STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0014656	A. BUILDING: _____ B. WING _____	R-C 05/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FLORIDA	125 GARFIELD ST FOND DU LAC, WI 54937

(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 05/07/2024, Surveyor conducted a verification visit at Florida. Information was received through 05/08/2024. One (1) of the previous 4 deficiencies was verified as corrected. Three (3) deficiencies were identified; all 3 deficiencies were repeat violations. Census: 6 Under statutory provisions of WI Stat. Ch. 50 a $200 revisit fee is being assessed.	{N 000}		
{N 387}	83.35(3)(b) Service plan development: parties involved Development. The CBRF shall involve the resident and the resident ' s legal representative, as appropriate, in developing the individual service plan and the resident or the resident ' s legal representative shall sign the plan acknowledging their involvement in, understanding of and agreement with the plan. If a resident has a medical prognosis of terminal illness, a hospice program or home health care agency, as identified in s. HFS 83.38(2) shall, in cooperation with the CBRF, coordinate the development of the individual service plan and its approval under s. HFS 83.38 (2) (b). The resident ' s case manager, if any, and any health care providers, shall be invited to participate in the development of the service plan. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Resident 1's Individual Service Plan (ISP) was signed by the resident,	{N 387}		

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

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{N 387}	Continued From page 1 acknowledging their involvement in, understanding of, and agreement with the plan. This is a repeat deficiency. See Statement of Deficiency (SOD) XVWL11, dated 01/10/2023. Findings include: On 05/07/2024, Surveyor reviewed Resident 1's electronic record. Resident 1 was elderly and had 26 listed diagnoses. Resident 1 was admitted to the facility on 11/17/2023. Resident 1 was his/her own legal decision maker upon admission and until 04/24/2024 when his/her power of attorney for health care was activated during a hospital admission. On 05/07/2024, Surveyor requested Resident 1's most current signed and dated ISP from Care Management Director C and Program Lead A on 05/07/2024 at 1:05 PM. As of 2:37 PM, when Surveyor left the facility, the provider was unable to locate the document. Program Lead A told Surveyor s/he thought it may have been signed in November during a care team meeting and s/he would try to locate a copy and provide it to Surveyor via email. On 05/08/2024, Surveyor sent an email to Care Management Director C with other documentation requests and wrote, "Also, if you are unable to provide a signed copy of the ISP we discussed yesterday, please let me know that." Care Management Director C replied to the email but did not address the request regarding the ISP. On 05/08/2024, Surveyor sent another email and wrote, "The signed ISP we discussed yesterday was not included in the attachments." Care Management Director C replied to the email on other topics, but did not address the ISP.	{N 387}		

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{N 387}	Continued From page 2 On 05/08/2024 at 3:21 PM, Surveyor conducted an interview with Care Management Director C and asked if there was evidence Resident 1 signed an ISP after admission on 11/17/2023. Care Management Director C replied, "There is not."	{N 387}		
{N 389}	83.35(3)(d) Service plans updated annually or on changes Individual service plan review. Annually or when there is a change in a resident ' s needs, abilities or physical or mental condition, the individual service plan shall be reviewed and revised based on the assessment under sub. (1). All reviews of the individual service plan shall include input from the resident or legal representative, case manager, resident care staff, and other service providers as appropriate. The resident or resident ' s legal representative shall sign the individual service plan, acknowledging their involvement in, understanding of and agreement with the individual service plan. This Rule is not met as evidenced by: Based on observation, interview and record review, the provider did not review and revise Resident 1's individual service plan (ISP) based on assessment after Resident 1 experienced changes in his/her needs, abilities or medical conditions. Between February 2024 and April 2024, Resident 1 experienced weakness and an inability to safely participate in transfers using a sit to stand lift (used to transfer individuals who can partially	{N 389}		

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{N 389}	Continued From page 3	{N 389}		

bear weight and have upper extremity strength). Resident 1's ISP was not updated based on assessment to identify his/her needs and interventions to ensure safe transfers and during the aforementioned timeframe, Resident 1 hit his/her head at least 4 times during staff assisted transfers.

Between December 2023 and April 2024, Resident 1 was seen in the emergency room once, hospitalized twice and underwent a surgical procedure. S/he had experienced cognitive decline and new diagnoses to include kidney stones, a potential bladder infection and chronic urinary tract infections (UTIs). Resident 1's ISP was not reviewed and revised to reflect the changes in his/her medical conditions. The ISP was also not revised to identify needs for health monitoring and care after surgery or for the need to monitor for signs/symptoms of kidney stones, bladder infections or urinary tract infections.

This is a repeat deficiency. See Statement of Deficiency XVWL11, dated 01/10/2023.

Findings include:

Surveyor interviewed Program Lead A on 05/07/2024 at 12:10 PM. Program Lead A. S/he said Resident was admitted with a UTI, continued to have "chronic UTIs" and had history of sepsis. Program Lead A said Resident 1 had just returned to the facility from a hospital stay and was placed on hospice.

NOTE: Sepsis is "a serious condition in which the body responds improperly to an infection. The infection-fighting processes turn on the body, causing the organs to work poorly. Sepsis may progress to septic shock. This is a dramatic drop

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{N 389}	Continued From page 4 in blood pressure that can damage the lungs, kidneys, liver and other organs. When the damage is severe, it can lead to death." Source: https://www.mayoclinic.org/diseases-conditions/sepsis/symptoms-causes/syc-20351214, retrieval date 05/09/2024. Surveyor interviewed Team Lead B on 05/07/2024 at 1:15 PM and 2:02 PM. Team Lead B said when Resident 1 was first admitted, "[S/he] was talking...[S/he] remembered so much," however over the past 5 months his/her ability to remember and communicate needs diminished. Team Lead B said Resident 1 had a "constant" UTI since admission and "they would put [him/her] on antibiotics and it would come right back." Resident 1 underwent surgery to remove a stent in his/her kidney hoping that would help, but within a week or two s/he was again diagnosed with a UTI. Team Lead B said when Resident 1 would have a UTI s/he typically would show signs of increased confusion and anger (some was baseline) and his/her urine had an odor. Team Lead B also said Resident 1 was having increased difficulty with transfers. S/he said, "[S/he] was not holding on to the sit to stand (lift) anymore" and was "unsteady". Surveyor observed Resident 1 on 05/07/2024 at 1:10 PM. S/he was laying in bed. Surveyor attempted conversation with Resident 1 and s/he would only respond with quiet, indecipherable noises. On 05/07/2024, Surveyor reviewed portions of Resident 1's facility record. S/he was elderly, admitted on 11/17/2023 and had 26 pre-admission diagnoses to include; Guillain-Barre Sydndrome	{N 389}		

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{N 389}	Continued From page 5 CIDP (Chronic inflammatory demyelinating polyneuropathy - affects the nerves and causes muscle weakness and abnormal sensations) Hemiplegia (paralysis) affecting right dominant side Muscle weakness (generalized) Urinary tract infection On 05/07/2024, Surveyor reviewed Resident 1's ISP located in the electronic record along with a corresponding list of "active cares." During an interview with Program Lead A at 1:31 PM, s/he confirmed the ISP and active cares in the electronic record were current and no changes had been made to the ISP since admission on 11/17/2023. S/he also confirmed when residents receive hospice services the provider maintains their own ISP. Surveyor noted the ISP and active cares documented the following: Communication: "Verbal" (date stamp 11/16/2023) Interaction: "requires staff assistance/intervention to maintain positive interactions with others..." (date stamp 11/16/2023) Chronic Illness: "has Guillain-Barre Syndrome and requires an outside facility to complete IV treatments every 21 days..." (date stamp 11/16/2023) The section did not identify a history of UTIs, sepsis or other infections. Mobility & Transferring "[S/he] will utilize a sit to stand lift and will hang on with 1 strong arm..." (date stamp 11/16/2023) Surveyor reviewed Resident 1's observation notes which documented Resident 1's changed abilities and needs for transferring. Examples include: 02/17 - transfers with sit to stand have "been	{N 389}		

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{N 389}	Continued From page 6 difficult due to the client not being able to properly hold handle bars or keep [his/her] body straight which could cause and incident in the future if not properly being transported in the right equipment." 02/18 - "bumped [his/her] head on the sit to stand bars as it was going down as [s/he] was dangling and couldn't hold [him/herself] up..." [sic-all] 03/13 - "when needing to get [Resident 1] in the sit and stand [Resident 1] couldn't hold the bar correctly and head was dangling as [s/he] was in the air and at another point [his/her] whole body went limp and [s/he] just dangled [Resident 1] was repeatedly asked if [s/he] could hold [him/herself] up to where [s/he] responded you hold me up I told [him/her] that was not possible and that [s/he] had to do do [his/her] part in helping the transition [Resident 1] replied I can't" [sic - all] 03/27 2:30 AM - "while writer had [Resident 1] in sit to stand [s/he was] leaning all the way forward and lightly hit [his/her] head against the bar [s/he] has no control in [his/her] body when using the sit to stand" [sic - all] 03/27 8:45 AM - "while...in the sit and stand [s/he] was leaning to [his/her] left side and when i...was trying to get [him/her] to lean more to the right [Resident 1] accidentally hit [his/her] head on the corner of [his/her] wall...I did a thorough check and made sure [s/he] was ok and i told [him/her] i was sorry and asked [him/her] if [s/he] was ok. [s/he] didn't answer me either way so i belive [s/her] was fine." 04/15 - "put [him/her] in the sit to stand as I was taking [his/her] pants off [his/her] head dropped and hit the bar (not to hard) I set [him/her] down on the bed [s/he] then fell back I will not keep stressing how unsafe this has been...due to the client not being in the appropriate machinery." [sic-all]	{N 389}		

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{N 389}	Continued From page 7 Upon request on 05/07/2024, Program Lead A provided Surveyor with documentation of all medical visits for Resident 1 since 12/23/2023. Surveyor noted Resident 1 experienced changes in condition: 12/23 - emergency room visit. Prescribed a new antibiotice medication. The after visit summary included patient information for bladder infections including "care and prevention strategies" and "when to get medical advice." 01/08 - infectious disease clinic visit for kidney stones and recurrent UTIs. A new antibiotic medication was prescribed. 03/02-03/06 - 4 day hospitalization. Diagnoses were not listed but two new antibiotic medications were prescribed. 03/14 - (observation note) "Please read [Resident 1] after care from surgery!! A little bleeding is normal [s/he] may have some pain when urinating Be careful while wiping if you see a string DO NOT PULL IT!! watch for a fever or heavy bleeding" [sic - all] 04/15 - clinic visit for reasons to include cognitive decline. 04/24-05/06 - 13 day hospitalization. Diagnoses included ureteral stone (kidney stone moved into ureter), altered mental status, acute febrile illness and acute UTI. The record documented a "history of sepsis." On 05/07/2024 at 2:02 PM, Surveyor interviewed Program Lead A, Team Lead B and Care Management Director C. The managers confirmed Surveyor's review of the record documenting changes in condition related to hospital stays, surgery and an ER visit as well as Resident 1's changed transfer needs. The management team also acknowledged the ISP was not reviewed and revised after the changes	{N 389}		

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{N 389}	Continued From page 8 in condition. Cross Reference: N0431 DHS 83.38(1)(g) Health Monitoring	{N 389}		
{N 431}	83.38(1)(g) Health monitoring. 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: Health monitoring. 1. The CBRF shall monitor the health of residents and make arrangements for physical health, oral health or mental health services unless otherwise arranged for by the resident. Each resident shall have an annual physical health examination completed by a physician or an advanced practice nurse as defined in s. N 8.02(1), unless seen by a physician or an advanced practice nurse as defined in s. N 8.02(1) more frequently. 2. When indicated, a CBRF shall observe residents ' food and fluid intake and acceptance of diet. The CBRF shall report significant deviations from normal food and fluid intake patterns to the resident ' s physician or dietician. 3. The CBRF shall document communication with the resident ' s physician and other health care providers, and shall record any changes in the resident ' s health or mental health status in the resident ' s record.	{N 431}		

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{N 431}	Continued From page 9 This Rule is not met as evidenced by: Based on record review and interview, the provider did not provide health monitoring to meet Resident 1's needs after s/he experienced changes in condition, an emergency room visit and 2 hospitalizations. This is a repeat deficiency. See Statement of Deficiency (SOD) XVWL11, dated 01/10/2023. Findings include: Surveyor interviewed Team Lead B on 05/07/2024 at 1:15 PM and 2:02 PM. Team Lead B said Resident 1 returned to the home the previous day after a long hospital stay and started with hospice services. Team Lead B said s/he was unsure why Resident 1 was hospitalized so long or what the diagnoses were. Team Lead B obtained the hospice binder and reviewed with Surveyor, however it did not provide information about new diagnoses/needs. Surveyor interviewed Program Lead A on 05/07/2024 at 12:10 PM, 1:08 PM and 1:31 PM. S/he described Resident 1 as experiencing "chronic UTIs" (urinary tract infections) since admission in November 2023. Program Lead A said Resident 1 had just returned to the facility from a hospital stay the day before and was placed on hospice. Program Lead A said when residents receive hospice services, the provider maintains their own ISP, however Program Lead also stated no updates to the individual service plan (ISP) had been made since November 2023. On 05/07/2024, Surveyor reviewed Resident 1's	{N 431}		

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{N 431}	Continued From page 10 facility record. Resident 1 was elderly, admitted on 11/17/2023 and had 26 pre-admission diagnoses to include; Guillain-Barre Syndrome, Chronic Inflammatory Demyelinating Polyneuropathy (affects the nerves and causes muscle weakness/abnormal sensations) and urinary tract infection. The diagnoses did not include a history of kidney stones or bladder infections. Upon request on 05/07/2024, Care Management Director C provided Surveyor with a policy titled "Change in Condition." Care Management Director C said the policy was not located anywhere in the facility and they had just received it via email from the office. Surveyor reviewed the policy which instructed notifications to legal representatives, the physician (depending on the nature of the change) and updates to the individual service plan (ISP.) It listed examples of changes in condition to include: hospitalization, urgent care or ER visit pain blood in urine or stool urinary frequency pain when urinating Surveyor requested from Program Lead A all documentation of medical visits for Resident 1 since 12/23/2023. On 05/07/2024, Program Lead A provided Surveyor with the documents below. Surveyor also reviewed Resident 1's current ISP and the provider's observation notes and incident reports. Surveyor noted the following timeline when Resident 1 experienced changes in condition without evidence of health monitoring or changes in the ISP.	{N 431}		

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{N 431}	Continued From page 11 Medical visits: 12/23 after visit summary (AVS) from an ER visit. The AVS did not identify a diagnosis but did include patient information for bladder infections which identified common symptoms as "pain or burning when urinating" and "blood in urine." It read, "Bladder infections are diagnosed by a urine test and urine culture. They are treated with antibiotics...Treatment helps prevent a more serious kidney infection...When to get medical advice - Call your healthcare provider right away if any of these occur: Fever of 100.4° F...discharge (from the peri area)" 01/08 AVS from infectious disease clinic. "The following issues were addressed: Nephrolithiasis (kidney stones)." A new antibiotic medication was prescribed. Surveyor noted symptoms of kidney stones can include blood in the urine, inability to urinate and pain while urinating. Observation notes: 02/20: caregiver observed "pink discharge" in Resident 1's brief which looked like "light blood." Resident 1 told the caregiver it hurt when s/he urinated. 02/24: appeared to be disoriented and made "unusual" statements 02/28: difficult to rouse, "could barely" keep [his/her] eyes open and displayed confusion. 03/02: "4:30 AM...noticed [s/he] was very hot...took temp which is coming at back at 100.5...does have acetaminophen as a prn (as needed medication) unfortunately their isn't any to provide...did try to reach out to (managers) and of course it being late I didtn receive an answer...4:15 PM...asked [Resident 1] if [s/he] would like to go to the er by ambulance and [s/he] said no...has had a fever on and off all day [s/he] is able to take tylenol but does not have any to give..." [sic - all] 03/03: late entry documenting the ambulance was	{N 431}		

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{N 431}	Continued From page 12 called "last night" because "[s/he] was running a fever throughout the day" and at the "end of the day it was 105.3...writer then called [Care Management Director C] and [s/he] told me to call the ambulance and that to explain to Resident 1 how [s/he] could get really sick and go into a coma if [s/he] didn't get medical attention." The caregiver contacted the hospital on 03/03 and was was informed Resident 1 had a UTI and continued fever. 03/06: "I [Caregiver D] brought [Resident 1] home from the hospital...is very confused." Medical visits: 03/06 AVS from 4 day hospital admission. The diagnoses were not listed but 2 new antibiotic medications were prescribed. 04/15 AVS (time stamped 9:00 AM) for clinic visit for reasons to include "cognitive decline." A lab appointment was scheduled for 45 minutes later at 9:15 AM for tests to include a urinalysis with culture (UA/UC.) The record did not contain information to confirm the urine sample was collected or the results. Observation notes: 04/19: "PLEASE MAKE SURE WE'RE PUSHING FLUIDS ON ALL SHIFTS. RESIDENT WAS DRY ALL NIGHT AND THAT IS NOT LIKE [HIM/HER]." 04/23: changes in condition noted to include resistance to using the sit to stand, confusion and weakness. 04/24: 5:00 PM documented confusion 04/24: 6:00 PM "Incident report created...Staff noticed that [Resident 1] was more unresponsive and disoriented than [s/he] had been throughout the day. Writer would ask [him/her] a question, and [s/he] would open [his/her] eyes slightly and fall back asleep ...was not able to respond verbally to staff at all during this time ...decided to call an ambulance." No entries after 4/24	{N 431}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0014656	A. BUILDING: _____ B. WING _____	R-C 05/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FLORIDA	125 GARFIELD ST FOND DU LAC, WI 54937

(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 431}	Continued From page 13 On 05/07/2024 at 2:02 PM during an interview with Program Lead A, Team Lead B and Care Management Director C, Surveyor asked about a portion of the aforementioned timeline between 02/20 and 03/02. Surveyor noted Resident 1 experienced changes in condition including pain, blood in the urine and fever and asked if those symptoms warranted medical evaluation. Program Lead A replied, "[S/he] refused. [S/he] was [his/her] own person." Later in the interview, Care Management Director C acknowledged although Resident 1's power of attorney for health care was only recently activated, s/he had experienced cognitive decline in the preceding months that may have impacted his/her ability to make medical decisions. On 05/08/2024, Surveyor sent an email to Care Management Director C and requested the following documentation: recorded vitals since 12/23 (Note: vital signs measure the basic functions including body temperature/fever) diagnoses for the hospitalization 03/02-03/06 results of the 04/15 UA/UC On 05/08/2024, Care Management Director C replied via email,"Pain is the only vital that we tracked due to meds. We do not track other vitals...Attached are the documentations that we received from [his/her] doctor directly. If needed, I can call [his/her] doctor's offices and have them send over more information, unfortunately this all that was given..." The attached documentation did not include a discharge summary from the 03/02-03/06 hospitalization or the results of the 04/15 UA/UC. The documentation included a discharge	{N 431}		

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{N 431}	Continued From page 14 summary from the 04/24-05/06 hospitalization. It read, "Pt comes from asst. Living, has been ill, last 8 hrs [s/he] has deteriorated, not conversing as [s/he] normally can do, lethargic with fever." [sic - all] Diagnoses associated with the hospitalization were, ureteral stone, altered mental status, acute febrile (fever) illness and acute UTI. On 05/08/2024, Surveyor replied via email, "I would like to verify my review of the email and documentation. Based on what you provided, there was no documentation in the record regarding the diagnoses from the 03/02-03/06/24 hospital stay or the results of the 04/15/24 UA." Care Management Director C replied via email on 05/08/2024, "The information given to you is exactly what was given to us from the hospital and doctors themselves. We do not, unfortunately, have control of what they provide on the after visit summaries." On 05/08/2024 at 3:21 PM, Surveyor conducted a follow up interview with Care Management Director C. S/he reiterated the provider was not responsible for the content of the medical documentation and said, "What we don't receive we can't control." Surveyor explained the concern that Resident 1 had changes in condition that required awareness and ongoing monitoring. Surveyor asked if there was a process to proactively obtain information from medical providers about diagnoses and after care instructions if AVSs are unclear. Care Management Director C replied by stating Program Lead A is "in communication after anybody is in the hospital. Unfortunately we don't have that paper to show you." Care Management Director C asked Surveyor how they should	{N 431}		

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{N 431}	Continued From page 15 proceed with documentation since they are not a "medical facility." Surveyor reviewed the regulatory requirements to review and revise the ISP and to record all changes in health status in the resident record. Care Management Director C stated s/he felt it was unfortunate they were going to get "dinged" (cited) for documentation and felt Program Lead A did a good job obtaining information from medical providers. Note: the Department of Health Services publication dated 01/2018 and titled, "Assisted Living Facility and Hospital Interface" reads in part, "A report from the Centers for Health Care Research and Transformation states, 'Poorly coordinated care transitions from the hospital to other care settings...often result in poor health outcomes.'" It details the consequences of poor communication between hospitals and assisted living facilities to include "re-hospitalizations...lack of appropriate client monitoring...and other unfortunate outcomes. Communication of key information about the ALF (assisted living facility) client from the hospital to the ALF prior to discharge is vitally important." The publication identifies the importance of assisted living providers to do the following: conduct a thorough assessment prior to the resident's return make updates to the ISP ensure receipt and review of the discharge summary provide information and education to caregivers about any changed care needs. Cross Reference: N0389 DHS 83.35(3)(d) Service Plans Updated Annually and on Change	{N 431}		