| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0017805 | A. BUILDING: _____ B. WING _____ | C 12/06/2024 |

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| HARTFORD ESTATES I | 109 LONE OAK LN HARTFORD, WI 53027 |

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| N 000 | Initial Comments<br><br>From 12/05/2024 to 12/06/2024, Surveyor conducted a complaint investigation at Hartford Estates I, a CBRF in Hartford.<br><br>One deficiency was identified.<br><br>The complaint was substantiated.<br><br>Census: 8 | N 000 | | |
| N 165 | 83.12(4)(c) Reporting incidents with serious injury<br><br>A CBRF shall send a written report to the department within 3 working days after any of the following occurs: Any incident or accident resulting in serious injury requiring hospital admission or emergency room treatment of a resident.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the provider did not report to the department within 3 working days after the provider learned of an allegation that a resident was left on the ground for 4 hours following a fall.<br><br>Findings include:<br><br>From 12/05/2024 to 12/06/2024, Surveyor investigated a complaint alleging poor staff response to emergencies.<br><br>DHS Chapter 46.90 (1)(f) defines "neglect" as the failure of a caregiver, as evidenced by an act, omission, or course of conduct, to endeavor to secure or maintain adequate care, services, or supervision for an individual, including food, | N 165 | | |

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

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clothing, shelter, or physical or mental health care, and creating significant risk or danger to the individual's physical or mental health.

On 12/05/2024 at approximately 10:00 a.m., Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider's facility on 10/18/2022 and discharged on 09/07/2024. Resident 1's record indicated s/he was his/her own decision maker. Resident 1's individual service plan (ISP), dated 03/14/2024, indicated s/he needed cueing and reminders with ambulation, was independent with transfers and was a fall risk. The record included the following regarding a 08/22/2024 fall:

- Incident report, dated 08/22/2024 at 1:04 p.m., completed by Former Manager C: Resident 1 had sustained a fall at approximately 1:00 a.m. Emergency personnel were contacted for lift assistance, but unable to come to the facility. Staff assisted resident up and noted his/her left lower extremity was swollen, but Resident 1 refused transport. Resident 1 later went to the hospital at approximately 1:00 p.m. due to left foot pain rated at a "9." *Documentation did not indicate how long Resident 1 was on the ground.
- Progress Note, dated 08/22/2024 at 6:30 a.m., completed by Caregiver B: Resident 1 had explosive loose stool overnight. Resident 1 fell on the floor stating his/her legs had given out. Staff contacted emergency services, who stated it would be after 6:30 a.m. before they would arrive. Staff recruited caregiver from affiliated facility next door to assist with lift. *Documentation did not indicate how long Resident 1 was on the ground.

On 12/05/2024 at approximately 10:15 a.m., Surveyor reviewed hospital documentation,

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obtained by Surveyor. The report, dated 08/22/2024, stated Resident 1 was seen at the hospital for left foot pain following a mechanical fall. The report stated Resident 1 felt lightheaded and lost his/her balance at approximately 1:00 a.m. and waited on the ground for assistance from facility staff for approximately 4 hours. The report indicated Resident 1 was diagnosed with a second metatarsal nondisplaced fracture and discharged with a boot and pain medications.

On 12/05/2024 at approximately 10:30 a.m., Surveyor interviewed Administrator A regarding Resident 1's fall. Administrator A stated at the time of Resident 1's fall, the fall would have been reported to Former Manager C. Administrator A stated s/he was aware of Resident 1's fall but was not made aware of the allegation that Resident 1 was left without assistance for hours until early November. Administrator A stated s/he was unaware of any follow up or action taken by Former Manager C on 08/22/2024, but that Administrator A initiated an investigation after s/he learned of the allegation.

On 12/05/2024 at approximately 11:00 a.m., Surveyor reviewed Administrator A's investigation. The investigation documented the following:

- Incident Report Date: 11/03/2024
- Date of Incident: 08/22/2024
- Description of the Incident: "On 11/04/2024, I was completing routine audits of staff files, resident charts, and our building documentation binders including: Fire Safety, State, Psych Med Reviews, Quality Assurance, [statement ends]"
- Resident: "[Resident 1]"
- Investigation Process: Get information and written statement from caregiver on duty at time of fall. Talk to pharmacy re: controlled

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substances.
- Steps Taken: *Blank
- Findings: *Blank
- Corrective Action: *Blank
- Immediate Actions Taken: *Blank
- Long-Term Preventative Actions: "All staff have been educated on leaving residents and reviewing company policies and procedures."
- Conclusion: "Leaving residents unattended for any period of time goes against our company policy, procedure and standards. This employee has been terminated. Facility will file a self-report with DHS. *Employee terminated was not identified in report, but verbally reported by Administrator A to be Former Caregiver D.
- "This investigation is still ongoing. As of 11/18/2024."
- Update 11/23/2024: "Cannot get a hold of family. Cannot prove how long resident was on the floor. [Managed Care Organization] not helpful during investigations (no return call or emails). Unable to speak with resident. Unable to contact [Former Caregiver D], other staff on duty at time. At this time, investigation re: resident on floor for four hours is unsubstantiated. 11/23/2024 9:12 a.m."

On 12/05/2024 at approximately 11:15 a.m., Surveyor reviewed provider timecards. The records indicated Caregiver B worked the overnight shift at the facility on 08/22/2024. The records indicated Former Caregiver D worked the overnight shift at the affiliated facility next door on 08/22/2024. The records indicated Caregiver B remained a current employee of the facility and Former Caregiver D worked until 11/07/2024. Administrator A also showed Surveyor text messages exchanged with Former Caregiver D, after 11/03/2024, contradicting Administrator A's comment in his/her investigation that s/he was

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unable to contact Former Caregiver D.

On 12/05/2024 at approximately 11:30 a.m., Surveyor followed up with Administrator A regarding his/her investigation. Administrator A informed Surveyor that his/her investigation began on 11/01/2024 after talking with Resident 1's MCO, not 11/03/2024 as documented. Surveyor shared concern that Resident 1's allegation of being left on the floor for 4 hours was made on 08/22/2024, yet the allegations were not investigated until 11/01/2024 and findings not concluded until 11/23/2024. Surveyor also shared concerns that there were no interventions identified to safeguard residents from the time the allegation was made on 08/22/2024 to 11/23/2024 as Caregiver B, who was responsible for Resident 1's care on 08/22/2024, remained a current caregiver and Former Caregiver D, who provided assistance on 08/22/2024, was employed until 11/07/2024. Administrator A stated s/he completed training regarding falls and wasn't sure what other action Surveyor would be looking for. Surveyor asked if the facility staffed 1 caregiver/shift from 08/22/2024 to 11/23/2024 and if Caregiver B and Former Caregiver D worked by themselves. Administrator A replied, "Yes."

On 12/05/2024 at approximately 2:20 p.m., Surveyor interviewed Case Manager E, who worked with Resident 1. Case Manager E stated Resident 1 had informed him/her of being left on the floor for 4 hours "sometime before business hours" on 08/22/2024. Case Manager E stated s/he followed up with Former Manager C that morning to inform him/her of the allegation. Case Manager E stated Former Manager C denied being aware of the allegation until Case Manager E's call. Case Manager E stated Resident 1 was

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not an individual that "would make things up" and that Resident 1's family was unable to confirm with dispatch that a call for lift assistance was even made.

On 12/05/2024 at approximately 2:50 p.m., Surveyor interviewed Resident 1. Resident 1 stated s/he called out for help from Caregiver B at approximately 1:00 a.m. on 08/22/2024. Resident 1 stated Caregiver B said s/he could not lift Resident 1 so s/he would call 911. Resident 1 stated Caregiver B then followed up with Resident 1 stating, "You aren't a priority [for rescue squads]." Resident 1 stated s/he was left on the ground, in his/her own fecal matter, and continued to call for assistance. Resident 1 stated at approximately 2:00 or 3:00 a.m., Caregiver B stated s/he would call for assistance again. Resident 1 stated it wasn't until Former Caregiver D came to the facility at approximately 5:00 a.m. that Resident 1 was assisted off the floor. Resident 1 stated from 08/22/2024 until his/her discharge on 09/07/2024, Caregiver B continued to work at the facility which made Resident 1 uncomfortable and intimidated him/her. Resident 1 stated no one a the facility ever followed up with him/her regarding the 08/22/2024 incident.

On 12/06/2024 at approximately 1:00 p.m., Surveyor shared concern with Administrator A that the provider had learned of allegations of neglect on 08/22/2024; however, an investigation was not initiated until 11/01/2024 and no action was taken to ensure resident safety during that time. Surveyor also shared concern that from the time the investigation was initiated on 11/01/2024 to the time the allegation was deemed unsubstantiated on 11/23/2024, no action was taken to ensure resident safety. The incident was not reported to the department. Administrator A

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| N 165 | Continued From page 6<br>verbalized frustration with the investigation because the parties s/he reached out to to interview were not cooperative. | N 165 | | |