STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	110130	A. BUILDING: _____ B. WING _____	C 08/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHPORT GROUP HOME	1602 NORTHPORT DR MADISON, WI 53704

(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 08/02/2024, with information gathered through 08/16/2024, Surveyor conducted a complaint investigation at Northport Group Home. One deficiency was identified. Complaint was substantiated. Census: 8	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 expressing that s/he did not feel well and was having shortness of breath. Resident 1 passed away. Findings include: On 07/31/2024, the Department received a concern alleging a resident, who had sustained an unwitnessed fall, did not receive medical attention, resulting in his/her death. On 08/02/2024, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the facility, 10/08/2008, with diagnosis including schizophrenia. Resident 1 was his/her own	N 353		

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N 353	Continued From page 1 person. Resident 1's "Incident Reports" documented: 07/01/2023 - [Resident 1] did have a physical episode that required writer to call 911. Writer went to [Resident 1's] room to check on [him/her] because [s/he] is usually up by 7AM. Writer knocked on the door 3 times while calling [Resident 1's] name. ... Writer found [Resident 1] lying in [his/her] bed in a fetal position. Writer called [his/her] name and there was no response. Writer shook [his/her] arm while calling [his/her] name and [Resident 1] remained unresponsive. ... The ambulance arrived within 5 minutes. 07/04/2023 - Staff knocked on [Resident 1's] door today 07/04/2023 around 8:20 AM and there was no response. Staff entered the room and found [Resident 1] dead in [his/her] bed. 911 was called and [Resident 1] was pronounced dead. The paramedics said that [Resident 1] died in [his/her] sleep. Resident 1's progress notes documented: "06/29/2023 - (2pm-10pm) - Written by Caregiver D - ... [Resident 1] requested a soda and [his/her] last 5 cigarettes, which the Writer granted ..." "06/30/2023 - (2pm-10pm) - written by Caregiver D - Writer asked [Resident 1] if [s/he] was feeling ok, as [his/her] appetite has been abnormal last few days. ... Writer noted that [Resident 1] was exhibiting (typical) signs of agitation, such as shaking hands and/or feet, also noticed that [Resident 1] sounded like [s/he] might have a respiratory infection, [his/her] cough sounded 'wet.' "07/01/2023 - (7am-3pm) - written by Caregiver F - [Resident 1] did have a physical episode that required writer to call 911. Writer went to [Resident 1's] room to check on [him/her]	N 353		

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N 353	Continued From page 2	N 353		

because [s/he] is usually up by 7AM. Writer knocked on the door 3 times while calling [Resident 1's] name. ... Writer found [Resident 1] lying in [his/her] bed in a fetal position. Writer called [his/her] name and there was no response. Writer shook [his/her] arm while calling [his/her] name and [Resident 1] remained unresponsive. ... The ambulance arrived within 5 minutes. ... All of [his/her] vitals were normal and [his/her] oxygen level was good. [Resident 1] did not have any signs of lung congestion. When the paramedics left they advised writer to check on [Resident 1] throughout the shift and writer has been doing that including conversing with [him/her]."

"07/01/2023 - (2pm-10pm) - Written by Caregiver E - Writer checked in with [Resident 1] 30 minutes after each medication time and there were no side effects observed or reported. Writer checked in with [Resident 1] 4x throughout the shift to see how [Resident 1] was feeling due health/safety concerns that presented over the 1st shift."

"07/02/2023 - (2pm-10pm) - written by Caregiver E - [Resident 1] was in [his/her] room when Writer arrived ...Writer also closely checked in with [Resident 1] 3x (3 times) throughout the shift to physically evaluate (observe) [Resident 1] and engage in conversation with [him/her]. Writer did this as a safety protocol since [Resident 1] was unresponsive yesterday. ..."

"07/03/2023 - (2pm-10pm) - written by Caregiver D - Writer alerted [Resident 1] and [his/her] peers when dinner was ready. [Resident 1] did not immediately come down with everyone else, so Writer went up to [Resident 1's] room knocked on [his/her] door and gain informed [him/her] dinner was ready. [Resident 1] came down several minutes later; [Resident 1] still not feeling well, [s/he] [him/herself] said [s/he] felt 'lousy' when

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asked by Writer and in addition, Writer observed [Resident 1] ate very little of [his/her] dinner. [Resident 1] coughed frequently during dinner and Writer also observed that [s/he] seemed to be short of breath. Writer conducted safety checks 3x throughout the shift. Writer also closely checked in with [Resident 1] 3x throughout the shift to physically evaluate [Resident 1] and engage in conversation with [him/her]. [Resident 1] appeared to be coping, but [his/her] respiratory health is still a concern of this Writer at present, as [Resident 1's] cough seems worse, and [s/he] is less [him/herself] than usual. ... [Resident 1] went outside and sat in roking [sic: rocking] chair after taking [his/her] HS (evening) meds, but did not smoke much. Writer monitored and observed [Resident 1] 30 minutes after taking [his/her] PM and HS medications and there were no side effects observed or reported." "07/04/2023 - (7am - 3pm) - written by Caregiver F - around 8:05 AM Writer heard a staff member [name] shouting in an effort to wake [Resident 1] for [his/her] morning medication. I went upstairs and found [Resident 1] unresponsive. [His/her] fingers were blue and [his/her] arm was cold. I instructed [staff] to call 911 and stayed with [him/her] and also talked to the dispatcher. ... Writer waited for the EMT's (emergency medical technicians) to come ... While they worked on [Resident 1] the EMT person asked Writer about [Resident 1's] current health. Writer explained that Writer called 911 on Saturday 07/12/2023 [sic: 07/02/2023] because [Resident 1] was unresponsive to questions. [S/he] was however able to walk around then. Saturday the EMT's checked [Resident 1's] vials [sic: vitals] oxygen level everything was normal. They found [his/her] lungs to be clear. Sunday, [Resident 1] was breathing harder than normal and [s/he] told Writer that [s/he] had fallen. Writer asked

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[him/her] if [s/he] got hurt and [s/he] said no." EMT's pronounced Resident 1 deceased.

Resident 1's "Individual Service Plan," dated 01/2023, documented:
"Resident-Identified Strengths: [Resident 1] laughs a lot and appears joyful. [Resident 1] is a generous person. [Resident 1] is motivated by [his/her] sincere desire to do the right thing."
The ISP did not outline health monitoring related to his/her respiratory signs and symptoms.

Resident 1's June and July 2024 Medication Administration Records did not document any new medications or as needed (PRN) medications related to respiratory concerns.

Surveyor noted that Resident 1 was a heavy smoker and s/he was smoking less on 07/03/2023. Resident 1's appetite had been decreasing. Resident 1's cough was getting worse. Resident 1 stated, "I feel lousy," on 07/03/2023. Caregiver D did not contact management to receive guidance on whether or not 911 should be contacted since Resident 1 was displaying a change of condition.

On 08/02/2024, at approximately 10:15 AM, Surveyor interviewed Director of Residential Services (DRS) A and House Manager B. DRS A stated when Resident 1 was found deceased in his/her room, it was not expected. DRS A explained that residents had been dealing with a summer cold, so Resident 1's cold like symptoms were not overly concerning. Resident 1 was also a smoker, and his/her breathing and coughing were affected by this. DRS A stated staff contacted EMS (emergency medical services) on 07/01/2023 when Resident 1 experienced an unresponsive episode and the EMTs said

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N 353	Continued From page 5 Resident 1 was fine. House Manager B stated EMS should have been contacted on 07/03/2024 when Resident 1 stated s/he felt lousy and appeared to be displaying breathing concerns. DRS A stated, "If there are ever concerns, staff should error on the side of safety, call 911." DRS A stated s/he was not aware of Resident 1 sustaining an unwitnessed fall. On 08/05/2024, at approximately 9:10 AM, Surveyor interviewed Resident 1's mental health Care Manager (CM) C. CM C stated s/he was surprised to receive a phone call that Resident 1 had passed away as we had not received any reports that s/he was not feeling well. CM C stated, "If [Resident 1] was expressing concerns with breathing, [s/he] should have been sent to the emergency room."	N 353		