STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016149	A. BUILDING: _____ B. WING _____	C 06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW PERSPECTIVE-HOWARD	**2790 ELM TREE HILL HOWARD, WI 54313**

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N 000	Initial Comments On 06/18/2024, Surveyor conducted a complaint investigation at New Perspective Howard. Additional information was gathered through 06/20/2024. As a result of the investigation the complaint was substantiated and 1 deficient practice was identified. Census: 61	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 ensure an investigation was completed into Resident 1's injuries of an unknown source. The provider could not state who conducted an investigation, an investigation was not immediately conducted, the resident was not immediately protected, all caregivers potentially involved were not interviewed, the investigation was not documented, and a written summary was not provided to the legal representative after 4 grievances were made. Findings include: On 06/18/2024 at approximately 11:30 AM, Surveyor requested to review Resident 1's Face Sheet (FS), last Individual Service Plan (ISP,) January 2024 Observation Notes (ON,) Hospice	N 161		

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

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Notes (HN,) Emergency Department Documentation (ED D,) E-mail Communication with POA A (EC,) and all associated Investigation Documentation (ID) and Incident Reports (IR.)

Resident 1 was admitted to the facility on 05/31/2017 with diagnoses including intermittent vertigo, mild cognitive impairment, other symptoms and signs involving cognitive functions and awareness, history of wedge compression fracture of second lumbar vertebra, degenerative joint disease, and fracture of unspecified parts of lumbosacral spine and pelvis. It was identified in Resident 1's Individual Service Plan (ISP)(dated 01/20/2024) Resident 1 required 1 staff assistance with a gait belt for pivot transfers, had a four wheeled walker and a wheelchair, and was at risk for falls. Resident 1 was on palliative services until 01/22/2024 and then began hospice services. Resident 1 had an activated Power of Attorney (POA A.)

Timeline of Events With Associated Record Review And Interviews

01/07/2024:
IR: 7:00 PM, "What did the resident tell you about what happened?: Resident first reported that [s/he] fell yesterday [01/06/2024] while getting [his/her] pajamas from [his/her] closet, then later reported back pain and was given Tylenol. Later [s/he] said [s/he] fell next to [his/her] bed. At the hospital [s/he] told [POA A] that [s/he] fell on [her/her] butt while brushing [his/her] teeth and staff heled[sic] [him/her] to standing [sic.] Describe what you saw and heard: Around 2PM resident referred frequently to the fall "yesterday." [S/he] first described what staff concluded was the fall when [s/he] broke [his/her] hip as resident has not dressed [him/herself] independently since

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that incident. At 3 pm [sic] presented with back pain and was given Tylenol. at [sic] 6:40 PM [his/her] back pain was worsening. resident [sic] was in tears, [sic] had a fever of 101.1 and started talking about a fall near [his/her] bed. Staff acted on the assumption that [s/he] may have experienced a fall that wasn't witnessed or reported and called triage. Triage directed us to call 911 and send [him/her] out for evaluation ... Original Information Provided By: [Caregiver F] Completed By: [LPN D] Comments: Resident did not have a fall on 1/6/24 or 1/7/24 ..."

On 06/18/2024 at approximately 12:10 PM, Surveyor interviewed Wellness Director B with RN C present. Wellness Director B stated after an incident occurs, the caregivers will document the occurrence in a handwritten note that is later transcribed into an IR by a member of the administration. Wellness Director B reviewed the IR dated 01/07/2024 and noted the IR was created by LPN D with the original information provided by Caregiver F. Wellness Director B reviewed the "Comments" written by LPN D and could not state how the provider could document with certainty that no fall occurred on 01/06/2024 or 01/07/2024. Wellness Director B stated s/he was unaware of an associated investigation into a potential fall on 01/06/0224 or 01/07/2024 that occurred and did not have corresponding documentation of an investigation to corroborate the documented comment.

ON: "01/07/24 [6:42 PM,] TRIAGE CALL: Med passer called to report that resident stated [s/he] was having severe back pain, was in tears due to pain and then resident stated the pain is from her fall last night. No fall reported to staff or triage last night. No bruising or swelling noted to back, resident was walking earlier today with no issues

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but now is not able to move due to pain and area is also tender to tough [sic.] Resident had PRN Tylenol around [3:00 PM] next PRN dose cannot be given until [9:00 PM.] Med passer instructed to call 911 for EMS eval [sic,] resident transported to Saint Vincent's ER via ambulance. POA notified and will meet resident at hospital ..."

Per ED D dated 01/07/2024, and interview with POA A on 06/18/2024 at 4:40 PM, at the hospital Resident 1 verbalized s/he had a fall the previous day and gave a different account of event to his/her family and the ED physician. The resident was assessed at the hospital and no evidence of physical injury to his/her musculoskeletal or integumentary system was documented. The ED D included due to Resident 1's history of mild cognitive impairment s/he was an "unreliable historian." Despite Resident 1's inability to accurately recall events, the medical report included the self-reported fall as presumed to have occurred and causative to exacerbating his/her chronic back pain.

01/08/2024:
ON: 01/08/24 [1:46 AM] TRIAGE CALL: Med passer called to report that resident returned from ER. No new orders at this time. Med passer instructed to notify nursing with any changes or concerns. Community nurse to follow up with resident on 1/8/2024."

Per interview with POA A on 06/18/2024 at 4:40 PM, on 01/08/2024 at approximately 8:30- 9:00 AM, POA A visited Resident 1 and observed multiple injuries including right elbow, forearm, face and ear. (Photos 1, 2, 3, 4, and 5.) POA A asked staff (unidentified) what occurred, with no staff being able to account for the injuries. POA A sent a written statement, "1/08/2024. I went to

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N 161	Continued From page 4 see [Resident 1] at New Perspectives. I noticed [his/her] elbow was red with black and blue the size of a baseball, [his/her] forearm was red, [his/her] ear was black and blue and [his/her] face was black/blue/yellow. I asked staff and no one knew about what happened. I emailed the nurse to see what happened [s/he] was going to forward it to [Care Team Manager I] at New Perspectives and [s/he] said [s/he] would get back to me ..." This was the first notice (in person to the staff present) and 2nd notice (via e-mail to the LPN) of a grievance from the legal representative to the provider. Surveyor reviewed the record and noted there was no documentation indicating the provider assessed him/her for physical injuries upon return to the facility. Additionally, the notes from the community nurse LPN D, who was to follow up with Resident 1 on 01/08/2024 were entered at 12:12 PM, and again at 4:22 PM without mention of the injuries of unknown source that were discovered and reported to the staff by POA A in the morning of 01/08/2024. POA A stated in an interview on 06/18/2024 at 4:40 PM, s/he spoke with LPN D on 01/08/2024 and told him/her about the injures s/he found on Resident 1 that morning. The follow up note by LPN D in the ON regarding the conversation with POA A did not mention the injuries of unknown origin. 01/09/2024: Per interview with POA A on 06/18/2024 at 4:40 PM and POA A's written summary, POA A received an e-mail from LPN D confirming the injuries POA A observed on 01/08/2024: EC from LPN D to POA A at 2:52 PM: " ... I just wanted to send an email to let you know that [Resident 1] has bruising on [his/her] left forearm	N 161		

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and redness near the elbow and [sic] a quarter sized bruise on [his/her] left ear. From what I could understand [s/he] did not recall hitting it on anything or having a fall, do you recall seeing this when you were with [him/he] in the ER over the weekend?"

The statement in the EC is inconsistent with the resident's record. A review of the ON, ED D, or IR would have indicated Resident 1 had been consistently complaining of a fall, though not able to recall the circumstances, and had associated pain enough to be sent out to the hospital. Additionally, POA A stated in an interview on 06/18/2024 at 4:40 PM, s/he had already discussed with LPN D on 01/08/2024 that s/he originally noticed the injuries in the morning on 01/08/2024 and had reported them to the staff (unidentified) that was working at the time.

POA A's written summary noted, "01/09/2024: I did receive and [sic] e-mail from the nurse about [Resident 1's] bruisings [sic] and asked if I noticed in the ER. I did also call [him/her] and said there would be no way [Resident 1] could pick [him/herself] up if [s/he] fell which [s/he] agreed. [S/he] was too weak ..."

On 01/09/2024 at 3:37 PM LPN D e-mailed RN C and Care Team Manager I regarding the injuries of unknown origin and allegation of a fall. LPN D indicated the need for the provider to conduct an investigation and speak to relevant staff from when a fall was suspected on 01/06/2024 but does not mention the injuries were not present at the ER and did not appear until 01/08/2024, which could indicate a separate event may have occurred at or after the hospital visit that would need to be investigated. The e-mail additionally indicates if any investigation did occur, it was not

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immediately after the provider was notified of the injuries of unknow origin on 01/08/2024, and did not take steps to immediately protect the resident:

EC from LPN D to RN E, Care team Manager I, and Care Team Assistant Manager K at 3:37 PM, "Hi guys, I just wanted to bring this to your attention; [Resident 1] went out on Sunday evening to the ER. [S/he] does have bruising on [his/her] left arm and ear, I spoke with [POA A] and [s/he] stated that [Resident 1] told [him/her] and the ER MD that [s/he] was brushing [his/her] teeth when [s/he] fell on [his/her] buttocks.

I cannot see [Resident 1] getting [him/herself] off the floor, however based on the bruising I would guess [s/he] possibly did lose [his/her] balance and fall to the side, into a wall maybe. [POA A] as well cannot see [Resident 1] getting [him/herself] off of the floor.

Could we see who was with [him/her] on Sunday evening (PM) shift and find out if this was witnessed? [Resident 1] did state [s/he] had a caregiver with [him/her.] [POA A] is upset that if [s/he] did have a fall [s/he] was not notified."
No responding EC was provided for review. No ON, IR, or ID was provided to corroborate an investigation occurred into the fall allegations prior to the hospital stay or the injuries of unknown origin found after the hospital stay.

01/16/2024:
POA A's written summary noted, "01/16/2024: I again emailed nurses [LPN D and RN C] asking once again if they ever ask staff if [s/he] fell or what happened on Saturday 1/6/2024. [LPN D's] reply once again was [s/he] will have [Care Team Manager I] e-mail me regarding if [s/he] found out anything from staff and the suspected fall in the

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N 161	Continued From page 7 bathroom. I never heard anything from [Care Team Manager I] at all. Something obviously happened. How and when did [s/he] get this [sic] bruises ... after this [s/he] had extreme back pain. We did take [him/her] to [his/her] doctor for X-rays on January 16th ..." EC sent from POA A to LPN D and RN C at 9:39 AM: " ...Did you ever ask staff if [s/he] fell or what happened a week ago Satieday [sic] night. [sic.]" This is the 3rd notice (via e-mail to LPN D and RN C) of a grievance from the legal representative to the provider. LPN D responds to POA A at 10:52 AM, "I will have [Care Team Manager I] e-mail you regarding if [s/he] found out anything from staff and the suspected fall in the bathroom." 01/24/2024: Resident 1 passed away. 03/01/2024: EC sent from POA A to Care Team Manager I at 2:29 PM, " ... I am just emailing you because I never got an email from you regarding [Resident 1] when [s/he] supposedly fell on January 6th. I know [sic] has since passed away. [LPN D] forwarded the email to you and I was told you would follow up with staff. I never heard from you. Attached are photos that I took. Nothing was reported and there would be no way [Resident 1] could of picked [him/herself] up off the floor. [S/he] did go into the ER the next day and is documented at the ER saying a fall. [sic] This has been bothering me as to what happened and concerning as you never got back to me as to what happened. [S/he] was diagnosed with pneumonia at the ER ..."	N 161		

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N 161	Continued From page 8 This is the 4th notice (via e-mail to Care Team Manager I) of a grievance from the legal representative to the provider. 03/04/2024: POA A stated in an interview on 06/18/2024 at 4:40 PM, s/he did not receive the following follow up e-mail from Care team Manager I: EC from Care Team Manager I to POA A at 1:48 PM, " ... my apologies for the late response I believe there was breakdown in communication regarding myself reaching back out to you I did look into the suspected fall and speak with staff we did not find out anything new as regards to a report of a fall ..." The e-mail responds to the potential fall and does not address the injuries of unknown source, or include written summary of the grievance, the findings, the conclusions, and any action taken as is required by Chapter 83. Additional Interviews On 06/18/2024 at approximately 12:15 PM, Surveyor interviewed Care Team Manager I via phone with Wellness Director B present. Care Team Manager I initially stated s/he could not recall if an investigation into injuries of unknown origin was completed. Care Team Manager I then stated s/he may have conducted an investigation but could not recall if or who s/he interviewed. After reviewing the names of the staff members who were present on 01/06/20204 and 01/07/2024 (when a potential fall occurred,) through 01/08/2024 (when the injuries of unknown origin were reported,) Care Team Member I could not recall who of the staff had	N 161		

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been interviewed. Care Team Manager I stated s/he did not have documentation of an investigation, and could not state the date, time, place, circumstances, people involved, when the investigation was initiated, how or if the resident was immediately protected, if potentially involved staff members were put on leave until and investigation was completed, or who the potential staff members involved were.

On 06/18/2024 at approximately 12:20 PM, Surveyor interviewed Caregiver F via phone with Wellness Director B present. Caregiver F stated someone had asked him/her questions about Resident 1's injuries but could not recall who or when.

On 06/18/2024 at approximately 12:25 PM, Surveyor interviewed Caregiver E via phone with Wellness Director B present. Caregiver E stated no one asked him/her about Resident 1's injuries and that to his/her knowledge, an investigation into the injuries of unknown origin had not been conducted.

On 06/18/2024 at approximately 12:40 PM, Wellness Director B stated if an investigation had been completed it may have been done by Administrator H. Administrator H was not present for the survey and Wellness Director B stated s/he would speak with Administrator H and see if s/he had any knowledge of an investigation or any associated documentation. Wellness Director B stated s/he would send Surveyor any additional information s/he could find. As of 07/10/2024, no additional information or documentation has been received.