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N 000	Initial Comments On 10/23/2024, with information obtained through 11/01/2024, the Bureau of Assisted Living, Southern Regional Office, conducted a self-report investigation and complaint investigation at Heritage Muskego, a community-based residential facility (CBRF) located in Muskego, WI. As a result of the survey, 1 deficiency was identified. The complaint was substantiated. There were no deficiencies identified in relation to the self-report investigation. Census: 61	N 000		
N 426	83.38(1)(b) Supervision. 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: Supervision. The CBRF shall provide supervision 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 that supervision appropriate to Resident 1's needs were provided in relation to his/her assessed high fall risk and	N 426		

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

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history of 17 falls since s/he was admitted to the provider on 11/23/2023.

Findings include:

On 10/23/2024, Surveyor conducted an investigation into concerns regarding the handling of resident falls.

At approximately 10:15 a.m., Surveyor interviewed Caregiver B. Caregiver B reported that Resident 1 required staff assistance for all cares and used a Broda chair for ambulation. Caregiver B reported that Resident 1 "constantly" attempted to self-transfer, even though s/he required assistance from staff for all transfers, and was experiencing worsening dementia. Caregiver B reported that Resident 1 was a "very high" fall risk and had experienced multiple falls that mostly occurred during second and third shifts. Caregiver B reported that staff thought Resident 1 required direct 1:1 supervision due to his/her fall risk and had discussed it with management sometime during the past summer but s/he hadn't heard anything further as to how this concern was being addressed. Caregiver B reported that during the daytime Resident 1 was kept out in the common area with staff typically directly nearby him/her to supervise him/her and keep him/her engaged in activities for distracting self-transferring attempts. Caregiver B reported that s/he was aware of Resident 1 having experienced a "really bad" fall sometime during the summer where staff had called Resident 1's family member to alert him/her that Resident 1 had fallen, but when Resident 1's family member had arrived on site s/he found Resident 1 still on the floor and bleeding.

At approximately 10:35 a.m., Surveyor

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interviewed Supervisor C. Supervisor C reported that staff had "extreme difficulties" keeping Resident 1 seated in his/her Broda chair, which s/he had been using for at least the past several months for ambulation. Supervisor C reported that Resident 1 was a high fall risk and required staff assistance for all cares, including transfers, but that s/he frequently attempted to self-transfer. Supervisor C reported that with Resident 1's dementia s/he didn't seem to understand needing staff assistance for all transfers. Supervisor C reported that Resident 1 has had multiple falls. Supervisor C reported that s/he thought Resident 1 required direct 1:1 supervision due to needing constant reminders and supervision for not self-transferring, but that the facility didn't typically provide this for residents. Supervisor C reported that despite this, staff had been unofficially assigning a caregiver to provide constant supervision to Resident 1 when s/he was out in the common area with the expectation that there was someone always to be out with him/her. Supervisor C reported that s/he discussed his/her concerns regarding Resident 1's direct 1:1 needs with Resident 1's activated power of attorney for healthcare as well as management staff.

At approximately 11:05 a.m., Surveyor observed Resident 1 in the common area, seated in his/her Broda chair at a table. Several other residents were in the common area as well. Two staff were observed in the common area engaging with the residents.

At approximately 3:05 p.m., Surveyor observed Resident 1 again. Resident 1 was seated in his/her Broda chair at the same table as earlier, visiting with Family Member E. A staff member was also present sitting in a chair right next to the table.

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N 426	Continued From page 3 At approximately 3:06 p.m., Surveyor interviewed Certified Nursing Assistant (CNA) D. CNA D reported that Resident 1 was a fall risk and that s/he was known to attempt to self-transfer. CNA D reported that staff mostly had Resident 1 remain in the facility's common areas for supervision until s/he went to bed. At approximately 3:18 p.m., Surveyor interviewed Family Member E, who was Resident 1's activated power of attorney (POA) for healthcare. Family Member E reported concerns with Resident 1 having experienced multiple falls since his/her admission. Family Member E reported concerns with staff adequately supervising Resident 1 and assisting him/her with cares. Family Member E reported that Resident 1 frequently complained of staff not assisting him/her when needed, including when s/he had to use the bathroom, which occasionally led to him/her attempting to self-transfer to address his/her care needs. Family Member E also reported that due to Resident 1's worsening memory s/he was known to forget about his/her limited mobility and attempt self-transferring, which led to him/her experiencing falls. On 10/23/2024, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider on 11/23/2023 with diagnoses including Parkinson's disease, history of right total hip arthroplasty, repeated falls, unspecified dementia, and unspecified anxiety disorder. Since Resident 1's admission, 15 fall risk assessments were completed for him/her between 01/04/2024 and 10/11/2024. Ten of the assessments, dated 03/09/2024, 04/17/2024, 04/18/2024, 04/19/2024, 05/18/2024, 05/29/2024,	N 426		

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N 426	Continued From page 4 07/14/2024, 07/28/2024, 08/06/2024, and 10/11/2024, identified Resident 1 as a high fall risk. Surveyor reviewed Resident 1's incident notes, which detailed falls s/he experienced, between 01/01/2024 - 10/23/2024, and observed the following 17 falls documented: 1. Unwitnessed fall on 01/01/2024 (8:30 a.m.): Staff heard [him/her] "scream for help" and found him/her on the floor of his/her bathroom. Resident 1 complained of back pain after the fall. 2. Unwitnessed fall on 01/23/2024 (11:10 a.m.): Resident 1 was found on the ground in the doorway of the memory care unit dining room. 3. Unwitnessed fall on 03/09/2024 (12:23 a.m.): Resident 1 called out verbally for assistance and was found standing in his/her doorway holding his/her head. "Resident told staff that [his/her] head is bleeding and that [s/he] was trying to get up from [his/her] bed to go to the bathroom and stood up and fell backwards and hit [his/her] head on the metal part of [his/her] bed ..." The assessment documented that a laceration was observed at Resident 1's posterior head and that s/he was sent out via emergency medical services (EMS) transport. Surveyor's review of Resident 1's corresponding medical reports identified that Resident 1 was admitted to the hospital from 03/09/2024 - 03/12/2024 with admission diagnoses that included fall and gait instability. 4. Unwitnessed fall on 04/17/2024 (11:08 p.m.): Resident 1 was found sitting on the floor in front of his/her toilet and "told staff [s/he] was trying to transfer [him/herself] from [his/her] [wheelchair] to	N 426		

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the toilet and missed the toilet."

5. Unwitnessed fall on 04/18/2024 (8:33 a.m.): Resident 1 slid out of his/her wheelchair onto his/her buttocks

6. Unwitnessed fall on 04/19/2024 (1:05 p.m.): Staff "heard a loud boom and saw resident sitting on [his/her] buttocks in the hallway ...Resident told staff that [s/he] wanted to walk so [s/he] stood up and pushed [his/her] [wheelchair] and then fell to the ground on [his/her] buttocks ..." Resident 1 complained of right hip pain after the fall.

7. Unwitnessed fall on 05/16/2024 (2:00 a.m.): Resident 1 was found by staff laying on the ground next to his/her bed. Surveyor's review of Resident 1's corresponding medical reports identified that Resident 1 was brought to the emergency department out of concern for left lower leg pain post-fall, later found by imaging to be a minimally displaced left greater trochanter (part of the femur) fracture.

8. Unwitnessed fall on 05/29/2024 (5:15 a.m.): Staff were answering Resident 1's call pendant and found him/her lying on the floor next to his/her bed. "Resident told staff [s/he] was trying to transfer [him/herself] and fell."

9. Unwitnessed fall on 07/14/2024 (4:50 p.m.): Resident 1 was found by staff in the lounge area on the floor yelling for help. "Resident told staff that [s/he] was trying to self transfer from broda chair to a chair at the table and fell." Resident 1 complained of left cheek and left elbow pain post-fall.

10. Witnessed fall on 07/28/2024 (7:30 p.m.):

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Resident 1 was found by staff attempting to stand up from sitting in the Broda chair. "Staff verbally asked resident to sit down but resident kept trying to stand up and fell to the floor landing on residents [sic] left side before staff could intervene ..." Resident 1 complained of back pain post-fall.

11. Unwitnessed fall on 08/02/2024 (6:25 p.m.): Resident 1 tipped over in his/her wheelchair and fell on his/her left side.

12. Unwitnessed fall on 08/03/2024 (7:34 p.m.): "Resident was in [his/her] room and attempted to walk and had a fall." The assessment documented that Resident 1 sustained "2 small skin tears to left shoulder" post-fall.

13. Unwitnessed fall on 08/06/2024 (7:00 p.m.): Resident 1 was found by staff in the common area lying on the floor next to his/her Broda chair. Resident 1 complained of right shoulder and left elbow pain post-fall.

14. Unwitnessed fall on 08/18/2024 (5:07 a.m.): Fall alert from Resident 1's room alerted staff to a fall, and staff found Resident 1 on the floor near his/her recliner. "Resident was attempting to self transfer to bathroom when [s/he] fell." Resident 1 was discovered with a bleeding laceration above his/her left eye and bruising/swelling to his/her periorbital area. Surveyor's review of Resident 1's corresponding medical reports identified that Resident 1 was brought to the emergency department via EMS. While in the emergency department, s/he was assessed to have "significant" swelling of his/her left eye with periorbital ecchymosis (bruising). Resulting imaging revealed that Resident 1 had sustained a left orbital wall fracture. Resident 1's facial

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laceration required 8 stitches and s/he was also found to have skin tearing of his/her left arm as well as right lower extremity abrasions.

15. Unwitnessed fall on 08/29/2024 (5:20 p.m.): Resident 1 was found by staff on the floor by his/her Broda chair, "noted as attempting to stand out of broda chair in attempt to go to bathroom." The assessment noted "old yellowing bruising from previous fall" on Resident 1's left shoulder.

16. Unwitnessed fall on 09/13/2024 (1:50 p.m.): Resident 1 fell in the dining area while "attempting to stand from broda chair. Resident fell forward and had hit head on the floor."

17. Unwitnessed fall on 10/11/2024 (10:45 a.m.): Resident 1 was found by staff in the common area "sitting on [his/her] buttocks on the floor in front of [his/her] broda chair."

Surveyor reviewed Resident 1's current individual service plan (ISP), most recently reviewed on 10/07/2024, as well as historic ISPs since his/her admission. Each version of his/her ISP documented that s/he required staff assistance for transfers. Under the "Falls" section of his/her current ISP, staff documented a running list of fall prevention/fall risk mitigation measures that appeared to correlate with the number of falls above and also correlated with "Actions added to the ISP" which were documented in Resident 1's fall assessments. Surveyor observed the following when comparing Resident 1's fall assessments and corresponding interventions:

- Post-fall 03/09/2024 intervention: "Remind resident to call for staff assistance with transferring and ambulating." No other intervention was documented. Surveyor observed

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that this was documented as a fall prevention intervention already in place as of 01/01/2024 (after Resident 1's first fall on 01/01/2024).

- Post-fall 04/17/2024 intervention: "Remind resident to push call pendent [sic] for assistance using the restroom." No other intervention was documented. Surveyor observed that reminding Resident 1 to request assistance was already an intervention that had been utilized after his/her 01/01/2024 fall as well as his/her 03/09/2024 fall.

- Post-fall 04/19/2024 intervention: "Remind resident if [s/he] wants to walk to ask for staff assist walking with walker." No other intervention was documented. Surveyor observed that reminding Resident 1 to request assistance was already an intervention that had been utilized after his/her 01/01/2024 fall, 03/09/2024 fall, and 04/17/2024 fall.

- Post-fall 05/16/2024 intervention: "Resident to be evaluated prior to return to community for higher level of care." As noted above, Resident 1 was hospitalized after this until 05/28/2024. No other interventions were documented in response to this fall, until a new intervention was added to his/her ISP on 05/29/2024 in response to a fall s/he experienced on that day.

- Post-fall intervention on 07/14/2024 intervention (after Resident 1 had an unwitnessed fall in the lounge/day area): "Staff to not leave resident unattended in day area." The post-fall intervention for the fall experienced by Resident 1 two falls later, on 08/02/2024, documented, "Staff caregiver to be present in the common area." The fall sustained by Resident 1 on 08/06/2024 described, "Per caregiver staff they were sitting in the common area with resident and they got up to

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go let a family member into the unit and when they walked back to the common area resident was lying on the floor on [his/her] left side next to residents [sic] broda chair." The post-fall intervention for this fall documented, "Staff need to make sure another staff is is [sic] in the area before leaving for resident safety." No other intervention was documented for this occasion. Surveyor observed that staff needing to be present in the common area and staff not leaving Resident 1 unattended in the common area were already interventions that staff were to be utilizing at the time of this fall.

- Post-fall assessment on 08/29/2024 documented, "Staff passing through common area observed lying on Left side by broda [wheelchair]. Resident noted as attempting to stand out of broda chair in attempt to go to bathroom." Surveyor noted that this fall occurred at 5:20 p.m. and that the report for how the fall was discovered by staff appeared to conflict with the ISP intervention from 08/02/2024 that a staff member was to have been already present in the common area (where Resident 1 was directed to be during daytime hours from his/her 08/03/2024 post-fall intervention).

- Post-fall assessment on 09/13/2024 documented, "Resdient [sic] was placed in dinning [sic] room to participate in music entertainments [sic]. Resident had noted fall as attempting to stand from broda chair. Resident fell forward and had hit head on the floor ...Entertained [sic] noted resident on the floor and notified staff." Surveyor observed that Resident 1 needing to be attended to by staff in a common area was an intervention directed by his/her ISP on 08/06/2024.

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- Post-fall assessment on 10/11/2024 documented, "Staff caregiver supervisor walked into the common area (day area) and noted resident sitting on [his/her] buttocks on the floor in front of [his/her] broda chair." No interventions were documented in his/her ISP, but the new intervention from the fall assessment documented, "One staff member to be present in common area in between meals for safety." Surveyor observed that Resident 1 needing to be attended to by staff in a common area was already directed by his/her ISP on 07/14/2024 and 08/06/2024, and as of 08/02/2024 staff were to already directed to be present in the common area.

At approximately 4:30 p.m., Surveyor interviewed (Interim) Director of Nursing A. Director of Nursing A reported that Resident 1 needed constant reminders to not self-transfer. Director of Nursing A reported that staff gave him/her activities to keep him/her occupied as well as kept Resident 1 out in the common areas most of the time to have increased supervision of him/her. When discussing Surveyor's concern about the above discrepancies between Resident 1's falls, corresponding interventions, and staff's supervision as directed in Resident 1's ISP, Director of Nursing A reported that s/he understood Surveyor's concerns. Regarding the repeated interventions of reminding Resident 1 to request staff assistance, despite Resident 1's continued falls between 01/01/2024 - 04/19/2024, Director of Nursing A acknowledged Surveyor's concerns that the reminders did not appear to be an effective intervention given Resident 1's dementia and successive attempts to self-transfer. Director of Nursing A reported s/he wasn't sure why this intervention was repeated. Regarding Resident 1's 08/06/2024 unwitnessed

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fall in the common area, Director of Nursing A acknowledged Surveyor's concern that staff were already supposed to have been not leaving him/her unattended as per his/her 07/14/2024 ISP fall prevention intervention. Regarding Resident 1's 08/29/2024 unwitnessed fall, Director of Nursing A confirmed that 5:20 p.m. (time of the fall) would have likely been around dinner time, and so staff could have been attending to other residents or assisting them in/out of the dining area which was why they were only "passing through" the common area as opposed to already having been present. Regarding Resident 1's 09/13/2024 and 10/11/2024 falls, Director of Nursing A acknowledged Surveyor's concern that staff did not appear to have been already attending to Resident 1 despite that being the direction in his/her ISP.

When asked to clarify the discrepancies, Director of Nursing A reported that no resident, including Resident 1, could be provided direct 1:1 supervision by an individual staff member since that was not a service provided by the facility, but the most staff could do for supervision would be to keep Resident 1 in the common areas where staff were more likely be able to supervise him/her. Director of Nursing A confirmed that despite this, there would be times where staff would occasionally have to leave common areas to conduct other tasks, including addressing care needs for residents. Director of Nursing A reported that s/he had spoken with Family Member E about the reality that staff could not provide direct 1:1 supervision.