STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0012537	A. BUILDING: _____ B. WING _____	C 12/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRILLION WEST HAVEN	220 ACHIEVEMENT DR BRILLION, WI 54110

(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 12/13/2024-12/18/2024, Surveyor conducted a complaint investigation and standard survey at Brillion West Haven. One deficiency was identified. The complaint was unsubstantiated. Census: 52	N 000		
N 383	83.35(1)(c) Listed areas for assessments. Assessment. Areas of assessment. The assessment, at a minimum, shall include all of the following areas applicable to the resident: 1. Physical health, including identification of chronic, short-term and recurring illnesses, oral health, physical disabilities, mobility status and the need for any restorative or rehabilitative care. 2. Medications the resident takes and the resident ' s ability to control and self-administer medications. 3. Presence and intensity of pain. 4. Nursing procedures the resident needs and the number of hours per week of nursing care the resident needs. 5. Mental and emotional health, including the resident ' s self-concept, motivation and attitudes, symptoms of mental illness and participation in treatment and programming. 6. Behavior patterns that are or may be harmful to the resident or other persons, including destruction of property. 7. Risks, including, choking, falling, and elopement. 8. Capacity for self-care, including the need for any personal care services, adaptive equipment or training. 9. Capacity for self-direction, including the ability to make decisions, to act independently and to make wants or needs known. 10. Social participation, including interpersonal relationships, communication skills, leisure time	N 383		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0012537	A. BUILDING: _____ B. WING _____	C 12/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRILLION WEST HAVEN	220 ACHIEVEMENT DR BRILLION, WI 54110

(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 383	Continued From page 1 activities, family and community contacts and vocational needs. This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not ensure the resident assessment, at a minimum included all areas applicable to the resident including the use of adaptive equipment. Findings include: This facility provides care up to 60 residents in the following client groups: irreversible dementia/Alzheimer's, advanced aged, terminally ill, and physically disabled. According to the Food and Drug Administration, "National surveys of patient deaths occurring in the bed environment demonstrate the risk of entrapment when a patient slips between the mattress and bed rail or when the patient becomes entrapped in the bed rail itself. The population at risk for entrapment are patients who are frail or elderly or those who have conditions such as agitation, delirium, confusion, pain, uncontrolled body movement, hypoxia, fecal impaction, and acute urinary retention that cause them to move about the bed or try to exit from the bed. The absence of timely toileting, position change, and nursing care are factors that may also contribute to the risk of entrapment. The risk may also increase due to technical issues such as the mis-sizing of mattresses, bed rails with winged edges, loose bed rails, or design elements such as wide spaces between vertical	N 383		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0012537	A. BUILDING: _____ B. WING _____	C 12/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRILLION WEST HAVEN	220 ACHIEVEMENT DR BRILLION, WI 54110

(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 383	Continued From page 2	N 383		

bars in the rails themselves..." (Source: U.S. Food and Drug Administration (FDA) Hospital Bed Safety Workgroup, Clinical Guidance For the Assessment and Implementation of Bed Rails In Hospitals, Long Term Care Facilities, and Home Care Settings, April 2003, https://www.fda.gov/media/88765/download (retrieval date - December 18, 2024).)

On 12/13/2024 at 11:00 AM, Surveyor toured the facility with Director of Nursing (DON) A. Surveyor observed Resident 1's bedroom. Surveyor observed half rails attached to each side of Resident 1's bed. The bed rails were in the up position. DON A stated s/he did not know how long Resident 1 had bed rails and usually the facility does not allow the use of bed rails with the risk of entrapment.

Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider on 06/17/2021 with diagnoses including chronic obstructive pulmonary disease, paranoid schizophrenia, and convulsions. Resident 1's current individual service plan (ISP) dated 06/11/2024 and annual assessment, dated 11/12/2024-neither of which contained information regarding his/her bed rails. Resident 1's current ISP documented:
Under the "Mobility and Transfers Assistance" heading: "[Resident 1] requires utilization of sit to stand for all transfers. [S/he] utilizes wheelchair for mobility and is able to propel chair independently."

On 12/13/2024 at 2:25 PM, Surveyor interviewed DON A regarding Resident 1's use of bed rails. DON A acknowledged bed rail use should be on resident assessments and ISPs. DON A reported s/he was unaware when Resident 1 started using the bed rails. DON A stated s/he would complete

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0012537	A. BUILDING: _____ B. WING _____	C 12/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRILLION WEST HAVEN	**220 ACHIEVEMENT DR BRILLION, WI 54110**

(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 383	Continued From page 3 an assessment and make sure Resident 1's ISP was updated.	N 383		