STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013881	A. BUILDING: _____ B. WING _____	R-C 09/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SWIFTHAVEN COMMUNITY	124 HENRY STREET EDGERTON, WI 53534

(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
{U 000}	INITIAL COMMENTS On 08/26/2024, with information gathered through 09/04/2024, Surveyor conducted a verification visit and a complaint investigation. One deficiency was identified. Complaint was substantiated. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census: 30	{U 000}		
U 137	89.23(4)(d)2.c. SERVICES PROVIDER QUALIFICATIONS. Staff training. Staff providing residential care apartment complex services to tenants shall have documented training or experience in the following areas: c. Assigned duties and responsibilities, including the needs and abilities of individual tenants for whom staff will be providing care. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure caregivers received training in the physical, functional, and psychological characteristics associated with aging and the implications for service needs. Caregiver E, Caregiver G, and Caregiver H did not receive training in repositioning of hospice	U 137		

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

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U 137	Continued From page 1	U 137		

tenants.

Findings include:

On 07/19/2024, the Department received a concern alleging a resident had injuries of unknown origin.

On 08/26/2024, Surveyor reviewed the provider's incident report, written by Director A, regarding Tenant 2's injury of unknown origin which documented:
"On Thursday July 18, 2024 at 3PM, [hospice Registered Nurse (RN) J] came to my office concerned about bruises on the legs ... of resident in [room number]. I listened to what evidence [s/he] had on the bruising and I called staff member (Resident Care Assistant [RCA] H) on the phone, to find out if anything transpired the day before (Wednesday) that would cause any bruising or swelling. By [his/her] statement, nothing out of the ordinary had happened for the exception of having to get [him/her] cleaned up in the afternoon from voiding both urine and BM (bowel movement). Staff have been changing [him/her] regularly and repositioning [him/her] to avoid breakdown. Staff have to touch [his/her] legs in order to change and remove and place a pillow between [his/her] legs for positioning. Residents body is very ridged when trying to care for [his/her] needs as [s/he] is at end of life. I then had a face-to-face conversation with staff member (RCA F) around 4 pm on Thursday. ... It wasn't until the afternoon on Thursday that the Swelling was noted as well as the bruising on her legs. By (RCA F's) statement nothing out of the ordinary had transpired that day besides depend changes and repositioning. Before leaving on Thursday around 4:30 pm I (Director A) had a conversation with my facility Nurse (Nurse B)

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about requiring 2 staff to change and reposition [room number] resident and that we should monitor this resident's body for any changes in appearance in regards to additional swelling or bruising. This was set into place before leaving the building for the day at 5pm. At 5:15 pm on Thursday, I received a call back from one of the overnight staff members (RCA K) that was on shift the night before in regards to resident in [room number]. [S/he] stated that nothing out of the ordinary happened that night in regards to this resident. But [s/he] did state that [s/he] offered staff member (RCA L) assistance if [s/he] needed it with this resident in [room number] ... On Friday July 19th at 1:24 pm, I was able to reach staff member (RCA L) for a statement of what went on with the resident in [room number]. [S/he] stated that nothing out of the ordinary happened that night. [S/he] changed and repositioned this resident throughout the night and did notice the leg bruises ... [RCA L] stated that [s/he] did not require assistance from [his/her] co-worker in regards to caring for this resident. Today Monday July 22nd, 2024, I have concluded this investigation on the unexplained bruising ... I could not find any malfeasance by facility staff in regards to the resident in [room number]. The bruising appears to be a result of touching and positioning this residents legs to offer comfort while being bed bound. ... The exact origin of how and why these marks have appeared is unknown."

On 08/27/2024, at approximately 3:50 PM, Surveyor interviewed Tenant 2's hospice RN I. RN I stated s/he was unaware of any training being provided to the staff regarding how to properly reposition and/or roll Tenant 2.

On 08/27/2024, at approximately 4:40 PM,

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Surveyor interviewed Resident Care Assistant (RCA) H. RCA H stated s/he observed the bruising on Tenant 2 and reported it to hospice. RCA H stated the bruising along Tenant 2's leg looked like bruises caused from pressure by an inexperienced staff member's finger from rolling the tenant over.

On 08/27/2024, at approximately 5:05 PM, Surveyor interviewed RCA E. RCA E stated, "When I assisted [Tenant 2], I always asked another staff member to assist me. That way, you can have one person on each side of the bed to assist with repositioning and/or rolling. It is easier for the staff member, along with the resident."

On 08/27/2024, at approximately 6:30 PM, Surveyor interviewed RCA F. RCA F stated the bruising appeared to have been caused by improper rolling. RCA F stated, "If you aren't trained as a CNA (certified nursing assistant) and/or how to care for hospice patients, you won't know how to properly roll a patient." RCA F stated there had been conversations with human resources that staff need to be trained on how to care for hospice patients and/or how to utilize a draw sheet for repositioning; but staff did not receive the training.

On 08/30/2024 at 5:28 PM, Surveyor emailed Director A and Nurse B. Surveyor stated there were concerns on what training staff received regarding the proper technique for repositioning and/or rolling a tenant.

On 09/03/2024 at 12:31 PM, Director A emailed Surveyor. Director A stated, "We do have a policy on proper positioning using a draw sheet in our policy and procedure manual (policy # 7231). All

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U 137	Continued From page 4 staff must read this manual at time of orientation. I will reach out to hospice to schedule an in-service on this as well, so going forward there is no question about staff knowledge on this situation."	U 137		