STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0010987	A. BUILDING: _____ B. WING _____	R-C 02/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMFORTS OF HOME HUDSON	1111 HEGGEN HUDSON, WI 54016

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{N 000}	Initial Comments On 02/07/2024, Surveyors conducted a verification visit and complaint investigation at Comforts of Home Hudson. Data was collected through 02/28/2024. Two of 4 complaints were substantiated. Three violations were identified. Two of 3 violations were repeat deficiencies. See Statement of Deficiencies (SOD) LHNW11, dated 03/31/2021; SOD LHNW13, dated 02/08/2022; and SOD LHNW14, 08/11/2022. Under statutory provisions of Wis. Stat. ch. 50, a $200 revisit fee is being assessed. Census: 34	{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 source. Resident 1 was noted to have various injuries between 10/28/2023 and 11/09/2023 that could not be adequately explained by a witnessed event or Resident 1, and the provider did not investigate the source of the injury.	N 161		

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

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N 161	Continued From page 1 This is a repeat violation. See Statement of Deficiencies (SOD) LHNW11, 03/31/2021; SOD LHNW13, 02/08/2022; and SOD LHNW14, 08/11/2022. Findings include: On 02/07/2024, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the facility on 10/03/2023 and discharged on 11/04/2023. Resident 1 was described as a "busy body" by his/her medical provider due to his/her restlessness, wandering, and tendency to rearrange furniture and household items. Resident 1's admitting diagnoses included Lewy body dementia, and s/he was noted to have an unsteady gait and frequent falls. Resident 1's monthly nurse assessment, dated 10/30/2023, indicated Resident 1 had "Bruising to multiple different areas in different healing stages." Resident 1's progress notes indicated the following: 10/28/2023: "Resident has a small bruise on [his/her] left arm. Resident not able to tell staff how it got there. [S/he] does not appear to be in any pain." 10/30/2023: "Resident received shower, last 3 toes on left foot bruised, rib cage on right side of back is bruised and looks to have rug burn, left shoulder blade has another rug burn spot and light bruising, resident also said ouch when lifting [his/her] left arm to put on shirt." Administrator A replied to the progress note on 10/31/2023, "Residents injuries are resulted [sic] from behaviors."	N 161		

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N 161	Continued From page 2 10/31/2023: "Staff noticed resident's right wrist is bruised and swollen from previous behavior activities." Resident 1's record contained 2 incident reports - a fall report dated 10/12/2023 and a fall report dated 11/02/2023. Neither incident provided an explanation for the injuries noted above in the progress reports. According to progress notes, Resident 1 was hospitalized on 11/04/2023. Administrator A wrote a progress note on 11/04/2023 that Resident 1 was found to have a fracture near his/her skull, brain bleed, rib fracture, and pelvis fracture. On 02/21/2024, Surveyor requested all injuries of unknown origin investigations from Administrator A, for dates 10/01/2023 through 11/09/2023. Administrator A responded via email at 3:29 PM, "There are no Injury of Unknowns for the requested dates."	N 161		
N 408	83.37(1)(i) PRN psychotropic medication. As needed (PRN) psychotropic medication. When a psychotropic medication is prescribed on an as needed basis for a resident, the CBRF shall do all of the following: 1. The resident ' s individual service plan shall include the rationale for use and a detailed description of the behaviors which indicate the need for administration of PRN psychotropic medication. 2. The administrator or qualified designee shall monitor at least monthly for the inappropriate use of PRN psychotropic medication, including but not limited to, use contrary to the individual service plan, presence of significant adverse side effects, use for discipline or staff convenience, or contrary	N 408		

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N 408	Continued From page 3	N 408		

to the intended use. 3. Documentation in the resident ' s record shall include the rationale for use, description of behaviors requiring the PRN psychotropic medication, the effectiveness of the medication, the presence of any side effects, and monitoring for inappropriate use for each PRN psychotropic medication given.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure Resident 2's individual service plan (ISP) included a rationale for use and detailed description of the behaviors that indicated the need for administration of his/her as-needed (PRN) psychotropic medication.

Findings include:

On 02/07/2024, Surveyor reviewed Resident 2's record. Resident 2 was admitted to the facility on 08/09/2023 and discharged to the hospital on 12/15/2023 due to injuries s/he sustained during an altercation. On 12/08/2023, Resident 2 was moved to the memory care unit due to his/her disruptive and aggressive behaviors. Progress notes indicated Resident 2's behavior in the memory care unit included verbal aggression toward staff and residents, throwing water/pushing/hitting/scratching residents, and attempting to hit people with his/her cane. A note, dated 12/12/2023, indicated Administrator A and Resident 2's power of attorney discussed Resident 2's behavior and a possible medication adjustment. The note did not provide details about the medication changes but Resident 2's medication administration record (MAR) showed quetiapine 25 mg, take 1/2 tab by mouth 2 times daily PRN for agitation, was added on 12/13/2023. The medication was administered 1

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N 408	Continued From page 4 time on 12/14/2023 and charted as effective. Surveyor reviewed Resident 2's ISP, updated 12/20/2023. The ISP included a list of Resident 2's behaviors and described Resident 2 as being "quick to change moods." Interventions for Resident 2's behaviors included redirection and monitoring. On 02/21/2024 at 1:00 PM, Surveyor interviewed Administrator A. Administrator A stated when a resident had an order for a PRN psychotropic medication, it was policy that staff attempted and documented 3 non-psychotropic interventions prior to administering the PRN. Administrator A reviewed Resident 2's record and confirmed staff did not document the 3 non-psychotropic interventions prior to administering Resident 2's PRN on 12/14/2023. Administrator A stated the provider's ISP format included a section for psychotropic medications. Administrator A reviewed Resident 2's ISP and confirmed Resident 2's ISP did not include the section for psychotropic medication and it did not include reference Resident 2's PRN. Administrator A stated Resident 2's PRN was prescribed for agitation (as stated in the MAR and on the written order).	N 408		
N 431	83.38(1)(g) Health monitoring. 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: Health monitoring. 1. The CBRF shall monitor the health	N 431		

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N 431	Continued From page 5 of residents and make arrangements for physical health, oral health or mental health services unless otherwise arranged for by the resident. Each resident shall have an annual physical health examination completed by a physician or an advanced practice nurse as defined in s. N 8.02(1), unless seen by a physician or an advanced practice nurse as defined in s. N 8.02(1) more frequently. 2. When indicated, a CBRF shall observe residents ' food and fluid intake and acceptance of diet. The CBRF shall report significant deviations from normal food and fluid intake patterns to the resident ' s physician or dietician. 3. The CBRF shall document communication with the resident ' s physician and other health care providers, and shall record any changes in the resident ' s health or mental health status in the resident ' s record. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure health monitoring services were provided to Resident 1. Resident 1 fell on 11/02/2023, his/her condition was not monitored per the provider's protocol and medical intervention was not sought until 11/04/2023. The provider did not maintain record of all communication with Resident 1's physician. This is a repeat deficiency. See Statement of Deficiencies (SOD) LHNW13, dated 02/08/2022 and SOD LHNW14, dated 08/11/2022.	N 431		

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N 431	Continued From page 6 Findings include: In November 2023, the Department received 2 complaints related to resident care and treatment. On 02/07/2024 at approximately 10:00 AM, Surveyor requested Resident 1's record from Administrator A. Administrator A stated part of Resident 1's record was confiscated by the police department. Between 02/07/2024 and 02/28/2024, Surveyor obtained and reviewed records for Resident 1 from the provider, the police department, and a local hospital system. Resident 1 was admitted to the facility on 10/03/2023 and discharged on 11/04/2023. Resident 1 was described as a "busy body" by his/her medical provider due to his/her restlessness, wandering, and tendency to rearrange furniture and household items. Resident 1's admitting diagnoses included Lewy body dementia, and s/he was noted to have an unsteady gait and frequent falls. Resident 1's record included a fall report, dated 11/02/2023. The report indicated the fall occurred at 2:40 PM, and it read: "Incident Description: ... Resident had a witnessed fall in main common area by TV. Resident has a small cut below [his/her] R [right] eyebrow. Resident was observed without walker and was unsteady this morning... Immediate action taken: ... Staff completed vitals and cleaned residents [sic] cut. Resident was assisted up. Staff updated management and POA (power of attorney). All vitals were within normal range and resident had no complaints of pain. Injuries Report Post Incident... Level of Consciousness: Comatose	N 431		

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(un-arousable to verbal or physical stimuli) ... Mobility: Bedridden... Resident sustained injures post fall. Resident has fractures in L8, 9, 10 vertebrae, fracture of R hip and wrist. Resident also has several acute brain bleeds."

A progress note written by staff suggested Resident 1's fall did not occur at 2:40 PM. On 11/02/2023 at 11:45 AM, staff wrote, "Late Entry ...Resident had a fall in main area, 1st set of vitals good, small cut under [his/her] right eyebrow, wound was cleaned. Management notified, [POA D] notified."

Based on review of numerous incidents during the current survey, the provider had a policy to monitor and document resident vitals for 3 hours post fall. Resident 1's record did not include evidence staff monitored Resident 1's vitals or condition after the fall. Resident 1's record did not include the 1st set of vitals obtained (referenced in the above progress note) or subsequent vitals obtained post fall.

At 1:00 PM on 11/02/2023, staff documented that Resident 1 needed to be fed his/her lunch. According to Resident 1's temporary service plan, Resident 1 did not require eating assistance at baseline. Other changes noted post fall included: 11/02/2023, "Resident right thumb, wrist and down forearm looks bruised and swollen. Resident did have a fall this morning."

11/03/2023, "Resident was sleeping in bed for majority of the PM shift. Did wake up to take medications."

11/04/2023, "Resident refused breakfast this morning when asked at around 8:15am. Staff then went to go get resident up at around 9:30am

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and while staff were trying to sit up resident, [s/he] started screaming of pain in [his/her] leg and stated 'my leg hurts' [sic] staff then left resident in bed and called management... Management then advised staff to call home health nurse to come assess resident. Home health nurse requested for [him/her] to be sent in after staff tried to administer PRN (as needed) acetaminophen and resident would not open mouth to take it. Staff then called POA and asked permission to send resident in."

Resident 1's record did not include evidence that the provider notified Resident 1's physician about the fall, change in condition, or injuries, until 11/04/2023.

Resident 1 was hospitalized from 11/04/2023 through 11/09/2023. Diagnoses included: subarachnoid hemorrhage, closed fracture of multiple ribs of right side, hemothorax on right, contusion and hematoma of pleura without open wound of thoracic cavity, closed fracture of neck of left femur, severe Lewy body dementia with psychotic disturbance. Emergency room notes read, "Pts [patient's] foley catheter removed and replaced. Existing catheter bag strap incorrectly attached to pt's leg causing bag to back up. Cloudy foul-smelling urine noted in old bag ... Called and spoke with staff at [facility]. Spoke with [Caregiver G] who was [Resident 1's] caregiver this morning prior to pt's transport to the ED (emergency department). [S/he] states that an incident report was filed after the pt fell on Thursday. Per [Caregiver G] pt had a witnessed fall and was not evaluated after that fall. [S/he] stated today a home health RN was with the pt and [s/he] requested that pt be evaluated in the ED as [s/he] winced in pain with ROM (range of motion) to LLE (left lower extremity)." A Care

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Management Initial Assessment read, "[POA D] reports [s/he] visited pt. frequently and that [s/he] was never concerned about the care [s/he] was receiving. [POA D] reports that [Resident 1] was impulsive and that [s/he] would fall a lot, but [s/he] is concerned that no medical attention was sought sooner. [Resident 1's child] is also present and reports [s/he] would also like more answers on how this occurred."

On 02/20/2024 at 3:00 PM, Surveyor interviewed Caregiver E. Caregiver E stated, "The main thing I remember is [s/he] had a catheter - the catheter bag on [his/her] leg." Caregiver E said s/he was concerned that Resident 1 was admitted to the facility with a catheter because the provider did not have skilled staff to monitor it. Caregiver E said the catheter bag had to be strapped to Resident 1's leg and it caused his/her leg to become red and puffy.

On 02/21/2024 at approximately 3:00 PM, Surveyor interviewed Resident 1's home health nurse, Registered Nurse (RN) F. His/Her home health agency became involved with Resident 1's care on 10/10/2023. RN F stated s/he encouraged facilities to contact home health whenever there were changes, incidents, or concerns.

RN F stated the provider called him/her on 11/04/2023 because they believed Resident 1 had an issue with his/her catheter. RN F said staff informed him/her that Resident 1 appeared to be in pain when they tried to reposition Resident 1 on the morning of 11/04/2023. The pain appeared to be coming from his/her left leg (the leg with the catheter bag strapped to it), so staff assumed there was an issue with his/her catheter.

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N 431	Continued From page 10 RN F stated s/he got to the facility between 10 and 10:30 AM on 11/04/2023 and found Resident 1 alone in his/her room with the door shut. Resident 1's lower body was hanging off his/her bed. RN F stated, "I couldn't get a response from [him/her] ... I did a head to toe to try and figure out where the pain was ... I got a little pain response when I moved [his/her] left leg ... [s/he] looked very dazed." RN F explained that Resident 1's blood pressure was "very elevated," and s/he was concerned Resident 1 was having a stroke. RN F said s/he told staff that Resident 1 needed to go to the ER (emergency room). Resident 1 was found to have multiple brain bleeds, rib fractures, hemothorax on his/her right side, and left hip fracture. Resident 1 discharged home on hospice care and passed away soon after. RN F said staff told him/her that Resident 1 had been asleep since his/her fall on 11/02/2023, which was very unusual for Resident 1. RN F questioned why they did not call RN F sooner but the provider did not have an answer. RN F stated Resident 1's home health agency was not notified of any other falls or changes in condition during Resident 1's placement. RN F stated, "I do believe the outcome would have been different if [Resident 1] had treatment on the 2nd or 3rd ... would have survived ... [Resident 1] definitely wasn't imminent or hospice appropriate prior to the fall." On 02/21/2023 at 1:00 PM, Surveyor interviewed Administrator A. Surveyor asked if the provider recorded Resident 1's vitals post fall for 3 hours per policy. Administrator A responded that s/he would check for the physical copy of the incident report and get back to Surveyor later. Surveyor requested Administrator A find the report before	N 431		

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they went any further. Administrator A responded immediately, "The paper fall report is shredded. We shred them after we put them in PCC (the provider's electronic charting system)." Surveyor asked if there was evidence elsewhere that the provider monitored Resident 1's vitals after the fall. Administrator A stated, "The vitals were completed. The vitals were not out of norm (unusual) because if they were, the MD would have been notified."

Surveyor asked Administrator A when the fall occurred on 11/02/2023. Administrator A reviewed Resident 1's documentation and stated s/he did not know the time but it was sometime between breakfast and lunch. Administrator A stated the provider's rounding physician was in the building at the time of the fall and s/he observed Resident 1 after the fall. Surveyor asked if there was documentation of this assessment or communication with Resident 1's physician. Administrator A stated there was not.

Surveyor questioned how long Resident 1 was noted to be in bed on 11/03/2023. Administrator A stated there were no progress notes written for the AM shift on 11/03/2023. Administrator A stated, "Change of condition wasn't noticed until the 4th."