| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0016164 | A. BUILDING: _____ B. WING _____ | 07/16/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PARK TERRACE | 1047 HILL STREET WATERTOWN, WI 53098 |

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| N 000 | Initial Comments<br><br>From 07/15/2024 to 07/16/2024, Surveyor conducted a standard survey at Park Terrace, a CBRF located in Watertown.<br><br>Six deficiencies were identified. Two deficiencies were repeat deficiencies - See Statement of Deficiency (SOD) I0HC11 dated 05/30/2019 and SOD B77I11, dated 11/10/2021.<br><br>Census: 36 | N 000 | | |
| N 302 | 83.28(4)(a) Resident health screening and documentation<br><br>Resident health screening. 1. Within 90 days before or 7 days after admission, a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse shall screen each person admitted to the CBRF for clinically apparent communicable disease, including tuberculosis, and document the results of the screening. 2. Screening for tuberculosis and all immunizations shall be conducted using centers for disease control and prevention standards. 3. The CBRF shall maintain the screening documentation in each resident ' s record.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the provider did not ensure 3 of 3 residents reviewed were screened for clinically apparent communicable disease, including tuberculosis, within 90 days before or 7 days after admission. Resident 3, Resident 2 and Resident 1 did not | N 302 | | |

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

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| N 302 | Continued From page 1<br>have a tuberculosis test completed within 90 days before admission or 7 days after admission.<br><br>Findings include:<br><br>On 07/15/2024 at approximately 10:10 a.m., Surveyor reviewed resident records provided by LPN A. Records documented the following:<br><br>- Resident 3 was admitted to the provider's facility on 02/13/2023. Resident 3's record did not include documentation of a communicable disease screen/assessment or tuberculosis test.<br>- Resident 2 was admitted to the provider's facility on 04/08/2024. Resident 2 had a communicable disease screen/assessment completed on 04/09/2024. Resident 2's record did not include documentation of a tuberculosis test.<br>- Resident 1 was admitted to the facility on 02/12/2024. Resident 1's tuberculosis test was administered on 02/20/2024, 8 days after his/her admission date.<br><br>On 07/15/2024 at approximately 10:30 a.m., Surveyor interviewed LPN A. Surveyor stated 3 of 3 resident records reviewed did not include tuberculosis tests. LPN B, who was covering for the facility's administrator, stated s/he provided what s/he could locate in records and s/he wasn't sure why there were not tuberculosis tests within 90 days prior to admission or 7 days after. | N 302 | | |
| N 384 | 83.35(1)(d) Retain written report of assessment.<br><br>Assessment documentation. The CBRF shall prepare a written report of the results of the assessment and shall retain the assessment in the resident ' s record. | N 384 | | |

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| N 384 | Continued From page 2<br>This Rule is not met as evidenced by:<br>Based on record review and interview, the provider did not ensure a written report of the pre-admission assessment was retained in the resident's record for 1 of 3 residents reviewed. Resident 3's record did not include his/her pre-admission assessment.<br><br>Findings include:<br><br>On 07/15/2024 at approximately 10:10 a.m., Surveyor reviewed Resident 3's record. Resident 3 was admitted to the provider's facility on 02/13/2023. Resident 3's record did not include documentation of a pre-admission assessment.<br><br>On 07/15/2024 at approximately 10:30 a.m., Surveyor asked LPN A if s/he could provide Resident 3's pre-admission assessment. LPN A stated s/he provided all the records s/he could and that at the time of Resident 3's admission the provider would have documented on paper rather than electronically. LPN A stated the provider "had gotten in trouble by state" regarding admission assessments at a different facility and had now fixed the issue. | N 384 | | |
| N 389 | 83.35(3)(d) Service plans updated annually or on changes<br><br>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 | N 389 | | |

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| N 389 | Continued From page 3 | N 389 | | |

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 record review and interview, the provider did not ensure the individual service plan (ISP) was updated when there was a change in need or at least annually for 2 of 3 residents reviewed. Resident 2's ISP was not updated to address his/her falls or need for assistance with bathing. Resident 3's ISP did not address his/her history of falls and was not reviewed at least annually.

This is a repeat deficiency. See Statement of Deficiency (SOD) I0HC11 dated 05/30/2019 and SOD B77I11, dated 11/10/2021.

Findings include:

On 07/15/2024 at approximately 10:10 a.m., Surveyor reviewed resident records provided by LPN A. Records documented the following:

Example 1 - Resident 2:

Resident 2 was admitted to the provider's facility on 04/08/2024. Resident 2's record included an assessment, dated 04/09/2024, that indicted s/he needed cues with bathing and was a high fall risk. Resident 2's record included the following incident reports:

- 06/01/2024: Found on the floor next to his/her toilet with blood running down his/her face. Resident 2 was sent to the emergency room.

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| N 389 | Continued From page 4 | N 389 | | |

*Follow up progress note documented Resident 2 received staples to his/her head.
- 06/02/2024: Resident found sitting on his/her butt next to his/her recliner.
- 07/09/2024: Resident found lying on his/her right side on the floor in front of his/her toilet. Resident had a bruise forming on his/her left hip.

Resident 2's ISP, dated 04/12/2024, did not address Resident 2's bathing needs and did not include Resident 2's high fall risk or interventions put into place to prevent falls.

Example 2- Resident 3:

Resident 3 was admitted to the provider's facility on 02/13/2023. Resident 3's record included the following incident reports, dated 07/08/2023 to 07/16/2024:

- 07/08/2023: Found sitting on floor next to recliner.
- 08/29/2023: Found on floor in front of recliner.
- 09/06/2023: Found sitting in front of chair s/he uses in the dining room.
- 09/26/2023: Found kneeling on floor next to bed.
- 11/05/2023: Found on floor between wheelchair and recliner.
- 12/02/2023: Found sitting on floor next to bed.
- 12/24/2023: Found face down on floor next to bed.
- 12/25/2023: Found on bathroom floor. Said s/he went to the bathroom, fell and hit his/her head.

Resident 3's record included an ISP, most recent revision dated 03/01/2024. The ISP included the following, "Falls: Will be encouraged to call for assistance when needed [Revision: 09/28/2023], Fall interventions are: encourage resident to have

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| N 389 | Continued From page 5<br>shoes on during awake hours and grippy socks at night, sign hung in residents room to remind resident to call for help, make residents bed early in AM to prevent resident from doing [him/herself] [Revision 03/01/2024]. Referral to home health for assessment [Date Initiated: 09/28/2023]. Remind to call for assistance before transferring [Revision: 11/06/2023]. Safety Checks for Falls: Frequently [Revision: 11/20/2023]. Surveyor noted the ISP did not include interventions that correlated with each fall that occurred. Surveyor also noted the ISP had not been signed, indicating review and agreement by Resident 3's legal representative, since 05/18/2023, greater than 1 year ago.<br><br>On 07/15/2024 at approximately 12:00 p.m., Surveyor interviewed LPN A, Nurse Consultant B and Director of Nursing C (DON C). Surveyor shared observation that 2 of 3 ISPs were not updated to include assistance or interventions needed. DON C stated staff should assess for an appropriate intervention after each incident and place the intervention in the ISP. Nurse Consultant B stated s/he had recently been auditing charts to make sure interventions identified in incident reports were manually entered into ISPs. LPN A stated, "I noted that," when Surveyor shared Resident 3's ISP was overdue for a review. | N 389 | | |
| N 525 | 83.47(2)(d) Fire drills.<br><br>Fire drills. 1. Fire evacuation drills shall be conducted at least quarterly with both employees and residents. Drills shall be limited to the employees scheduled to work at that time. Documentation shall include the date and time of the drill and the CBRF ' s total evacuation time. | N 525 | | |

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| N 525 | Continued From page 6<br>The CBRF shall record residents having an evacuation time greater than the time allowed under s. HFS 83.35(5) and the type of assistance needed for evacuation. Fire evacuation drills may be announced in advance. 2. At least one fire evacuation drill shall be held annually that simulates the conditions during usual sleeping hours. Fire evacuation drills may be announced in advance. Drills shall be limited to the employees scheduled to work during the residents ' normal sleeping hours.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the provider did not ensure fire drills were conducted at least quarterly with both employees and residents. The provider did not have documentation of fire drills completed in 2022 and 2023.<br><br>This is a repeat deficiency. See Statement of Deficiency (SOD) B77I11, dated 11/10/2021.<br><br>Findings include:<br><br>On 07/15/2024 at approximately 12:00 p.m., Surveyor reviewed the provider's environmental binder provided by Maintenance Director D and Administrator Intern E. The binder did not include documentation of fire drills.<br><br>On 07/15/2024 at approximately 12:05 p.m., Surveyor interviewed Maintenance Director D. Surveyor requested documentation of fire drills conducted in 2022 and 2023 from Maintenance Director D. Maintenance Director D stated s/he worked at the facility for 17 ½ years, left for 5 | N 525 | | |

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| N 525 | Continued From page 7<br>years and just returned to the facility 5 weeks ago. Maintenance Director D stated s/he was still working on getting records together but didn't believe fire drills were documented in 2022 and 2023. Maintenance Director D stated s/he believed fire drills were done, but not documented. The provider was given until 07/16/2024 to provide follow up documentation.<br><br>On 07/16/2024 at approximately 8:30 a.m., Administrator Intern E updated Surveyor that they were unable to locate evidence of fire drills conducted in 2022 and 2023. | N 525 | | |
| N 526 | 83.47(2)(e) Other evacuation drills.<br><br>Other evacuation drills. Tornado, flooding, or other emergency or disaster evacuation drills shall be conducted at least semi-annually.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the provider did not ensure other evacuation drills, such as tornado, flooding, or other emergency or disaster evacuation drills, were conducted at least semi-annually. The provider's documentation indicated 1 other evacuation drill was completed in 2023 and 2024.<br><br>Findings include:<br><br>On 07/15/2024 at approximately 12:00 p.m., Surveyor reviewed the provider's environmental binder provided by Maintenance Director D and Administrator Intern E. The binder included documentation of 1 tornado drill, dated 04/11/2024. | N 526 | | |

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| N 526 | Continued From page 8<br><br>On 07/15/2024 at approximately 12:05 p.m., Surveyor interviewed Maintenance Director D. Maintenance Director D stated s/he worked at the facility for 17 ½ years, left for 5 years and just returned to the facility 5 weeks ago. Maintenance Director D stated s/he was still working on getting records together, but didn't believe other evacuation drills were documented. Maintenance Director D stated s/he believed drills were done, but not documented. The provider was given until 07/16/2024 to provide follow up documentation.<br><br>On 07/16/2024 at approximately 8:30 a.m., Administrator Intern E updated Surveyor that they were unable to locate documentation of additional evacuation drills. | N 526 | | |
| N 639 | 83.59(2)(a) One-hand, one-motion door operation<br><br>All doors shall have latching hardware to permit opening from the inside with a one-hand, one-motion operation without the use of a key or special tool.<br><br>This Rule is not met as evidenced by:<br>Based on observation and interview, the provider did not ensure 1 of 3 doors, identified as an emergency exit, was able to open from the inside without the use of a key or special tool.<br><br>Findings include:<br><br>On 07/15/2024 at approximately 8:15 a.m., Surveyor toured the provider's facility, which is divided into 2 separate units, known as "Assisted Living" and "Memory Care." The 2 units are separated by a walkway, which requires a key fob to entire. Surveyor observed the emergency exit plan on each unit which identified 3 emergency | N 639 | | |

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| N 639 | Continued From page 9<br>exits. Two of the three emergency exits went directly outside. The third emergency exit was considered the "main entrance" and how visitors would come and go from a larger common area that housed additional levels of care. Surveyor noted the memory are "main entrance" required a key fob to exit.<br><br>On 07/15/2024 at approximately 12:00 p.m., Surveyor shared observation with Maintenance Directory D that 1 of 3 exits in "Memory Care", identified as an emergency exit, was not able to open from the inside without the use of a key or special tool. Maintenance Director D confirmed the "main entrance" door required a fob. Maintenance Director D stated the exit did not need to be identified as an emergency exit since there were 2 unobstructed exits from "Memory Care" aside from the "main entrance." | N 639 | | |