STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0014466	A. BUILDING: _____ B. WING _____	C 10/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REM WI 5560 CYNDI COURT	5560 CYNDI COURT EAU CLAIRE, WI 54703

(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
M 000	INITIAL COMMENTS On 10/10/2023, Surveyor conducted a complaint investigation at REM WI 5560 Cyndi Court. Data collection continued through 10/18/2023. The complaint was substantiated. Two deficiencies were identified. Census: 4	M 000		
M 134	88.03(5)(e)1 SIGNIFICANT CHANGE TO THE RESIDENT Within 24 hours, a significant change in resident status, such as but not limited to an accident requiring hospitalization, missing from the home or a reportable death. A death shall be reported if there is reasonable cause to believe the death was related to use of a physical restraint or psychotropic medications, was a suicide or was accidental. This Rule is not met as evidenced by: Based on record review and interview, the provider did not report to the department within 24 hours, a significant change in Resident 1's condition which resulted in emergency room (ER) treatment for a spiral fracture of the left tibia. Findings include: On 07/06/2023, the Department received a complaint alleging Resident 1 was evaluated in the ER for an injury of unknown source on 07/02/2023.	M 134		

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

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M 134	Continued From page 1 On 08/09/2023, the Department received a self-report for Resident 1. The self-report indicated staff observed Resident 1 was making more vocalizations during cares and sent him/her in to be evaluated at the ER. Resident 1 was diagnosed with a spiral fracture of the left tibia of unknown origin. The self-report indicated police and adult protective services (APS) were involved and the provider was doing an internal investigation to determine the cause of injury. The provider indicated Resident 1's fracture was probably caused by a twist that occurred during a reposition, change, or transfer. On 10/10/2023 at approximately 10:00 AM, Surveyor interviewed Program Director (PD) C. PD C confirmed, on 07/02/2023, staff noticed a change in Resident 1's condition on the evening shift with Resident 1 becoming more "irritated" and "whiney." PD C stated Resident 1 was sent to the ER around 9:00 PM on 07/02/2023 to be evaluated. At approximately 10:30 PM, Surveyor interviewed Area Director (AD) B. AD B stated PD C was responsible for reviewing incident reports and sending them to the Department as self-reports. AD B stated PD C was off when Resident 1's incident occurred and that was the reason the self-report was sent in so late. AD B stated they had a plan now for staff to contact him/her to prevent this from occurring again if PD C was off work. At 11:16 AM, Surveyor exited the survey with AD B and PD C. Surveyor expressed concern about how late the self-report was submitted to the Department. PD C stated it was his/her fault due to going on vacation and not having a back-up	M 134		

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M 134	Continued From page 2 process. The provider did not report to the department within 24 hours, a significant change in Resident 1's condition which resulted in emergency room (ER) treatment for a spiral fracture of the left tibia with unknown origin on 07/02/2023. The self-report was submitted over 1 month later, on 08/09/2023.	M 134		
M 412	88.06(3)(d)1 DESCRIPTION OF SERVICES A description of services the licensee will provide to meet the assessed need. This Rule is not met as evidenced by: Based on record review, observation, and interview, the provider did not ensure Resident 1's individual service plan (ISP) reviewed, identified Resident 1's health needs, related to his/her spiral fracture of the left tibia, with a description of services staff were to provide to prevent future bone fractures. Findings include: On 07/06/2023, the Department received a complaint alleging Resident 1 was evaluated in the ER for an injury of unknown source on 07/02/2023. On 08/09/2023, the Department received a self-report for Resident 1. The self-report	M 412		

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M 412	Continued From page 3	M 412		

indicated staff observed Resident 1 was making more vocalizations during cares and sent him/her in to be evaluated at the emergency room (ER). Resident 1 was diagnosed with a spiral fracture of the left tibia of unknown origin. The provider indicated Resident 1's fracture was probably caused by a twist that occurred during a reposition, change, or transfer.

On 10/10/2023 at approximately 10:10 AM, Surveyor interviewed Program Supervisor (PS) A. PS A stated a care team meeting took place after Resident 1's incident on 07/02/2023 and nothing changed on the ISP other than adding in Resident 1's orthopedic physician. PS A stated Resident 1 was to have his/her leg brace on the left leg at night to help stabilize the leg.

At 10:21 AM, Surveyor observed PS A change Resident 1's incontinent brief. PS A showed Surveyor Resident 1's brace and placed it at the bedside prior to changing him/her. Surveyor did not observe Resident 1's brace on him/her during cares.

At approximately 11:00 AM, Surveyor reviewed Resident 1's record.

A medical referral and consultation form, dated 08/14/2023, indicated Resident 1's brace was altered to prevent a pressure sore on his/her knee. The form also indicated Resident 1 was supposed to have the brace on his/her leg during Hoyer lift transfers and off at night. Resident 1's next follow-up appointment would be on 10/11/2023.

Resident 1's ISP, dated 07/20/2023, indicated Resident 1 had a brace for his/her right ankle but not the left leg. The ISP indicated Resident 1 was

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M 412	Continued From page 4	M 412		

to be transferred via Hoyer lift and changed every 2 hours but did not specify the processes to prevent injury. The ISP did not mention range of motion or contracture management for Resident 1.

A physical therapy note, dated 09/08/2023, indicated physical therapy provided staff education on how to work with Resident 1's range of motion, contractures, and positioning to improve Resident 1's comfort and decrease risk of medical complications due to contractures.

An occupational therapy note, dated 09/12/2023, indicated occupational therapy provided staff education how to work with Resident 1's upper extremity contractures, range of motion, and skin integrity. The note indicated occupational therapy provided education to staff on safe transfer strategies with Resident 1 using his/her current Hoyer lift transfer sling.

A physical therapy note, dated 10/04/2023, indicated Resident 1 was being discharged from physical therapy services. The note indicated they recommended staff continue with passive range of motion to bilateral lower extremities with use of pillows or towels to decrease progression of lower extremity contractures. The note stated, "[Resident 1] is not able to extend legs out of B figure four position with PROM (passive range of motion), but ROM (range of motion) did improve at hip, knee and ankle joints allowing improved ease of ADLs (activities of daily living)/cares."

An orthopedic progress note, dated 10/12/2023, stated, "As they are concerned for another pathologic fracture we will have them use [Resident 1's] splint for transfers only. It should be off at all other times."

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M 412	Continued From page 5 Resident 1's ISP did not identify the services staff were to provide to Resident 1 for left leg tibia fracture in regard to when and for how long to wear the left leg brace. Resident 1's ISP also did not identify what staff were supposed to do for his/her contractures, skin integrity, range of motion, transfers, and positioning management to maintain Resident 1's level of function and prevent future injuries.	M 412		