STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0014642	A. BUILDING: _____ B. WING _____	R-C 08/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK PARK PLACE AUTUMN LANE II	719 JUPITER DR MADISON, WI 53718

(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 08/16/2023, Surveyor conducted a verification visit and 1 complaint investigation at Oak Park Place Autumn Lane II. Two deficiencies were identified. One of 2 deficiencies was a repeat violation. See Statement OF Deficiency UFS811, dated 01/04/2023. The complaint was substantiated. Under statutory provisions of Wis. Stat. ch. 50, a $200 revisit fee is being assessed. Census: 49	{N 000}		
N 353	83.32(3)(i) Rights of Residents: Adequate treatment In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Prompt and adequate treatment. Receive prompt and adequate treatment that is appropriate to the resident ' s needs. This Rule is not met as evidenced by: Based on interview and record review, the provider did not ensure the resident's right to prompt and adequate treatment appropriate to the resident's needs. Two of 2 residents reviewed experienced call pendant wait times exceeding 20 minutes. From 06/01/2023-07/11/2023, Resident 6 experienced 8 call pendant wait times exceeding 20 minutes.	N 353		

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

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From 06/01/2023 - 08/15/2023, Resident 13 experienced 27 call pendant wait times exceeding 20 minutes.

This is a repeat deficiency. See Statement OF Deficiency UFS811, dated 01/04/2023.

Findings include:

The facility is licensed as a Class CNA (nonambulatory) CBRF able to serve up to 67 residents within the client groups of advanced age and irreversible dementia/Alzheimer's.

On 07/17/2023, the Department received a complaint regarding long call pendant wait times.

Example 1- Resident 6
On 08/16/2023, Surveyor reviewed Resident 6's record. S/he was admitted 01/20/2022 and discharged on 07/11/2023.

Individual service plan (ISP) dated 03/16/2023 (summarized) stated Resident 6 was hard of hearing, incontinent of bowel and bladder and was transferred with 2 assist and a Hoyer lift.

On 08/16/2023 at approximately 1:45 PM, Surveyor reviewed Resident 6's call pendant wait times from 06/01/2023-07/11/2023 with Assistant Director of Housing Q:
Call pendant wait times exceeding 20 minutes:
06/03/2023 9:03 AM-32 minutes, 40 seconds
06/03/2023 10:05 AM- 42 minutes, 34 seconds
06/04/2023 9:45 AM- 22 minutes, 09 seconds
06/05/2023 10:23 AM- 24 minutes, 34 seconds
06/18/2023 12:04 AM- 23 minutes, 3 seconds
06/22/2023 7:37 AM- 29 minutes, 18 seconds
07/02/2023 12:20 PM- 20 minutes, 8 seconds

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N 353	Continued From page 2 07/07/2023 10:31 AM- 20 minutes, 44 seconds Example 2- Resident 13 On 08/16/2023, Surveyor reviewed Resident 13's record. S/he was admitted 12/30/2019. Diagnoses included acute infarction of spinal cord, incontinence without sensory awareness, and acute pain. ISP dated 04/16/2023 (summarized) stated Resident 13 required assistance with showers, dressing, lower body hygiene, peri/incontinence care, medications (including as needed and creams for itching) and 2 staff assist and Hoyer lift for all transfers. Physician orders included Acetaminophen 325 MG 2 tablets every 4 hours as needed for pain management related to acute pain. On 08/16/2023 at approximately 1:30 PM, Surveyor reviewed Resident 6's call pendant wait times from 06/01/2023-08/15/2023 with Assistant Director of Housing Q: Call pendant wait times exceeding 20 minutes: 06/18/2023 7:28 AM- 36 minutes, 17 seconds 06/20/2023 7:14 PM- 29 minutes, 25 seconds 06/20/2023 8:50 PM- 35 minutes, 40 seconds 06/22/2023 5:08 PM- 21 minutes, 0 seconds 06/26/2023 9:19 AM- 28 minutes, 52 seconds 07/01/2023 1:46 PM- 26 minutes, 36 seconds 07/01/2023 12:05 PM- 20 minutes, 55 seconds 07/02/2023 7:53 AM- 30 minutes, 12 seconds 07/02/2023 11:55 AM- 41 minutes, 41 seconds 07/06/2023 7:23 AM- 21 minutes, 47 seconds 07/11/2023 6:22 AM- 26 minutes, 45 seconds 07/15/2023 9:44 AM- 30 minutes, 25 seconds 07/16/2023 7:29 AM- 21 minutes, 35 seconds 07/22/2023 10:50 AM- 20 minutes, 12 seconds 07/25/2023 6:59 PM- 20 minutes, 18 seconds	N 353		

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07/29/2023 7:29 AM- 34 minutes, 17 seconds
07/19/2023 9:16 AM- 1 hour, 6 minutes
07/29/2023 10:41 AM- 44 minutes, 20 seconds
07/30/2023 7:18 AM- 31 minutes, 46 seconds
07/30/2023 1:07 PM- 25 minutes, 06 seconds
08/07/2023 7:24 AM- 21 minutes, 28 seconds
08/07/2023 9:13 AM- 33 minutes, 23 seconds
08/12/2023 12:36 AM- 34 minutes, 20 seconds
08/12/2023 3:49 PM- 23 minutes, 58 seconds
08/13/2023 6:05 AM- 20 minutes, 42 seconds
08/13/2023 6:09 AM- 46 minutes, 28 seconds
08/13/2023 11:27 AM- 39 minutes, 29 seconds

On 08/16/2023 at approximately 2:00 PM, Surveyor reviewed 2 Pendant Exception forms for Resident 13:
06/22/2023- Response time 29 minutes "
...Pendant didn't clear tried a few times ..."
07/05/2023- Response time 19 minutes "
...Response time 15 minutes ..."

On 08/16/2023 at 11:30 AM, Surveyor interviewed Resident 13 who stated staff's response time to call pendant varied, and on occasion over an hour. Resident 13 stated s/he used his/her call light when s/he needed a pain pill, to be transferred into wheelchair, recliner, or bed, and changed due to incontinence. Resident 13 stated s/he activated his/her call pendant an hour prior to needing to get into wheelchair for activities but was still often late for activities.

On 08/16/2023 at 2:36 PM, Surveyor discussed concern of long call pendant wait times with Regional RN H and Assistant Housing Director Q. Regional RN H stated the expectation was call lights were to be answered within 15 minutes or staff were to complete a Pendant Exception form. RN H stated call lights were answered within 15 minutes but not cleared. RN H stated the button

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N 353	Continued From page 4 on the pendant needed to be held until 2 sets of blinking lights turned off, but some staff thought it was cleared after the 1st set of lights stopped blinking. RN-H stated from 06/01/2023-08/16/2023, only 2 Pendant Exception forms were completed for Resident 13 and from 06/01/2023-07/11/2023 none were completed for Resident 6.	N 353		
Y3234	50.09(1)(e) Treatment (1) RESIDENTS' RIGHTS. Every resident in a nursing home or community based residential facility shall, except as provided in sub. (5), have the right to: (e) Be treated with courtesy, respect and full recognition of the resident's dignity and individuality, by all employes of the facility and licensed, certified or registered providers of health care and pharmacists with whom the resident comes in contact. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the resident's right to be treated with courtesy, respect, and dignity by all employees of the facility. Resident 6 was not treated with dignity when the caregiver rushed through personal cares and a dime sized bruise was found on forearm	Y3234		

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Y3234	Continued From page 5	Y3234		

afterwards.

Findings include:

The facility is licensed as a Class CNA (nonambulatory) CBRF able to serve up to 67 residents within the client groups of advanced age and irreversible dementia/Alzheimer's.

On 07/17/2023, the Department received a complaint regarding staff's treatment of Resident 6 during personal cares.

On 08/16/2023, Surveyor reviewed Resident 6's record. S/he was admitted 01/20/2022 and discharged on 07/11/2023.

Progress Notes:
06/09/2023 3:18 PM- "Note Text: Will continue to monitor and ensure resident is comfortable and feels safe. No further injury noted."
06/15/2023 8:43 AM- "Note Text: Writer looked at residents [sic] left forearm where dime size bruise was. Bruise is healing well. Skin intact, no open areas. No pain. Resident is satisfied with conclusion of investigation as long as caregiver is not providing direct cares to [him/her] in the near future."

Per Resident 6's individual service plan (ISP) dated 03/16/2023 (summarized), s/he was hard of hearing, incontinent of bowel and bladder and transferred with 2 assist and a Hoyer lift.

Summary of Incident, dated 06/09/2023, not signed: " ...Resident feels that [Caregiver R] is in a bad mood and is not being careful when assisting resident in rolling from side to side. Caregiver was rough when [s/he] grabbed [his/her] arm and left a dime sized bruise on

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Y3234	Continued From page 6 [his/her] left forearm ...6 [sic] additional residents were interviewed. The 6 were chosen because the caregiver in question was working with them the evening in question. One of the 6 mentioned they felt the caregiver in question was also rushed with [him/her] ...[Caregiver R] returned to work on 06/14/2023 after [s/he] completed Resident Rights [training] ..." On 08/16/2023 at 1:20 PM, Surveyor interviewed Regional RN H, Assistant Director of Housing Q and Director of Healthcare Services S. Regional RN H stated the investigation into Resident 6's complaint regarding Caregiver R began 06/09/2023 and Caregiver R was taken off the schedule immediately. Regional RN H stated the dime sized bruise was first noted after the rushed event with Caregiver R, but they were not able to determine if the bruise occurred during the rushed event or not, especially since Resident 6 may have bumped it while driving electric chair and was on a blood thinner. Regional RN H stated Caregiver R would have been written up regardless of the bruise due to rushing because the residents have the right to receive cares without the burden of staff's bad mood. On 08/16/2023 at 2:36 PM, Surveyor discussed concern of Caregiver R's treatment of Resident 6 on 06/08/2023 during personal cares with Regional RN H and Assistant Housing Director Q. Regional RN H stated they were unable to locate the 06/09/2023 investigation or its conclusion due to Administrator J's absence, but would forward it to Surveyor as soon as possible. On 08/17/2023 at 11:17 AM Surveyor received Resident Rights Concern/Grievance Report, investigation, and the signed Disciplinary Action Form via email from Administrator J.	Y3234		

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Y3234	Continued From page 7 Resident Rights Concern/Grievance Report completed by Administrator J and dated 06/12/2023: " ...[Resident 6] asked to speak to writer regarding a concern [with] [Caregiver R]. Resident stated caregiver was very rough [with] [him/her] when providing incontinence care & getting [him/her] ready for bed. Caregiver grabbed [Resident 6's] left arm to help turn [him/her] over & left a small dime sized bruise on [his/her] left forearm. Writer asked if [s/he] felt the caregiver intentionally tried to harm [him/her] and [s/he] answered "No, [s/he] just needs to slow down." ...Date and Time Incident Occurred: 6/8/2023 8:00 PM ...Caregiver was placed on suspension pending investigation ...Caregiver was not allowed to provide cares to this resident for resident's comfort. Caregiver is placed on a final written warning & will go to Resident Rights training on 06/14/2023 & customer SVC [service] training on 06/17/2023 ..." Disciplinary Action Form dated 06/13/2023: " ...Major Offense #8- Violation of health and safety standards, including infection control, unsafe conduct or unsafe acts which result in minor injury to self or others ...[Caregiver R] was rough with a resident when [s/he] was performing incontinence care and getting resident ready for bed. Resident did not feel [s/he] was being cared for in an appropriate way and felt [s/he] was being rushed. Resident had a small dime size bruise on [his/her] left forearm ...[Caregiver R] will perform care on each and every resident with respect and dignity. [S/he] will take [his/her] time and not make the resident feel rushed or make the resident feel as if they are burden to care for ..." Signed and dated by Administrator J on 06/13/2023.	Y3234		