STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019070	A. BUILDING: _____ B. WING _____	C 10/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONGREGATIONAL HOME INC	13900 W BURLEIGH RD BROOKFIELD, WI 53005

(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 10/27/2025, Surveyors conducted a complaint investigation at Congregational Home Ine. Two deficiencies were identified. Complaint was substantiated. Census: 20	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 record review and interview, the provider did not ensure 1 of 1 resident (Resident 1) received adequate treatment after sustaining an unwitnessed fall. Resident 1 was to receive a Stat (immediate) X-ray which did not occur. Resident 1 continued to transfer on left hip, which was affected by the fall. Resident 1 was transported to the hospital the next day where it was determined s/he had fractured his/her hip. Findings include: On 10/14/2025, the Department received a concern alleging residents do not receive adequate medical treatment. On 10/27/2025, Surveyors reviewed Resident 1's record.	N 353		

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

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N 353	Continued From page 1 Resident 1 was admitted to the facility, 04/10/2025, with diagnosis including congestive heart failure, transient ischemic attack (TIA) [mini strokes], and cerebral infarction (stroke). Resident 1's "Incident Reports" documented: 10/12/2025 - Found lying on his/her left side next to his/her bed. Unwitnessed. Resident complained of left hip paint, complained when putting weight on leg. Caregiver E heard a boom, scream help. Ran to help, found Resident 1 on floor, head on nightstand, Gave him/her a pillow. Called the nurse. New Intervention: "Stat Xray." Sent to emergency room morning of 10/13/2025. Resident 1's "Progress Notes" documented: 10/12/2025 16:55 (4:55 PM) - Resident found lying on his/her left side on the floor next to his/her bed. Resident stated s/he hit his/her head on the nightstand. On-call Medical Doctor F contacted at 1620 (4:20 PM) - STAT left hip x-ray ordered. 10/12/2025 17:05 (5:05 PM) - Follow up fall, neuro check negative. Left lower extremity diminished. Medical Doctor F STAT left hip x-ray ordered Conf. # 48013051. Resident 2's Power of Attorney (POA) G updated about fall and x-ray order. 10/12/2025 17:14 (5:14 PM) - Writer assessed resident following an unwitnessed fall in his/her room. Resident said s/he hit his/her head on the bedside table and complained of left hip pain. No visible injuries noted. Resident had increased difficulty standing and with transfers following the fall. Stat X-ray of left hip ordered. 10/12/2025 20:27 (8:27 PM) - Techs are unable to come to obtain STAT left hip x-ray as they had a heavy load. They will send someone first thing in the morning to obtain x-ray. Updated supervisor.	N 353		

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10/13/2025 8:36 AM - Writer (Licensed Practical Nurse H) mentioned to NCM (NOC Care Manager) regarding resident in severe pain to left hip. Ice pack and acetaminophen does not seem to help relieve pain. POA G contacted and is on board for Resident 1 to be sent out for evaluation and treatment.

Resident 1's Medication Administration Record, dated 10/01/2025 to 10/13/2025, documented:
Acetaminophen Oral Tablet 325 MG (milligram) - Give 2 tablet by mouth every 8 hours as needed for pain.
Administered 10/12 at 2256 (10:56 PM) with a pain level of 9.

Resident 1's medical documentation reported:
10/13/2025 - Patient sustained unwitnessed fall at facility. CT (computed tomography) Pelvis shows mildly displaced comminuted L (left) inferior sacral ala fracture (complex injury involving the wing-like bony mass on the lower, left side of the sacrum, where the bone has broken into multiple pieces), nondisplaced L ischial body fracture (a stable fracture where the bone is cracked but remains in its correct alignment), and L obturator ring fractures (high energy fractures of the pelvic ring).

On 10/27/2025, at approximately 9:45 AM, Surveyors interviewed Med Passer C. Surveyors asked if s/he was aware of Resident 1's unwitnessed fall on 10/12/2025. Med Passer C explained that when s/he came in for his/her morning shift on 10/13/2025, s/he had been informed by the NOC shift that Resident 1 had been in pain all evening. Med Passer C stated s/he went to pass Resident 1's meds and s/he could hear him/her moaning in pain. Med Passer C stated s/he updated the nurse who then

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decided to have Resident 1 sent out via ambulance.

On 10/27/2025, at approximately 10:35 AM, Surveyors interviewed Director of Nursing (DON) I. Surveyors asked for clarification on what the provider's protocol was regarding when a resident would be sent out for medical treatment after a fall. DON I stated the decision would be based on information provided by staff. DON I stated s/he had not been notified of the fall and observed Resident 1 when s/he arrived at work the morning of 10/13/2025 due to staff expressing concerns of his/her pain level. After s/he observed him/her, s/he made the decision that Resident 1 should receive medical attention and was sent out by ambulance. Surveyors asked for clarification as to what the provider's process was regarding orders for a STAT x-ray that could not be completed STAT. DON I explained that the [virtual on-call service] would be contacted stating that a STAT x-ray could not be obtained and staff would obtain new orders. Surveyors asked for documentation showing that the follow-up call had been made. DON I stated that the [virtual on-call service] documented directly into the resident's progress notes and if there was no note, then the service was not contacted, which they should have been.

On 10/27/2025, at approximately 11:20 AM, Surveyor interviewed POA G. Surveyor asked POA G how s/he was notified of Resident 1's fall on 10/12/2025. POA G stated s/he had been contacted by the provider on 10/12/2025 around 5:00 PM and was informed Resident 1 had fallen and they were waiting for the mobile x-ray service to arrive. POA G stated s/he had not been contacted stating the x-ray could not be obtained but was contacted the following morning around

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7:00 AM, 10/13/2025, stating that Resident 1 was in significant pain. POA G stated when s/he arrived at the emergency department to be with Resident 1 there was no doubt that Resident 1 was in pain.

On 10/27/2025, at approximately 12:05 PM, Surveyors interviewed Chief Executive Officer A, Director B, and DON I. Surveyors stated it was documented that Resident 1 had difficulty with standing and with transfers following the fall. Surveyors asked for clarification if Resident 1 should have been standing and transferring after complaining of hip pain from a fall. Chief Executive Officer A stated it had been documented that Resident 1 was not experiencing significant pain. Surveyors reviewed Resident 1's MAR and STAT order for an x-ray with Chief Executive Officer A. Surveyors were informed that Resident 1 should not have been transferring on his/her hip until an x-ray had been obtained and if a STAT x-ray could not be obtained then Resident 1 should have been sent to the hospital to obtain one.

On 10/27/25 at 12:55 PM, Surveyor interviewed Medical Doctor F via telephone. Medical Doctor F indicated s/he was the physician who responded to the call on 10/12/2025 after Resident 1 fell and complained of left hip pain and head pain, from hitting it on a bedside table. Medical Doctor F indicated s/he ordered a STAT X-ray of Resident 1's left hip. Medical Doctor F indicated s/he was not aware that the mobile X-ray service could not get to the building right away and would be unavailable till the next day. Medical Doctor F indicated if s/he knew that the X-ray service was unavailable STAT s/he would have sent Resident 1 to the hospital right away. Medical Doctor F also indicated s/he told the staff

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N 353	Continued From page 5 at the facility not to move Resident 1 till they were instructed that it was ok. Medical Doctor F indicated s/he would normally call the facility to follow up with the X-ray if s/he didn't hear anything but because s/he was working for [virtual doctor consults] s/he has no way of doing that and calls are triage by which doctor is next on the list and s/he has no way to follow up.	N 353		
N 381	83.35(1)(a) Pre-admission and ongoing assessments. Scope. The CBRF shall assess each resident ' s needs, abilities, and physical and mental condition before admitting the person to the CBRF, when there is a change in needs, abilities or condition, and at least annually. The assessment shall include all areas listed under par. (c). This requirement includes individuals receiving respite care in the CBRF. For emergency admissions the CBRF shall conduct the assessment within 5 days after admission. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure an assessment of 1 of 1 resident's physical and mental condition was completed when there was a change in needs. Resident 1 sustained 5 falls between 05/27/2025 and 10/12/2025 and a new fall assessment was not completed. Findings include:	N 381		

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On 10/14/2025, the Department received a concern alleging residents do not receive adequate medical treatment.

On 10/27/2025, Surveyors reviewed Resident 1's record.

Resident 1 was admitted to the facility, 04/10/2025, with diagnosis including: dementia, congestive heart failure, transient ischemic attack (TIA) [mini strokes], and cerebral infarction (stroke).

Resident 1's "Incident Reports" documented:
05/27/2025 - Resident found lying on his/her back on the floor of his/her bathroom. His/her pants were around his/her knees, pull up was pulled up. Walker was tipped over on the floor. Unwitnessed.
08/28/2025 - Resident found on the floor from CNA's (certified nursing assistants). Floor wet. Resident stated s/he slid down from recliner chair. Unwitnessed. Resident started yelling for help, when I got to room resident was on the floor on his/her back.
09/02/2025 - Resident found on the ground in garden. States that s/he slid out of the chair. Unwitnessed.
09/04/2025 - Resident fell in bathroom, found on the floor in front of the toilet. Fall unwitnessed, resident had attempted to self-transfer to toilet.
10/12/2025 - Found lying on his/her left side next to his/her bed. Unwitnessed. Resident complained of left hip paint, complained when putting weight on leg. Caregiver E heard a boom, scream help [sic].

Resident 1's fall risk assessment, dated 04/11/2025, documented:
History of Falling: Yes

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Ambulatory Aid/Transfer:
None/bedrest/wheelchair/nurse assist. Transfer: Multiple attempts but successful.
Gait: Impaired
Mental Status: Knowns own limits. Modified Independence: some difficulty in new situations only.
Resident 1 had a score of 14 which equaled 'Low Risk.'
Surveyors noted the risk assessment also stated that s/he was a 'Moderate Risk' with a score of 14.

Resident 1's "Service Plan Report" (individual service plan), dated 09/21/2025, documented:
The resident is at risk for falls related to weakness. 04/11/2025
Remind resident to rise and change positions slowly. 04/11/2025
Inform the resident/caregivers about safety reminders and what to do if a fall occurs. 04/11/2025
Dicem (non-slip mat) to wheelchair. 04/16/2025
Dicem to recliner. 08/29/2025
Call before you fall sign in resident room. 09/11/2025

Resident 1's medical documentation reported:
10/13/2025 - Patient sustained unwitnessed fall at facility. CT (computed tomography) Pelvis shows mildly displaced comminuted L (left) inferior sacral ala fracture (complex injury involving the wing-like bony mass on the lower, left side of the sacrum, where the bone has broken into multiple pieces), nondisplaced L ischial body fracture (a stable fracture where the bone is cracked but remains in its correct alignment), and L obturator ring fractures (high energy fractures of the pelvic ring). ... PT/OT (physical therapy/occupational therapy) feel therapy limited by cognition/ability to

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N 381	Continued From page 8 follow commands & cooperate. On 10/27/2025, at approximately 12:05 PM, Surveyors interviewed Chief Executive Officer A, Director B, and Director of Nursing I. Surveyors stated Resident 1's fall risk assessment had not been reviewed after Resident 1 sustained 5 falls. Surveyors asked for clarification as to what level of a fall risk Resident 1 was since the current assessment stated that s/he was a low risk and a moderate risk. Chief Executive Officer A stated the assessment would be reviewed but that after each fall, Resident 1's individual service plan (ISP) was updated. Chief Executive Officer A stated Resident 1 was cognitive enough to understand that s/he was self-transferring. Surveyors reviewed risk assessment and stated that the assessment documented that Resident 1 knew his/her own limits but after a sign was posted to remind Resident 1 to call for assistance, s/he still attempted to self-transfer, resulting in a fall. The hospital documentation stated that due to his/her cognition PT and OT would not be considered. On 10/27/2025 at 2:49 PM, Director B emailed Surveyor and stated: "We are actively working on correcting the areas that transpired regarding the complaint you received. I want to bring something to your attention regarding the fall assessment form. Our procedure following a fall is that the nurse who completes the assessment puts an intervention in place right away following the fall report assessment, looking at the root cause of the fall. Then the fall team assesses further at the next morning meeting and any further changes or updates are decided upon at that time and put into the ISP and communicated to the team. This would be done in place of completing a new Fall	N 381		

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N 381	Continued From page 9 Assessment Form in [electronic computer system]. We are assessing and updating just with a different protocol, and I wanted to make you aware of this."	N 381		