STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0014514	A. BUILDING: _____ B. WING _____	C 05/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMNS PROMISE ASSISTED LIVING LLC	1700 SPARTAN RD GREEN BAY, WI 54311

(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 05/28/2025, with additional information gathered through 05/29/2025, Surveyors investigated 2 complaints and conducted a standard survey at Autumns Promise Assisted Living LLC. One of 2 complaints were substantiated, and one new deficiency was identified. Census: 26	N 000		
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 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 record review and interview, the provider did not ensure the individual service plan (ISP) was updated when a resident's needs or abilities changed for Resident 1. Findings Include: On 04/14/2025, the department received a complaint regarding a fall resulting in injury.	N 389		

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

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N 389	Continued From page 1 On 05/25/2025, at approximately 9:45AM, Surveyor interviewed Manager B regarding Resident 1's fall. Manager B explained Resident 1 was an amputee and only had one leg. Manager B advised prior to lunch the physical therapist was working with Resident 1. The physical therapist assisted Resident 1 to the dining room for lunch in his/her wheelchair but did not put the footrest on. After lunch, Resident 1 was returning to his/her room by scooting the wheelchair with his/her foot. A caregiver observed Resident 1 going down the hall and asked if s/he would like assistance. Resident 1 said yes. The caregiver began to push the wheelchair when Resident 1's leg dropped, causing him/her to fall face first out of the wheelchair and on to the floor. Resident 1 was transported to the emergency department. On 05/28/2025, at approximately 3:00PM, Surveyor reviewed Resident 1's after visit summary dated 02/05/2025, from Aurora Bay Care Medical Center - Emergency Department. The summary noted Resident 1 sustained a fall resulting in the following injuries: -Multiple skin tears -Abrasion -Closed fracture of the right orbital floor (bone below the eye) -Closed fracture of the nasal bone -Closed fracture of nasal septum (cartilage on nose that separates the nostrils) -Closed fracture of other bone on right side of face -Closed nondisplaced fracture of surgical neck of left humerus (upper arm) On 05/28/2025, at approximately 3:10PM, Surveyor reviewed Resident 1's ISP dated	N 389		

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N 389	Continued From page 2 02/11/2025. Regarding mobility, the ISP noted Resident 1 utilized a wheelchair and required full assistance. The ISP, dated 02/11/2025 included updated diagnosis of the injuries sustained, but was not updated to include information to ensure the footrest is attached prior to using the wheelchair to avoid future injury. . On 05/28/2025, at approximately 3:30PM, Administrator A acknowledged the findings and agreed the ISP should have been updated after the fall.	N 389		