STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018200	A. BUILDING: _____ B. WING _____	C 02/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE COMMONS II	W195N9550 ROLLING MEADOWS CIRC MENOMONEE FALLS, WI 53051

(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 02/06/2024, Surveyor conducted 1 complaint investigation at Grace Commons II. One deficiency was identified. The complaint was substantiated. Census: 22	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 ensure the individual service plan (ISP) was implemented as written for 2 of 3 residents reviewed. Findings include: On 01/08/2024, the Department received a complaint regarding the ISP not followed as written. Example 1 Resident 1 01/11/2024 at 4:20 PM the Department received a video recording via email dated 01/07/2024 and time stamped 4:56 PM from Family Member E. The video was recorded by a nanny camera in Resident 1's room. The video depicted Caregiver C pushing Resident 1 in a wheelchair into Resident 1's room from the hallway. Caregiver C parked the wheelchair next to Resident 1's bed. While standing behind the wheelchair, Caregiver C locked the wheelchair brake closest to the bed.	N 388		

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

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N 388	Continued From page 1 Caregiver C turned and began walking out of Resident 1's room while stating "See you later [Resident 1]." Resident 1 replied, "Goodnight." Caregiver C left the room. Resident 1 self-transferred him/herself onto the bed (Video 1). 01/11/2024 at 4:30 PM, the Department received a video recording via email dated 01/02/2024 and time stamped 12:03 PM from Family Member E. The video was recorded by a nanny camera in Resident 1's room. The video depicted Former Caregiver D pushing Resident 1 in a wheelchair into Resident 1's room from the hallway. Former Caregiver D parked the wheelchair near the side of Resident 1's bed and locked the wheelchair brake closest to the bed. Former Caregiver D asked Resident 1 if s/he needed anything. Resident 1 stated "No I don't." Caregiver D left the room and Resident 1 self-transferred him/herself onto the bed (Video 2). On 02/06/2024, Surveyor reviewed Resident 1's record. S/he was admitted 04/04/2023 and his/her Power of Attorney for Health Care was activated due to inability to make his/her own health care decisions. Assessment dated 08/30/2023 identified Resident 1 had memory loss and cognitive impairment, required assistance with activities of daily living, transfers and mobility and had a history of falls. ISP dated 08/30/2023: In the area of Mobility, Transport, Escort- " ...requires assist of one person getting out of chair or bed or transferring from chair to bed, etc ..." Example 2 Resident 2	N 388		

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N 388	Continued From page 2 On 02/06/2024 at 9:37 PM, Surveyor observed Caregiver F transfer Resident 2 from the wheelchair to the toilet using a sit to stand mechanical lift. No additional staff were present during the transfer. On 02/06/2024, Surveyor reviewed Resident 2's record. S/he was admitted 04/17/2023. Diagnoses included paraplegia, incomplete. S/he was his/her own health care decision maker. Assessment dated 08/28/2024 identified Resident 1 demonstrated aggressive behaviors and required assistance with activities of daily living, transfers, and mobility. ISP dated 06/21/2023: In the area of Buddy System (Behavior Patterns/Mood & Behavior)- " ...Two caregivers MUST be present when providing any care and/or transfers with the resident ..." In the area of Transferring- " ...Use 'Sit To Stand' mechanical device for transfers ...Assist of two care givers [sic] for all toileting and transfer needs ..." On 02/26/2024 at 12:57 PM, Surveyor interviewed Caregiver F who stated Resident 2 was transferred with 1 assist and a sit to stand lift. Caregiver F stated s/he did not know Resident 2's ISP stated Resident 2 was to be transferred with 2 staff and sit to stand lift. On 02/06/2024 at 12:40 PM, Surveyor discussed concern of Resident 1's and Resident 2's ISPs not implemented as written with Executive Director A and Assistant Executive Director B. Surveyor showed Executive Director A and Assistant Executive Director B the 2 videos received by the Department on 01/11/2024 (Video	N 388		

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N 388	Continued From page 3 1 and Video 2). Executive Director A identified Caregiver C in the video dated 01/07/2024 and time stamped 4:56 PM, and Former Caregiver D in the video dated 01/02/2024 and time stamped 12:03 PM. Executive Director stated s/he was shown the videos by Family Member E right after they were recorded, and s/he immediately followed up with the caregivers. Executive Director A stated Caregiver C received disciplinary action for not assisting Resident 1 with the transfer and Former Caregiver D was terminated in part for not providing Resident 1 assistance with the transfer. Executive Director A stated initially 2 caregivers were required during transfers and cares with Resident 2 due to his/her behaviors toward staff including pitting staff against each other and calling staff racial slurs. Executive Director A stated they would update Resident 2's ISP to 1 assist with transfers and cares since Resident 2's behaviors had decreased significantly.	N 388		