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N 000	Initial Comments On 06/21/2023, Surveyors conducted 2 compliant investigations at Heritage Court Middleton, a CBRF in Middleton. Five deficiencies were identified. Two deficiencies were repeat deficiencies -See Statement of Deficiency (SOD) TRW411, dated 02/17/2023. Both complaints were substantiated. Census: 17	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 insure that an investigation was completed for injuries of an unknown source. Resident 3 had a bruise to the left of his/her chin and 2 bruises on his/her right wrist. Cause of the bruises were not investigated. Resident 4 had bruises and injuries to his/her extremities. Cause of the bruises/injuries were not investigated. This is a repeat deficiency. See Statement of Deficiency (SOD) TRW411, dated 02/17/2023.	N 161		

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

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N 161	Continued From page 1 Findings include: On 06/21/2023, Surveyors conducted a complaint investigation related to residents having bruises and wounds of unknown causes. The following concerns were noted: Example 1 - Resident 3: On 06/21/2023 at approximately 10:20 a.m., Surveyors observed Resident 3 with a bruise to the left side of his/her chin and 2 bruises to his/her right wrist. Resident 3 was unable to state what the cause of his/her bruises were or how long the bruises had been present. At approximately 10:30 a.m., Surveyor reviewed Resident 3's record. Resident 3 was admitted to the provider's facility on 12/03/2020. Resident 3's record did not include documentation related to his/her bruises. At approximately 11:00 a.m., Surveyor requested Resident 3's "Body Check" forms, dated 05/20/2023 to 06/21/2023, from Manager C. "Body Check" forms are completed by caregivers when bruises or injuries are observed. No forms were received regarding Resident 3. At approximately 12:25 p.m., Surveyors reviewed concerns with Director of Nursing A, Regional Nurse B, Manager C and Interim Administrator D that Resident 3 was observed with bruises to his/her left chin and right wrist, but his/her record did not include documentation of the bruises or an investigation of the bruises. Manager C replied the bruises had just been reported that morning. At approximately 12:45 p.m., Surveyor	N 161		

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N 161	Continued From page 2	N 161		

interviewed Caregiver F. Caregiver F stated s/he observed the bruises on Resident 3 on 06/20/2023, after being off for a few days, and completed a "Body Check" form the morning of 06/20/2023 which documented the bruises.

At approximately 12:50 p.m., Surveyor asked Manager C for a second time if s/he had any "Body Check" forms for Resident 3. Manager C then returned with a "Body Check" form dated 06/20/2023 at 7:00 a.m., which documented "Upon getting [him/her] dressed staff noticed a bruise by [his/her] mouth (purple) and bruises on [his/her] right arm by [his/her] wrist ... Pain: 10." Manager C stated the "Body Check" form was in a stack of papers s/he had not gotten to yet, so the bruises had not been followed up on.

Example 2 - Resident 4:

On 06/21/2023 at approximately 9:00 a.m., Surveyor interviewed Caregiver F and asked if any residents currently had injuries or bruising. Caregiver F stated, "[Resident 4] has bruises all over."

At approximately 10:30 a.m., Surveyor reviewed Resident 4's record. Resident 4 was admitted to the provider's facility on 05/03/2023 with diagnoses of vascular dementia. Resident 4's progress notes included the following documentation:

- "Late Entry" 05/22/2023: No new skin concerns.
- "Late Entry" 05/24/2023 3:30 p.m.: No new skin concerns.
- "Late Entry" 05/24/2023 4:22 p.m.: Hospice nurse reported resident had an open area to his/her left outer heel 3 x 2.6 cm.
- "Lake Entry" 06/03/2023: No new skin concerns.

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- "Late Entry" 06/04/2023: No new skin concerns.
- 06/05/2023: No new skin concerns.

At approximately 11:00 a.m., Surveyor requested Resident 4's "Body Check" forms, dated 05/20/2023 to 06/21/2023, and any corresponding investigations of the injuries from Manager C. "Body Check" forms are completed by caregivers when bruises or injuries are observed.

At approximately 11:30 a.m., Surveyor reviewed "Body Check" forms that documented the following:

- 05/24/2023: 1 cm healing skin tear on left elbow, 3 x 2.6 open area left heel, scab top of great toe on left foot, bilateral healed areas with discoloration to both knees and top of great toe abrasion on right foot.
- 06/05/2023: A few sores that look old/foot sore that is being treated by staff.
- 06/07/2023: Bruising/scratches to right and left extremities, left side of back and bilateral knees.
- 06/12/2023: Left foot still open and painful. No other new skin conditions at this time.
- 06/14/2023: Bruising/cuts (closed) to both upper extremities, both lower extremities and left foot.
- 06/21/2023: Some cuts/bumps and bruises to bilateral upper extremities, sore in lower back and open sore left heel.

At approximately 12:25 p.m., Surveyor reviewed concern with Director of Nursing A, Regional Nurse B, Manager C and Interim Administrator D that Resident 4 had numerous bruises/injuries documented on "Body Check" forms, but his/her record did not include documentation or an investigation related to the cause of the injuries. Manager C stated some injuries weren't investigated because they were so small. Director

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N 161	Continued From page 4 of Nursing A stated the heel injury was from Resident 4 self-propelling in the wheelchair. Surveyor requested documentation of observation that self-propelling the wheelchair caused the wound and/or an investigation that concluded self-propelling the wheelchair caused the wound. Director of Nursing A replied, "It's speculation. No documentation." Director of Nursing A then stated hospice may have information related to the cause of wounds. Director of Nursing A was given the opportunity to follow up with Surveyor on 06/21/2023 with documentation from hospice related to cause of injuries; however, no additional documentation was received.	N 161		
N 162	83.12(3)(b) Documentation of investigations of injuries. Investigating injuries of unknown source. The CBRF shall maintain documentation of each investigation of an injury referenced under par. (a). The CBRF shall report the incident as required under sub. (2). This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure documentation was maintained for investigations related to Resident 2's injuries. Resident 2 had bruises to his/her bilateral upper extremities that were allegedly due to self-propelling his/her wheelchair; however, the provider did not have documentation of an investigation or cause of the bruises. Findings Include:	N 162		

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N 162	Continued From page 5 On 06/21/2023, Surveyors conducted a complaint investigation related to residents having bruises and wounds of unknown causes. At approximately 10:20 a.m., Surveyors observed Resident 2 with an approximately 4" bruise on his/her left upper extremity and approximately 6" bruise on his/her right upper extremity (Photo 1). Resident 2 was unable to tell Surveyors how the bruises occurred or how long the bruises had been present. At approximately 10:30 a.m., Surveyor reviewed Resident 2's record. Resident 2 was admitted to the provider's facility on 07/10/2020. Resident 2's record did not include documentation regarding bruises to his/her upper extremities. At approximately 11:00 a.m., Surveyor requested Resident 2's "Body Check" forms, dated 05/20/2023 to 06/21/2023, from Manager C. "Body Check" forms are completed by caregivers when bruises or injuries are observed. At approximately 11:30 a.m., Surveyor reviewed "Body Check" forms that documented the following: - 05/22/2023: Bruises to right and left upper extremities. - 05/29/2023: Large bruises to both arms and forearms. - 06/02/2023: Bruising to both upper extremities and lower extremities. - 06/05/2023: Scab/bruising to right and left upper extremities. - 06/19/2023: Bruising/scratch from shower chair on right forearm, left upper extremity and left knee. *Form does not specify which marking is due to shower chair.	N 162		

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N 162	Continued From page 6 At approximately 12:25 p.m., Surveyor reviewed concern with Director of Nursing A, Regional Nurse B, Manager C and Interim Administrator D that Resident 2 was observed with bruises on his/her upper extremities, but documentation did not indicate a cause of the bruises or include an investigation related to the bruises. Director of Nursing A stated the bruises were "ongoing" from Resident 2 self-propelling his/her wheelchair. Surveyor requested documentation that concluded Resident 2's bruises were from self-propelling his/her wheelchair. Director of Nursing A provided Resident 2's individual service plan (ISP), dated 04/21/2023, that stated "I self-propel my wheelchair and at times hit my arms on handrails." Surveyor discussed concern that the ISP does not document an investigation related to the bruises or indicate that the current bruises are due to self-propelling the wheelchair. Director of Nursing A had no response or feedback.	N 162		
N 408	83.37(1)(i) PRN psychotropic medication. As needed (PRN) psychotropic medication. When a psychotropic medication is prescribed on an as needed basis for a resident, the CBRF shall do all of the following: 1. The resident ' s individual service plan shall include the rationale for use and a detailed description of the behaviors which indicate the need for administration of PRN psychotropic medication. 2. The administrator or qualified designee shall monitor at least monthly for the inappropriate use of PRN psychotropic medication, including but not limited to, use contrary to the individual service plan, presence of significant adverse side effects, use for discipline or staff convenience, or contrary	N 408		

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to the intended use. 3. Documentation in the resident ' s record shall include the rationale for use, description of behaviors requiring the PRN psychotropic medication, the effectiveness of the medication, the presence of any side effects, and monitoring for inappropriate use for each PRN psychotropic medication given.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure the rational for use and description of behaviors was documented when PRN psychotropic medication was administered for 2 of 2 residents reviewed.

Resident 3's behaviors that required administration of his/her Quetiapine PRN were not documented 12 times from 05/01/2023 to 06/21/2023.

Resident 4's behaviors that required administration of his/her Quetiapine PRN or Lorazepam PRN were not documented 13 times from 05/01/2023 to 06/21/2023.

Findings include:

On 06/21/2023, Surveyors conducted a complaint investigation regarding behaviors/rational for use not being documented when residents are administered PRN psychotropic medications.

On 06/21/2023 at approximately 10:30 a.m., Surveyor reviewed resident records.

Example 1 - Resident 3:

Resident 3 was admitted to the provider's facility on 12/03/2020 with diagnoses including anxiety.

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N 408	Continued From page 8 Resident 3's physician orders included Quetiapine 25 mg - Take 1 tablet once daily PRN for anxiety/agitation/insomnia (Start Date: 11/09/2022). Surveyor reviewed Resident 3's Medication Administration Record (MAR), dated 05/01/2023 to 06/21/2023, progress notes and behavior charting. Resident 3's PRN Quetiapine was administered without a description of his/her behaviors/rational for use being documented on the following dates: 05/09/2023 11:44 a.m., 05/10/2023 11:30 a.m., 05/12/2023 8:37 a.m., 05/12/2023 2:57 p.m., 05/17/2023 8:00 a.m., 05/19/2023 2:33 p.m., 05/21/2023 7:36 p.m., 06/06/2023 6:18 a.m., 06/06/2023 6:06 p.m., 06/10/2023 3:07 p.m., 06/11/2023 3:16 p.m. and 06/12/2023 4:10 p.m. Example 2 - Resident 4: Resident 4 was admitted to the provider's facility on 05/03/2023 with diagnoses of vascular dementia. Resident 4's physician orders included Quetiapine 25 mg - Take 1 tablet twice daily PRN for agitation (Start Date: 02/24/2023) and Lorazepam .5 mg - Take 1 tablet PRN every 3 hours for anxiety/nausea/restlessness (Start Date: 05/12/2023). Surveyor reviewed Resident 4's MAR, dated 05/01/2023 to 06/21/2023, progress notes and behavior charting. Resident 4's PRN Quetiapine was administered without a description of his/her behaviors/rational for use being documented on the following dates: 05/09/2023 3:43 p.m., 05/21/2023 12:09 p.m. and 06/10/2023 6:58 p.m. Resident 4's PRN Lorazepam was administered without a description of his/her behaviors/rational for use being documented on the following dates: 05/18/2023 12:30 p.m., 05/27/2023 11:30 a.m., 05/29/2023 6:21 a.m., 06/04/2023 8:52 a.m., 06/05/2023 7:19 a.m., 06/10/2023 3:13 p.m.,	N 408		

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N 408	Continued From page 9 06/11/2023 1:05 p.m., 06/12/2023 3:51 p.m., 06/12/2023 10:44 p.m. and 06/14/2023 8:56 a.m. On 06/21/2023 at approximately 12:25 p.m., Surveyor reviewed concern with Director of Nursing A, Regional Nurse B, Manager C and Interim Administrator D that Resident 3 and Resident 4 received PRN psychotropic medications on several occurrences and the rational for use was not documented. Regional Nurse B reviewed the behavior tracker and MAR and acknowledged Surveyor's concern. Regional Nurse B stated the medication passer documented administration of the medications and whether the medications were effective, but it was the responsibility of the caregiver to document behaviors.	N 408		
N 425	83.38(1)(a) Personal care. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident's highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Personal care. Personal care services shall be designed and provided to allow a resident to increase or maintain independence. This Rule is not met as evidenced by:	N 425		

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Based on record review and interview, the provider did not ensure Resident 1 received assistance with personal cares.

Findings include:

On 06/21/2023 at approximately 11:00 a.m., Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider's facility on 11/28/2022. Resident 1's individual service plan (ISP), dated 05/01/2023, documented that s/he was incontinent of bowel and bladder, required assistance with peri-care and that caregivers should assist with changing Resident 1 every 4 hours and as needed.

On 06/21/2023 at approximately 12:00 p.m., Surveyor reviewed documentation from Family Member E that stated on 05/12/2023 s/he had observed Resident 1 with a depend on that had soaked through his/her clothes. Family Member E stated the depend had a date and time on it that indicated the depend had been on Resident 1 for a full 23 hours.

On 06/21/2023 at approximately 12:25 p.m., Surveyor reviewed concern with Director of Nursing A, Regional Nurse B, Manager C and Interim Administrator D that Resident 1 had been left in the same depends for 23 hours. Director of Nursing A replied, "Yup. [S/he] was left in the same depend for 23 hours." Director of Nursing A stated the provider's staff followed up with caregivers who reported they didn't know Resident 1 required assistance with toileting and thought s/he was independent. Regional Nurse B clarified that caregivers should have referenced Resident 1's ISP and would have known Resident 1 required assistance with toileting. Interim Administrator D stated the provider followed up

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N 425	Continued From page 11 with caregivers by having a meeting related to providing personal cares.	N 425		
N 431	83.38(1)(g) Health monitoring. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident ' s highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Health monitoring. 1. The CBRF shall monitor the health of residents and make arrangements for physical health, oral health or mental health services unless otherwise arranged for by the resident. Each resident shall have an annual physical health examination completed by a physician or an advanced practice nurse as defined in s. N 8.02(1), unless seen by a physician or an advanced practice nurse as defined in s. N 8.02(1) more frequently. 2. When indicated, a CBRF shall observe residents ' food and fluid intake and acceptance of diet. The CBRF shall report significant deviations from normal food and fluid intake patterns to the resident ' s physician or dietician. 3. The CBRF shall document communication with the resident ' s physician and other health care providers, and shall record any changes in the resident ' s health or mental health status in the resident ' s record.	N 431		

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N 431	Continued From page 12 This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not ensure the health of residents were monitored and changes documented in the resident record. Resident 1 was observed with a chipped tooth by an outside provider on 05/05/2023. The provider, who was responsible for assisting Resident 1 with oral cares, was not aware of the chipped tooth until 05/08/2023, when informed by Family Member E. This is a repeat deficiency. See Statement of Deficiency (SOD) TRW411, dated 02/17/2023. Findings include: On 06/21/2023 at approximately 9:00 a.m., Surveyor conducted a complaint investigation related to health monitoring concerns. On 06/21/2023 at approximately 10:30 a.m., Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider's facility on 11/28/2022. Resident 1's record included an investigation, dated 05/19/2023, related to a chipped front tooth. Resident 1's progress notes included the following: - Late Entry 05/05/2023: Hospice RN observed a chip in Resident 1's tooth. *Date this note was entered into progress note unknown due to "Late Entry." - Late Entry 05/08/2023: Email from Family Member E reporting that Resident 1 had a broken left front tooth. Resident reported it happened several days ago but does not remember how. *Date this note was entered into progress note	N 431		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE COURT MIDDLETON	6234 MAYWOOD AVE MIDDLETON, WI 53562

(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 431	Continued From page 13	N 431		

unknown due to "Late Entry."

Surveyor reviewed Resident 1's individual service plan (ISP), dated 05/01/2023, which documented that caregivers would physically assist Resident 1 with oral cares every morning and night. Surveyor then reviewed correspondence that documented Family Member E reached out to Director of Nursing A and Manager C on 05/08/2023 to inform them of Resident 1's broken left front tooth and asked if anyone noticed the broken tooth or documented about the tooth. After not receiving a response, Family Member E reached out to Director of Nursing A and Manager C again on 05/11/2023 and stated, "I am reaching out again, as I was surprised to not have received a response from either of you ... It's hard to believe that if a caregiver is helping [him/her] with brushing [his/her] teeth on a daily basis that no one would have noticed that they were chipped."

On 06/21/2023 at approximately 12:25 p.m., Surveyor discussed Resident 1's chipped tooth with Director of Nursing A, Regional Nurse B, Manager C and Interim Administrator D. Director of Nursing A stated the provider was unaware of Resident 1's chipped tooth until 05/08/2023. Surveyor asked why caregivers did not observe or document the chipped tooth in Resident 1's record prior to 05/08/2023 when the ISP indicated caregivers were responsible for assisting with oral cares. Director of Nursing A stated the chipped tooth was not observed because all new caregivers worked and didn't know the chipped tooth was new to Resident 1. Surveyor asked if a chipped tooth would be a concern that should be observed and reported to management. Director of Nursing A did not answer Surveyor's question. Interim Administrator D stated caregivers not reporting the chipped tooth was a lapse in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0014200	A. BUILDING: _____ B. WING _____	C 06/21/2023

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N 431	Continued From page 14 judgement or miscommunication.	N 431		