STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015685	A. BUILDING: _____ B. WING _____	C 09/03/2024

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EAGLE CREST SOUTH CBRF	622 BENNORA LEE COURT LA CROSSE, WI 54601

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N 000	Initial Comments On 08/26/2024, Surveyor conducted a complaint investigation at Eagle Crest South CBRF. Data collection continued through 09/03/2024. The complaint was substantiated. Two deficiencies were identified. Census: 94	N 000		
N 388	83.35(3)(c) Implement, follow the individual service plan Implementation. The CBRF shall implement and follow the individual service plan as written. This Rule is not met as evidenced by: Based on record review and interview, the provider did not implement Resident 1's individual service plan (ISP) as written. Findings Include: On 08/26/2024, at approximately 12:00 PM, Surveyor interviewed CA A. When asked about a recent staff misconduct report submitted to the department, CA A stated it was determined Caregiver D transferred Resident 1 independently when Resident 1 required 2 staff for assistance with transfers. At approximately 1:00 PM, Surveyor reviewed Resident 1's records. Resident 1 was admitted on 02/24/2017 with multiple diagnoses, including the following: Vascular dementia without behavioral disturbance, spasmodic torticollis, spondylosis without myelopathy or radiculopathy, lumbar	N 388		

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

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N 388	Continued From page 1 region, impingement syndrome of right shoulder, polymyalgia rheumatica, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side and polyosteoarthritis. An Individual Service Plan (ISP), signed and dated on 05/13/2024, stated the following under a "Transferring - Mechanical Lift" heading: "Full body mechanical to be used for all transfers with 2 assist." An incident report investigation was completed related to an incident on 06/22/2024. The conclusion section of the document stated Caregiver D transferred Resident 1 using a full-body lift without another staff assisting which was against the provider's transfer policy. The report stated Caregiver D would be a DNR (Do Not Return) staff as s/he independently transferred a resident using a full-body lift. The provider did not implement Resident 1's ISP as written when Caregiver D transferred Resident 1 without assistance from another staff member.	N 388		
Y3244	50.09(1)(L) Care (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 (l) Receive adequate and appropriate care within the capacity of the facility.	Y3244		

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Y3244	Continued From page 2	Y3244		

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure Resident 1 received adequate and appropriate care within the capacity of the facility.

Resident 1 experienced a fall and sustained multiple fractures requiring surgical intervention. The provider did not ensure Resident 1 was assessed by a member of the nursing staff prior to staff transferring Resident 1 back into bed after the fall. The provider did not follow their fall related policies and procedures.

Findings include:

On 06/26/2024, the department received a self-report from the provider. Under the incident description section, the report read, "On 06/22/2024 at approximately 8:30 pm [sic] [Resident 1] rolled out of bed while [Caregiver E], RCA (Resident Care Assistant) attempted to reposition [him/her] to the center of the bed, using the incontinent pad and sheet. [Resident 1] fell to the floor resulting in a fractured pelvis and femur." Under the incident outcome section, it read, in part, " ...[Resident 1's] fall resulted in a left and right femur fracture, a closed pelvic fracture, and a sacral fracture that required surgical repair. [S/he] had surgery on 06/24/2024."

On 07/11/2024, the department received a complaint with concerns of caregiver misconduct

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Y3244	Continued From page 3	Y3244		

and resident needs not being met.

On 08/26/2024, at approximately 10:45 AM, Surveyor interviewed Care Administrator (CA) A, Campus Manager (CM) B and Director of Quality (DOQ) C. CA A stated Caregiver E was repositioning Resident 1 when Resident 1 fell out of bed and sustained injuries. CA A stated the provider conducted interviews relating to the incident and did not conclude caregiver misconduct took place. CM B stated the hospital treating Resident 1 called the police because Resident 1 was confused about the incident, and the hospital could not reach the provider to follow up on the incident. CM B stated it sounded like a communication issue. CM B stated the police and adult protective services (APS) later visited the facility and explained their involvement. CM B stated the police called the provider on the night of Resident 1's injuries, but they called the wrong number.

At approximately 1:00 PM, Surveyor reviewed Resident 1's records.

Resident 1 was admitted on 02/24/2017 with multiple diagnoses, including the following: vascular dementia without behavioral disturbance, spasmodic torticollis, spondylosis without myelopathy or radiculopathy, lumbar region, impingement syndrome of right shoulder, polymyalgia rheumatica, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side and polyosteoarthritis.

The provider completed an incident report investigation for Resident 1, dated 06/22/2024. The report included the following timeline:

8:28 PM: Caregiver E and Caregiver F assisted

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Y3244	Continued From page 4 Resident 1 into bed. 8:47 PM: Caregiver E used Resident 1's call button. 9:35 PM: Triage Nurse (TN) H called Caregiver E. 10:13 PM: Caregiver E reached out to TN H and "AL wanted [him/her] sent in." 10:37 PM: EMS (Emergency Medical Services) arrived and were met by Licensed Practical Nurse (LPN) G. 10:48 PM: EMS left. The "Investigation Review" section of the report stated, in part, "Per statements from [Caregiver F] and [Caregiver E,] [Resident 1] was transferred back to bed before notifying the nurse. When questioned why [s/he] was transferred before the nurse had assessed [him/her,] it was reported that [Resident 1] was reporting pain and was asking repeatedly to be moved ..." Under the "Post-Fall" section of the report, it stated, in part, "Residents need to be assessed by a nurse before transfer. Failing to do so violated the [Provider] fall policy." The investigation report contained a page titled, "Statements," and included Caregiver E's name and position. The interview was conducted on 06/24/2024. The statements read, in part, " ...Resident did not hit [his/her] head on the floor, but may have hit [his/her] head on the table next to the bed. Per [Caregiver E], neither [s/he] nor [Caregiver F] had a phone to contact the nurse because the [Provider] Float phone was missing and that they were unsure if a nurse was in the building ...[Caregiver E] stated that resident could wiggle [his/her] toes and bend [his/her] knees and stated that although [s/he] knew that a nurse is to assess residents prior to moving them, [s/he] decided to have [Caregiver F] assist [him/her] with placing resident in full body sling and utilized	Y3244		

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Y3244	Continued From page 5	Y3244		

lift to get resident back into bed around 9:10pm ...phone call was made to [LPN G] with request to come and assess resident ...Patient was reporting neck pain ...[LPN G] decided to call previous shift nurse [TN H] to discuss ... [Caregiver E] called [TN H] at 9:35pm as [s/he] was concerned about resident and wanted to know what decision had been made in regards to sending resident to ED (Emergency Department) for assessment - Per [Caregiver E], [TN H] was "mulling it over". [sic] [Caregiver E] states [TN H] called [him/her] back at 10:13 pm and stated that since resident wasn't complaining of much pain, they would hold off on sending [him/her] in. [Caregiver E] then reports [TN H] "changed [his/her] mind" because resident was willing to go in ..."

The investigation report contained a page with Caregiver F's name and interview date of 06/24/2024. The summary stated, in part, " ... [Caregiver F] then heard the pendant for the resident alarming and when [s/he] went to the resident's room, [s/he] saw the resident 'sitting on the floor on [his/her] butt'. [sic] Per [Caregiver F], resident was stating that [s/he] was in a lot of pain while [s/he] was on the floor and that resident was requesting to be moved to [his/her] bed. [Caregiver F] states [s/he] and [Caregiver E] got resident in the sling and positioned [him/her] in the bed. Once the resident was in bed, [Caregiver F] stated that [s/he] noted that the resident's left leg looked swollen and that resident was complaining of pain in the left leg. Per [Caregiver F], [Caregiver E] called nurse around 9:00 - 9:15pm."

The investigation report contained a page with LPN G's name and interview date of 06/24/2024. The summary stated, in part, " ...[LPN G] went to

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Y3244	Continued From page 6	Y3244		

the resident's room and found the resident in [his/her] bed - the bed was elevated to the highest height. While performing flexion of the right leg, the resident "hollered out" in pain. Staff had also reported a potential head strike and the resident was not responding to [LPN G] which prompted [LPN G] to reach out to [TN H] for assistance in determining the resident baseline ...[LPN G] states [s/he] discussed the resident status with [TN H] and determined that the resident should be sent out for evaluation ..."

The investigation report contained a page with TN H's name and interview date of 06/24/2024. The summary stated, in part, "Per [TN H], [s/he] left the facility around 6:00pm and left [his/her] telephone number for nurse [LPN G] as a courtesy in case any questions came up during the night. [LPN G] called [TN H] and reported the resident's fall. Per [TN H], [LPN G] seemed overwhelmed [sic] and [LPN G] stated [s/he] had other tasks that [s/he] had to attend to. [TN H] reports that [LPN G] was not able to give a clear picture of the situation and that [LPN G] was unsure of what to do. [TN H] states [s/he] spoke to [Caregiver E] and [Caregiver E] reported that leg was reddened [sic] and that resident had pain when [s/he] moved the knee. At that time, [TN H] did not feel resident needed to be sent to ED for evaluation and [s/he] recommended that [Caregiver E] apply ice to the area and administer Tylenol for the pain. [TN H] later changed [his/her] mind and contacted [Caregiver E] around 10:15 with instructions to call Tri-State for transport to [Hospital.]"

Surveyor reviewed the provider's Fall Policy and Procedure. Under the definitions section, it stated, "Serious injury: An injury which involves significant/uncontrollable bleeding, signs of head

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	0015685	A. BUILDING: _____ B. WING _____	C 09/03/2024

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Y3244	Continued From page 7	Y3244		

injury, potential broken/fractured bones, significant pain." Under a section titled, "Post Fall Procedure," it read, in part, "In the event that a resident falls, staff will utilize the Post-Fall Checklist to determine if injury is present before allowing the resident to get up." Under a section titled, "If injury is suspected or occurs," it stated, in part, "Staff identifying the fall with serious injury or trauma will call 911 immediately. Resident is not moved unless nurse gives that direction ...Staff identifying a fall with Minor Injury: Contact facility nurse or on-call nurse to report fall and obtain guidance. If suspected head injury, nurse or Program Coordinator will notify HCPOA (Health Care Power of Attorney) and recommendation will be made to seek medical attention ...Resident will not be moved until nurse has determined that resident is safe for transfer ..."

Surveyor reviewed the provider's Post Fall Checklist. The checklist included the following instructions:
-If the fall resulted in major injury, call 911 immediately. Contact nurse after calling 911.
-Question resident regarding pain, numbness, and tingling. Call Tri-State ambulance immediately for any new complaints of pain.
-Check to see if resident is able to move limbs independently without discomfort. Call 911 immediately if arms/legs are not symmetrical or are in an abnormal position.

On 08/26/2024, at approximately 1:30 PM, Surveyor interviewed CA A, CM B and DOQ C. Surveyor shared concerns about the investigation report's determination that Caregiver E and Caregiver F transferred Resident 1 back to bed after the fall without being assessed by nursing staff. CA A stated Caregiver E moved Resident 1 without clearance and without following the

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Y3244	Continued From page 8	Y3244		

provider's process. CA A stated s/he felt Caregiver E was trying to make Resident 1 more comfortable, but Caregiver E went against policy by doing so. CM B stated Caregiver E made the wrong decision and received discipline for not following the provider's policy. CM B stated LPN G may not have prioritized the incident and may not have realized the severity of the fall. CM B stated s/he agreed with Surveyor's concerns and the provider put steps in action to avoid it happening again. CA A stated LPN G was a contracted staff at the time of the fall and no longer had a contract with the provider. Surveyor shared concerns with staff assessments and decision-making processes post fall. Surveyor noted the time lapse between the time of the fall and the time Resident 1 was transferred to the hospital for evaluation. CA A stated there was a lot to unpack systemically with the incident. CA A stated the provider identified the delay during their investigation. CA A stated the delay did not contribute to the fall happening but did impact it. CA A stated the provider implemented their own corrective action plan following the incident which included updating the fall policy and post fall checklist. CA A stated the provider completed in person staff trainings to address bed mobility and different fall scenarios. CA A stated communication with nurses was included in the staff re-education process.

On 08/29/2024, Surveyor contacted the police department involved in Resident 1's incident and requested any documentation to reflect the outcome of the investigation.

On 09/03/2024, Surveyor received documentation from the police department via email that included the following:

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Y3244	Continued From page 9 A police incident report, dated 06/23/2024, included a narrative and interview with Hospital Social Worker (HSW) J. The interview stated, in part, "I made contact with [HSW J] in the [Emergency Room], and [s/he] was verbally identified. [HSW J] advised that [Resident 1] presented to the Emergency Room at approximately 23:31 (11:31 PM) for leg pain ... [Resident 1] was given Tylenol and an ice pack, but later complained of severe pain, and was subsequently transported to [Hospital] via ambulance at approximately 23:30 (11:30 PM)." Under a section titled, "Attempted Contact with [LPN G]," it stated, in part, "I attempted to make contact in person at [Facility]. I tried all extensions for the after hours [sic] phone number and did not receive an answer and was directed to a voicemail. I was unable to enter the building and make contact with any worker ..." A police incident report, dated 07/14/2024, included a narrative that read, in part, "On 06/23/2024, [Officer I] responded to [Hospital] after a resident from [Provider] arrived with significant injuries ...[Officer I] determined that there were several individuals at [Provider] who had made reports to [Hospital] and there was not a clear consistent story as to who was attempting to assist [Resident 1] into bed ... [Officer I] was not able to determine exactly what happened as there were varying stories from staff members and requested further investigation into the incident due to the injuries sustained by [Resident 1.] Under a "Contact with [Provider] Staff" section, it read, in part, "I was advised that the incident was reported to the state that there was a fall with injuries and that internally the incident was viewed as an error by staff but there was no malicious intent or abuse/neglect." Under an "Event of Incident" section, it stated, in part, "Staff also	Y3244		

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Y3244	Continued From page 10 noted on the confusion of phone calls and reporting parties present, and the frustrations [Hospital] had that night as it was after normal business hours." Under an "Interview with [Caregiver E]" section, it stated, in part, "On 07/02/2024 at approximately 10:30 A.M., I made contact with [Caregiver E] who was identified verbally ... [Caregiver E] advised [Resident 1] was insistent about getting back in [his/her] bed and had started defecating. [Caregiver E] stated normally in these situations they are supposed to call for a nurse and [Caregiver E] did not believe that there was a nurse in the building and knew that there was not one on [his/her] floor. [S/he] also advised they did not have their phones on them during work and did not have a way to contact them. [Caregiver E] also stated it was [his/her] fault and was not according [sic] to protocol and instead of calling for a nurse [sic] assisted [Resident 1] back into bed with a sling ..." The provider did not ensure Resident 1 received adequate and appropriate care within the capacity of the facility when staff did not follow the provider's fall related policies and procedures.	Y3244		