injury entries, staff did not appear to check a box in the electronic record system that would've triggered an incident report to be completed which would then have alerted management staff. Wellness Director B reported that because this wasn't done, no further investigation was completed.	N 161		
N 165	83.12(4)(c) Reporting incidents with serious injury A CBRF shall send a written report to the department within 3 working days after any of the following occurs: Any incident or accident resulting in serious injury requiring hospital admission or emergency room treatment of a resident. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that a written report was sent to the department within 3 working days after Resident 4 experienced a fall and had 3 staples	N 165		

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N 165	Continued From page 4 placed in his/her head on 10/06/2023. This is a repeat deficiency. See Statement of Deficiency (SOD) 678Y12, dated 07/20/2021. Findings include: On 10/17/2023, Surveyor reviewed Resident 4's record. Resident 4 was admitted to the provider on 07/03/2017 with diagnoses including Alzheimer's disease. Surveyor reviewed observation notes from 09/01/2023 - 10/17/2023 and observed the following: - 10/06/2023 (8:38 p.m.): "[text cut off]...face, writer went and got staff from [Homestead 2, under same CBRF license] to come help, vitals taken at 7:26pm...Staff from [Homestead 2] with [resident], while writer called nursing home, hospice and [power of attorney]." - 10/06/2023 (9:16 p.m.): "[Emergency room] called and updated staff. [Resident] is being sent back with a 2.5cm laceration on the left side of [his/her] forehead. They did [text cut off]...had 3 staples put in..." - 10/06/2023 (10:07 p.m.): "Resident return at this time from the Hospital[sic]." On 10/17/2023, Surveyor reviewed Department records for the facility. Surveyor did not observe a self-report for the above injury resulting in forehead staple placement. At approximately 4:00 p.m., Surveyor interviewed Administrator A and Wellness Director B. Wellness Director B reported that the above injury occurred after Resident 4 had a fall. Administrator A confirmed a self-report was not submitted for	N 165		

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N 165	Continued From page 5 the above injury. Both reported thinking that injury self-reporting was related to injuries such as fractures. After reviewing the regulation with Surveyor, both acknowledged Surveyor's concern that this should have been a reportable event and denied having further questions. On 10/18/2023, Surveyor reviewed the emergency department note for the above incident, dated 10/06/2023. The note documented that Resident 4 arrived to the emergency department after s/he had an unwitnessed fall and was found on the floor with a laceration on his/her left forehead. The laceration was documented as being approximately 2.5 cm long and 4 mm deep. Three staples were documented as being placed.	N 165		
N 387	83.35(3)(b) Service plan development: parties involved Development. The CBRF shall involve the resident and the resident ' s legal representative, as appropriate, in developing the individual service plan and the resident or the resident ' s legal representative shall sign the plan acknowledging their involvement in, understanding of and agreement with the plan. If a resident has a medical prognosis of terminal illness, a hospice program or home health care agency, as identified in s. HFS 83.38(2) shall, in cooperation with the CBRF, coordinate the development of the individual service plan and its approval under s. HFS 83.38 (2) (b). The resident ' s case manager, if any, and any health care providers, shall be invited to participate in the development of the service plan.	N 387		

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N 387	Continued From page 6	N 387		

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure that the resident or the resident's legal representative for 2 of 3 residents reviewed who were admitted in 2023 signed the individual service plan (ISP) to acknowledge their involvement in, understanding of, and agreement with it.

The comprehensive ISPs for Residents 5 and 6 did not contain signatures by either themselves or their legal representatives.

Findings include:

Example 1: Resident 5

On 10/17/2023, Surveyor reviewed Resident 5's record. Resident 5 was admitted to the provider on 08/03/2023 with diagnoses including Parkinsons's disease. Resident 5 was documented as being his/her own legal decision maker. Surveyor reviewed Resident 5's ISP, dated 08/03/2023, but did not observe a signature by Resident 5.

At approximately 3:00 p.m., Surveyor interviewed Administrator A and Wellness Director B. Wellness Director B confirmed that Resident 5 was his/her own legal decision maker. Administrator A was observed interviewing other staff on the phone to find out whether or not there was evidence that Resident 5 had signed his/her ISP. After, Administrator A confirmed that there was no evidence that Resident 5 had signed his/her own ISP. Administrator A then asked Coordinator F to obtain Resident 5's signature, and at approximately 4:00 p.m., Surveyor

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N 387	Continued From page 7 observed Resident 5's signed ISP. Example 2: Resident 6 On 10/17/2023, Surveyor reviewed Resident 6's record. Resident 6 was admitted to the provider on 09/01/2023 with diagnoses including end stage renal disease and unspecified dementia. Resident 6 was documented as having an activated power of attorney for healthcare (POA). Surveyor reviewed Resident 6's ISP, dated 09/06/2023, but did not observe a signature by Resident 6's POA. On 10/18/2023, at approximately 12:28 p.m., Administrator A confirmed via e-mail with Surveyor that there was no signature for Resident 6's ISP by his/her POA.	N 387		