STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016219	A. BUILDING: _____ B. WING _____	R-C 07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW PERSPECTIVE NORTH SHORE	8875 N 60TH ST BROWN DEER, WI 53223

(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 07/18/2024, Surveyor concluded a standard survey, verification visit and three complaint investigations at New Perspective North Shore. As a result, 3 deficient practices were identified. Two of the three were repeat deficiencies. One was cited for a third time. Three complaints were substantiated. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census: 36	{N 000}		
{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 interview, the provider did not ensure each resident's Individual Service Plan (ISP) was implemented for 1 of 1 resident. Resident 5 had a history of falls. Resident 5's electric hospital bed failed on the second shift. Caregivers neglected to notify management and Resident 5 fell out of bed and suffered a blunt force injury to head. Resident 5 was hospitalized on 06/01/2024 and passed away on 06/09/2024. This deficiency is being cited for a third time. See Statement of Deficiency (SOD) HDNL11, dated 07/20/2023 and (SOD) LEFP12, dated 03/13/2024. Findings include:	{N 388}		

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

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{N 388}	Continued From page 1 On 06/04/2024 and 06/06/2024, the Department received complaints alleging resident neglect. From 06/07/2024 to 07/03/2024, Surveyor reviewed Resident 5's record and identified the following: -Resident 5 was admitted on 01/31/2023, with diagnoses including Alzheimer's disease with late onset and unspecified chronic pulmonary obstructive disorder. Resident 5's Health Care Power of Attorney was activated on 04/10/2020. Resident 5 resided in a secure, memory care unit. Resident 5 began utilizing hospice services on 04/21/2023. -Resident 5's comprehensive assessment, dated 4/23/2024, identified, "Professional Support Services. Referral made to outside service provider(s): No ...Transfer/Mobility- History of Falls: Yes. Transfer Assist: Mechanical Lift to Transfer (assistance of 2 required). Type of mechanical lift: Full Body Lift (Hoyer Type). Bed Mobility: includes assistance while in bed: Mechanical Lift (requires assistance of 2). DME (durable medical equipment), Mobility device(s) and other assistive equipment: Broda Chair and Hospital Bed. -Resident 5's record included an ISP with no signatures of agreement indicating the date the ISP went into effect. The document read, "Mobility. 01/31/23. Devise Assist. [Resident 5] utilizes a wheelchair for mobility. Team members are to update supervisor with changes to wheelchair." 05/02/2023. Bed mobility: Mechanical Lift. Use mechanical lift for bed transfers and repositioning. HOB (head of bed) to be elevated while [Resident 5] is in bed [sic]	{N 388}		

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{N 388}	Continued From page 2 Assist with bed transfers and repositioning [sic] Discipline: Caregiver [sic] ...Safety fall prevention. 01/31/23. Falls Management. [Resident 5] is at risk for falls. In comments section, on 04/09/2024, Health and Wellness Specialist (HWS) DD documented expected outcomes, "Mobility: will remain safe with wheelchair mobility [sic] Reviewed. Mobility: will remain safe while transferring with assistance [sic] Reviewed. Mobility: [Resident 5] will accept monitoring/assistive devices [sic] Reviewed." -Resident 5's record included Resident Service Agreement with no signatures of agreement indicating the date the Service Agreement went into effect. Under bed mobility, mechanical lift, the effective date was 05/02/2023. Under notes, it read, "Use mechanical lift for bed transfers and repositioning. HOB (head of bed) to be elevated while [Resident 5] is in bed. Assist with bed transfers and repositioning [sic]" Under falls management, the effective date was 01/31/2023. Under notes, it read, "[Resident 5] is at risk for falls." Under DME, assistive equipment, the note dated 04/24/2024 read, "Assist [Resident 5] with DME [sic], assistive equipment as instructed. Notify supervisor if DME, or equipment is broken, in need of repair or not in good working order. Notify nurse for changes in [Resident 5] condition, and if [Resident 5] has new DME or equipment." Facility Fall and Investigation Report On 06/07/2024, Executive Director (ED) A provided Surveyor with document titled: 'Fall with injury and possible neglect investigation report'. At the bottom of the document, it read, "Not final document." It was signed by ED A and dated	{N 388}		

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{N 388}	Continued From page 3	{N 388}		

06/07/2024. The report named Caregiver O, Caregiver P, Caregiver Q, Caregiver R, and Caregiver S as employees subject to investigation. The document read, "Chronology of investigation. Internal investigation was started on 06/01/2024. Interviews of team members who provided care from 05/31/2024 and 06/01/2024 conducted and [sic] those who witnessed the environment after the fall and were [sic] on the shift 06/01/2024."On 06/01/2024 at approximately 11:24 a.m., RN C received telephone call from Hospice Administrator (HA) W, who reported hospice nurse (HRN) M responded to facility call for Resident 5's fall. HA W and HRN M expressed concern to RN C about the extent of Resident 5's bruising. RN C arrived at facility and resident was already at the hospital. The investigation findings read Caregiver O and Caregiver P assisted Resident 5 with bedtime cares at approximately 7:30 p.m. After Caregiver O and Caregiver P provided cares, they both reported being unable to lower Resident 5's hospital bed. Caregiver O and Caregiver P checked Resident 5 at approximately 10:20 p.m. and were still unable to lower Resident 5's hospital bed. The investigation report read, "Neither Caregiver O and Caregiver P reported the malfunction in the bed and allowed [Resident 5] to sleep in the bed. Per care plan [sic] if any DME is not working [sic] it is to be reported. These actions of not reporting the DME not working [sic] contributed to a serious accident injury for [Resident 5]." The investigation report documented Caregiver R started his/her shift at 10:30 p.m. and was responsible for the care of Resident 5. Caregiver R stated that s/he first checked on Resident 5 around 11:30 a.m. [sic] and Resident 5 was sleeping in his/her bed. Caregiver R stated s/he checked on Resident 5 again at approximately 5:00 a.m. and noted Resident 5 was near the edge of the bed.

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{N 388}	Continued From page 4 Caregiver R stated s/he did not think Resident 5 would fall. Caregiver R did not provide the scheduled care of checking and changing Resident 5. Caregiver R also did not reposition Resident 5 in bed when s/he stated Resident 5 was near the edge of the bed. The action of not providing care, according to the care plan and not repositioning Resident 5, contributed to a serious accident injury to Resident 5. On 06/01/2024 first shift, Caregiver S and Caregiver Q entered Resident 5's room at approximately 8:45 a.m. and found Resident 5 on the ground. The caregivers proceeded to find other team members to assist them. The call was placed to the nurse at approximately 9:20 a.m. Both Caregiver S and Caregiver Q failed to report to New Perspective triage nurse in a timely manner. Incident Report On 06/01/2024 at 9:49 p.m., RN C documented 'initial record of incident'. At 8:45 a.m., RN C wrote Resident 5 was found on the floor in his/her bedroom. Per care staff report and triage note, Resident 5 was found in his/her room, on the floor, in supine position between bed and mechanical lift. Emesis was found on floor near Resident 5's face and blood on Resident 5's face and on mechanical lift. Abrasion and fresh bruising noted to Resident 5's face. Care staff contacted Triage Nurse (TRN) Z and EMS for assistance. Hospice provider was notified, and on-call hospice nurse visit was made. Advanced Practice Nurse Practitioner (APNP) CC and activated health care power of attorney POAHC V were notified of Resident 5's fall. Progress Notes On 06/01/2024 at 11:14 a.m., TRN Z documented	{N 388}		

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{N 388}	Continued From page 5	{N 388}		

for 9:20 a.m. S/He wrote that Resident 5 had an unwitnessed fall in his/her room. Caregivers found Resident 5 lying face down, 'mostly unresponsive.' Medication Passer (MedPass) X stated Resident 5 also appeared to have vomited. Due to Resident 5's position of his/her body and his/her neck, caregivers were not comfortable rolling him/her onto his/her back. TRN Z gave caregivers instructions to call 911 for lift assist without transport. TRN Z wrote, "EMS to assist [Resident 5] into bed comfortably and Hospice will send a nurse to community to assess [Resident 5]. "

On 06/01/2024 at 9:09 p.m., RN C documented, "At 8:45am [sic] [Resident 5] was found in his/her room, on the floor laying supine next [sic] between his/her bed and the mechanical lift. There was emesis on the floor close to the resident's face [sic] as well as blood on resident's face and the base of the mechanical lift. All extremities were in normal alignment. An abrasion and fresh bruise was [sic] noted on the resident's face. Care staff contacted the triage nurse and called EMS for assistance. Upon arrival EMT's examined [Resident 5]."

Caregiver Written Statements

On 05/31/2024, at around 7:30 p.m., Caregiver P documented, s/he provided bedtime cares for Resident 5. Caregiver P wrote, "My coworker tried lowering the bed after we changed [Resident 5] and got [Resident 5] in bed. We were unable to get the bed lowered. So [sic] we made sure there were no other objects was [sic] around the bed and [Resident 5] was placed in the middle of the bed." Caregiver P documented returning to Resident 5's room at 10:20 p.m., when they changed him/her. Caregiver P's coworker tried

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{N 388}	Continued From page 6	{N 388}		

lowering the bed again. The remote still didn't work for him/her to lower the bed. Resident 5 was in the middle of the bed before caregivers left.

On 05/31/2024, at around 7:30 p.m., Caregiver O documented putting Resident 5 to be around 7:30 p.m. Resident 5 was checked again at 9:00 p.m. and checked and changed 10:20 p.m. Caregiver O wrote, "[Resident 5] had needed to be changed as we got done changing him/her [sic] we tried putting the bed down again [sic] in this time we unplugged in plug [sic] it back in it still wouldn't go down [sic] so before leaving [sic] we made sure s/he was safe because of how light his/her bed was, making sure s/he was in the middle of the bed."

On the bottom of Caregiver O's written statement, there were two questions hand-written in, dated 06/03/2024 and initialed by ED A. The first question read, "How high was the bed? Top of my waist. I'm 5 foot 2." The second question read, "When you noticed that [Resident 5's] bed wouldn't lower [sic] did you report to anyone? No, did not call triage or report."

On 06/02/2024, OM T and RN C conducted a verbal interview with Caregiver R. Caregiver R stated that s/he first checked on Resident 5 around 11:30 p.m. and Resident 5 was sleeping in his/her bed. Caregiver R stated s/he checked on Resident 5 again at approximately 5:00 a.m. and noted Resident 5 was near the edge of the bed but did not appear to be falling off. Caregiver R did not provide the scheduled care of checking and changing or repositioning Resident 5 in bed when s/he stated Resident 5 was near the edge of the bed.

Emergency Medical Service (EMS)

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{N 388}	Continued From page 7 documentation On 06/01/2024 EMS incident report documented the ambulance arrived at the facility at 9:49 a.m. EMS U documented Resident 5 was found lying face down on the floor. Resident 5 fell out of bed at some point in the night. Staff reported it was unknown on what time s/he fell. Resident 5 was found with legs under the bed and torso out into the room in a prone position. Resident 5's face was bruised and swollen. Resident 5 had skin tears on both arms and legs, that were beginning to scab over. Resident 5's undergarments appeared to be full of urine and feces and the bed was soaked in urine. Resident 5 was lying in vomit that appeared to be crusted and hard. Staff stated they had checked in and found Resident 5 on the floor at 7:15 a.m. and had to follow protocols from hospice before calling EMS approximately 2 hours later. Staff stated Resident 5 was on hospice, so the patient was not supposed to go to the hospital. The nurse instructed staff to call for a lift assist only. Staff denied EMS doing vitals and only requested a lift off the floor. Staff stated a hospice nurse was on the way and s/he would evaluate and treat Resident 5. Resident 5 was assisted off the floor using a Hoyer lift from the facility and with assistance from staff. Hospice On 06/01/2024, HRN M was called for a PRN (as needed) visit following an unwitnessed fall with injuries. HRN M arrived at facility and was met by emergency medical services (EMS) in parking lot. They provided a report, stating they received a call at approximately 9:30 a.m. The staff reported to EMS that Resident 5 was found by facility staff at approximately 7:30 a.m.	{N 388}		

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{N 388}	Continued From page 8 HRN M arrived in Resident 5's room to find three, unnamed facility staff in room with Resident 5 lying in bed. HRN M interviewed the three staff, who stated their shift started at 6:30 a.m. They found Resident 5 on the floor, face down at approximately 8:00 a.m. The facility staff members reported that Resident 5's head was facing the Hoyer lift, which was on the side of the bed and wall, and Resident 5's feet were under the bed. Another staff member reported that Resident 5 was lying on the floor, face down with head towards the bed and feet towards the foot of the bed. Resident 5's face was lying in vomit. The facility staff reported Resident 5's bed was in an elevated position versus a lower position. On 06/01/2024 at 4:59 p.m., Hospice Assistant Director (HA) N documented, "Received call from [Emergency Room physician (ER MD) AA]. [ER MD AA] updated writer that CT and X-rays are negative at this point. [Resident 5] is still minimally responsive with "weird breathing" .... After discussion with [POAHC V], [ER MD AA] is understanding that s/he does not want [Resident 5] to go back to the facility." Milwaukee County Medical Examiner's Report On 06/12/2024, 11:57 a.m., Surveyor received the Milwaukee County Medical Examiner's preliminary report for Resident 5. The report described Resident 5 being found by a caregiver at 7:00 a.m. Resident 5 suffered blunt force injuries including a contusion of head, face and neck with underlying hematoma of the scalp and anterior soft tissue of the neck, abrasions of the left side of the face, superficial contusions of the right upper arm, abrasion of the upper left arm, abrasions and contusion of the lower legs.	{N 388}		

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{N 388}	Continued From page 9 On 06/20/2024 at 12:03 p.m., ED A provided Surveyor with document titled: 'Fall with injury and possible neglect investigation report' via email. Surveyor identified actions taken by facility as: separated employment from Caregiver O, Caregiver P, Caregiver Q, Caregiver R, and Caregiver S. Re-educated current care staff on expectations of reporting when durable medical equipment is not working properly. Re-educated staff on fall policy and procedure. Facility audited all current hospital beds and ensured they were working correctly and that their manual lowering was working. INTERVIEWS On 06/07/2024 at 9:48 a.m., Surveyor interviewed Executive Director (ED) A, who stated Resident 5 had a hospital bed that raised and lowered. The night before the fall, the staff had raised the bed to provide cares. After cares had finished, the staff could not lower the bed. According to staff reports, they could not manually lower the bed. ED A stated caregivers neglected to report malfunction to the on-call nurse. ED A stated, "[Resident 5's] service agreement read if any durable medical equipment is not working, caregivers are to report to nurse triage immediately." ED A stated Resident 5 had a history of falls, however, had not had a fall since end of April 2023, before s/he went on hospice. On 06/07/2024 at 1:50 p.m., Surveyor interviewed ED A, who stated caregivers followed the resident service agreement to know what cares to provide. ED A stated, "The caregivers knew the bed should have been lowered. It's right here in the service plan."	{N 388}		

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{N 388}	Continued From page 10 On 06/10/2024 at 11:19 a.m., Surveyor received voicemail from Resident 5's POAHC V. S/He informed Surveyor Resident 5 passed away on 06/09/2024. On 06/11/2024 at 8:30 a.m., Surveyor interviewed EMS U, who stated s/he arrived at facility and in Resident 5's room at approximately 9:35 a.m. EMS U stated, "We were there long before [HRN M]." EMS U described Resident 5 lying face down when s/he arrived. Resident 5 had dried vomit on his/her face and on the floor. Blood was forming scabs on Resident 5's face and knees. Staff confirmed they did not know when Resident 5 fell out of bed but told EMS U that it happened sometime on third shift. EMS U noted Resident 5's bed was 2-3 feet off the ground when they arrived. On 07/18/2024 at 10:46 a.m., Surveyor interviewed the physician from the Milwaukee County Medical Examiner (MD) FF, who stated Resident 5's autopsy/investigation was still pending. Cross Reference N0389 DHS 83.35(3)(d) Service Plans Updated Annually Or On Changes	{N 388}		
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	N 389		

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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 observation, record review, and interview, the provider did not update 1 of 1 resident Individual Service Plans (ISPs) annually or when there was a change in a resident's needs abilities or physical or mental condition. Resident 5's ISP was not updated when there was a change of condition. Resident 5's ISP did not include the hospice plan of care.

This deficiency is being cited for a third time. See Statement of Deficiency HDNL11, dated 07/20/2023 and LEFP12, dated 03/13/2024.

Findings include:

From 06/07/2024 to 07/03/2024, Surveyor reviewed Resident 5's record and identified the following:

-Resident 5 was admitted on 01/31/2023, with diagnoses including Alzheimer's disease with late onset and unspecified chronic pulmonary obstructive disorder. Resident 5's Health Care Power of Attorney was activated on 04/10/2020. Resident 5 resided in a locked, memory care unit. Resident 5 began utilizing hospice services on 04/21/2023.

-Resident 5's comprehensive assessment, dated 4/23/2024, identified, "Professional Support Services. Referral made to outside service

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provider(s): No."

-Resident 5's record included an ISP signed by health care power of attorney (POAHC) V dated 05/15/2023. Under third party care, expected outcomes/goals read, "Will have collaboration of care to meet needs through next review. Referral to third party providers as needed."

-Resident 5's record included an ISPs with a revision on 04/20/2023, the day before hospice was implemented. Under third party care, it read, Holistic Hospice Services. Under expected outcomes/goals, it read, "Will be reassessed and condition will be monitored as warranted and in accordance with state laws."

On 04/09/2024, in Resident 5's ISP comments section, Health and Wellness Specialist (HWS) DD documented expected outcomes, "Will be reassessed and condition will be monitored as warranted and in accordance with state laws [sic] Reviewed." Resident 5's updated ISP did not include any signatures of agreement indicating the date the ISP went into effect.

-Resident 5's record included a hospice interdisciplinary care plan with Brighton Hospice, dated 04/23/2024 at 8:45 a.m. The document reviewed Resident 5's current hospice care plan within the facility for the period of 04/16/2024-06/14/2024. Under the current care plan, problem 5 listed Resident 5 was a risk for falls/injury. Resident 5's goals listed having less than two falls per month for the next two months, having facility staff report falls to hospice and ensuring Resident 5 had a safe environment when hospice staff was not present. Specific fall interventions listed Resident 5's bed was to be in lowest position when not receiving cares and for

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	0016219	A. BUILDING: _____ B. WING _____	R-C 07/18/2024

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facility staff to be utilizing Hoyer lift for all transfers.

Progress Notes

On 04/12/2023 at 9:46 a.m., Resident 5's progress notes documented Holistic Hospice was given Resident 5's most recent weight and said they would discuss Resident 5's hospice qualifications with their team.

On 04/21/2023 at 2:24 p.m., Resident 5's progress notes documented Resident 5 was approved and enrolled into Holistic Hospice services on the night of 04/20/2023.

On 06/21/2023 at 8:44 p.m., Resident 5's progress notes documented Resident 5's health care power of attorney (POAHC) V switched Hospice organizations and is now with Brighton Hospice.

On 06/07/2024 at approximately 11:18 a.m., Surveyor interviewed ED A, who stated, "[Registered Nurse C] oversees updating ISP's and obtaining signatures from guardians. S/he may have the updated ISP."

On 06/07/2024 at 1:50 p.m., Surveyor interviewed ED A, who stated caregivers follow the resident service agreement to know what cares to provide. ED A stated, "The caregivers knew the bed should have been lowered. It's in the service plan."

On 06/07/2024 at 1:55 p.m., Surveyor asked RN C if Resident 5's current hospice care plan information, dated 04/16/2024-06/14/2024, was added to Resident 5's ISP. RN C looked through Resident 5's ISP and told Surveyor, "I thought I

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N 389	Continued From page 14 did. Maybe I missed it." Cross Reference N0388 DHS 83.35(3)(c) Implement, Follow the Individual Service Plan	N 389		
{N 426}	83.38(1)(b) Supervision. 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. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure residents received supervision appropriate to the needs for 1 of 1 resident. Resident 4 eloped from the building while being left unattended. On 05/03/2024, Caregiver G escorted Resident 4 to the main lobby. S/He went to the bathroom and left Resident 4 unattended. When s/he came out of the bathroom, Resident 4 was gone. Findings include: The facility is licensed to serve irreversible dementia/Alzheimer's, advanced aged, terminally ill, and physically disabled residents. On 05/10/2024, the Department received a	{N 426}		

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complaint alleging a resident had eloped from the facility and staff was unaware s/he was missing for approximately 1 hour.

On 05/30/2024, at 1:15 p.m., Surveyor reviewed Resident 4's record and identified the following:

-Resident 4 was admitted on 03/27/2024, with diagnoses including Alzheimer's disease and end stage renal disease. Resident 4 resided in a secured, memory care unit.

- Resident 4's Comprehensive Assessment, dated 03/24/2024, under Cognitive Pattern/Behavioral Expression, read, "All behavioral expressions selected, and interventions needed to manage expressions must be added to the resident's service plan's care plan." Under expressions, RN C wrote, "Forgetful and Anxious.". Under cueing needs, "Memory care. Does not respond to cues, needs interventions 7-9 times per 24 hours." Under vulnerable adult risk, "The following indicators of risk and vulnerabilities were identified ... memory loss vision and/or hearing difficulties and needs assistance, elopement risk (MC), unable to ambulate safely with without device and history of falls."

- Resident 4's ISP, dated 03/27/2024, did not identify Resident 4 had memory loss, behaviors or was an elopement risk.

- Resident 4's service agreement, dated 03/27/2024, read, "Evacuation Status ...Cognition: supervision needed to remain in or evaluate to designated location ...[Resident 4] is a third shift get up due to his/her dialysis schedule. Staff to assist [Resident 4] to shower and encourage participation in ADL's as much as able

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{N 426}	Continued From page 16 in order to promote feelings of independence ... Caregiver must remain with resident entire time." - On 05/03/2024 incident report stated, " ... [Resident 4] could not be located within building and (staff) was unsure if [Resident 4] made it onto transport van for transport to veterans administration building (VA) for his/her appointment." -On 05/03/2024, Resident 4's progress note, written by Nurse (RN) C stated, "Late entry for 05/03/2024. On 05/.3/.2024 [sic], CG 1 (Caregiver G) escorted [Resident 4] to the Community's front lobby between 3:30 and 3:50 am to await [Resident 4's] van ride to his/her dialysis appointment. CG 1 reported that they left [Resident 4] sitting in the lobby while they ran to the restroom. Upon caregivers return, the staff member believed [Resident 4] had gotten on the van for his/her appointment. When caregiver learned from fellow staff that resident had not been assisted to get on the van by fellow staff, caregiver reported resident missing to a community leader. The leader contacted dialysis who advised that the resident arrived safely to his/her appointment." On 05/29/2024 at 11:15 a.m., Surveyor interviewed Transit Driver (TD) J who explained s/he drove Resident 4 to dialysis on Monday's, Wednesday's, and Friday's at 4:00 a.m. S/He had been driving Resident 4 to dialysis long before s/he moved into the facility. On 05/03/2024, TD J pulled up to the facility front doors around 3:55 a.m. Resident 4 typically got in the van from the north side of the vehicle, while exiting the south side of the facility. TD J explained s/he parked directly in front of the doors and watched for movement in the lobby. TD J stated it was a	{N 426}		

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locked entrance, and s/he could not get into the facility. It was raining hard, and it was still dark outside. From 4:00 a.m. to 4:09 a.m., TD J filled out paperwork while waiting for Resident 4. At 4:09 a.m., Resident 4 came out of the dark via the south-side of the parking lot. TD J stated Resident 4 was, "Absolutely soaked to the bone (it was raining) and confused. S/He was shivering cold from being in the rain. There was water running off him/her, while s/he was sitting in his wheelchair (without foot pedals). TD J reported, during the ride to the VA, Resident 4 stated, "I rolled myself outside to look for you. I couldn't find you and then I could not get back into the building. So, I went to Walgreens (one building south of his/her facility through a large parking lot) and their doors were locked too."

On 05/29/2024 at 2:55 p.m., Surveyor interviewed Veterans Administration Officer (VA) K, who reported on 05/03/2024 at approximately 4:20 a.m., Resident 4 was "totally drenched" when s/he arrived at the VA. VA K stated even Resident 4's seat cushion was completely saturated. "[Resident 4] was shivering and cold when s/he got here; s/he was not even wearing a jacket. It was chilly that morning, especially with the rain." VA K explained, "At 4:45 a.m., Dialysis Nurse (DRN) L received a telephone call from a supervisor from [Resident 4]'s facility, asking if [Resident 4] was at the VA yet. At that point, Resident 4 was still entering the building. At 4:51 a.m., DRN L received an additional call from facility asking if the driver brought [Resident 4] to the dialysis unit. When DRN L asked why the facility was questioning where the resident was, the staff at facility hung up."

On 05/30/2024, at 9:50 a.m., Surveyor interviewed Caregiver H who stated Resident 4

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{N 426}	Continued From page 18 was woken up and dressed by third shift staff because s/he went to dialysis at 4:00 a.m. on Monday, Wednesday and Friday. Surveyor asked Caregiver H if dialysis information was in Resident 4's ISP. Caregiver H stated, "Not that I know of." On 05/30/2024, at 9:50 a.m., Surveyor interviewed Executive Director (ED) A who stated [Resident 4] goes out to dialysis anytime between 4:00 a.m. and 4:30 a.m. on Monday's, Wednesday's and Fridays. ED A explained RN C received a telephone call from Caregiver G, asking if RN C knew if Resident 1 made it to his/her dialysis appointment. Caregiver G told RN C s/he escorted Resident 4 to the main lobby. S/He went to the bathroom. When s/he came out of the bathroom, Resident 4 was gone. Caregiver H believed Resident 4 had gotten onto the transport van. Later during shift, Caregiver H thanked co-worker for assisting Resident 4 onto transit van. When co-work told CG H that s/he did not assist Resident 4 onto the transit van, Caregiver H called RN C. ED A stated s/he interviewed CG H, who attested to leaving Resident 4 alone in lobby. ED A stated s/he believed Resident 4 may have gone over to Walgreens but that could not be confirmed. Surveyor questioned ED A on how Resident 4 was moving around. ED A stated, "I thought s/he was using his/her walker. I did not think to ask that question." ED A confirmed it was dark and raining at the time resident 4 left the building. On 05/30/2024, at 9:15 a.m., Surveyor parked at Walgreens located at 6020 W. Brown Deer Road, which was south of facility and completed an electronic address look-up to 8875 N 60th Street Brown Deer observing a 700 feet distance between the two buildings.	{N 426}		

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{N 426}	Continued From page 19 On 05/30/2024 1:15 p.m., Surveyor interviewed ED A and RN C, who stated the resident service agreement (individualized service plan) had more in-depth information of resident needs. The service plan came from the resident service agreement. The service plan was what the caregivers referenced to provide cares to residents. On 05/30/2024 2:00 p.m., Surveyor interviewed Resident 4, who told Surveyor s/he went out to dialysis at the VA. Resident 4 stated s/he went out in the rain, s/he said she could not get back in. Resident 4 recalled that it was very dark and rainy. "I was outside for a long time. I was very cold and wet. Thank God for [TD J]." On 07/10/2024, at approximately 4:10 p.m., Surveyor interviewed ED A. ED A confirmed Resident 4 eloped, and staff were not aware s/he was missing. ED A reported retraining was conducted immediately after the elopement.	{N 426}		