STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009763	A. BUILDING: _____ B. WING _____	C 03/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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N 000	Initial Comments On 03/20/2024, the Bureau of Assisted Living, Southern Regional Office, conducted a complaint investigation at Heritage Court Deer Creek, a community-based residential facility (CBRF) located in New Berlin, WI. As a result of the survey, one deficiency was identified. The deficiency was a repeat deficiency. See Statement of Deficiency (SOD) JUEN11, dated 12/10/2019, and SOD LD2712, dated 04/02/2019. The complaint was unsubstantiated. Census: 26	N 000		
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 record review and interview, the provider did not ensure that Resident 1's	N 389		

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

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individual service plan (ISP) was revised when there were changes in his/her needs and abilities.

Resident 1's ISP was not revised to include fall risk mitigation interventions in accordance with his/her needs and was not revised to include Resident 1's current toileting information. Inconsistent information was provided from interviews by staff and POA H regarding whether Resident 1 was being transferred to the toilet for bladder/bowel needs. Resident 1 was documented as having 6 falls throughout his/her admission (11/28/2023 - 03/20/2024, day of survey), 1 of which resulted in a "minor laceration" and 3 head contusions, and 1 of which resulted in fractures of both his/her left radius and ulna.

This is a repeat deficiency. See Statement of Deficiency (SOD) JUEN11, dated 12/10/2019, and SOD LD2712, dated 04/02/2019.

Findings include:

On 03/20/2024, at approximately 10:00 a.m., Surveyor interviewed Caregiver E. Caregiver E reported that s/he heard about an incident where Resident 1 had fallen in his/her bathroom, but s/he wasn't working then and so wasn't sure of the details. Caregiver E reported that Resident 1 tries to do everything him/herself and didn't always request assistance like s/he was supposed to. Caregiver E reported that Resident 1 used a hoyer lift for all transfers, including those to the toilet. Caregiver E reported that staff were supposed to stay with Resident 1 and supervise him/her after transferring him/her to the toilet.

At approximately 10:05 a.m., Surveyor interviewed Caregiver F. Caregiver F reported

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that Resident 1 has had approximately 2 or 3 falls since s/he began working with the provider, with his/her most recent fall being a couple of weeks ago. Caregiver F reported that approximately 1-1.5 months ago, Resident 1 had fallen and injured his/her wrist, which required stitches. Caregiver F reported that Resident 1 was known to not reliably use his/her call light when s/he required assistance, and that s/he sometimes called out for help. Caregiver F reported that Resident 1 required the assistance of 2 staff and a hoyer for all transfers, including transferring to the toilet. Caregiver F reported that when s/he transferred Resident 1 to the toilet s/he stayed to supervise him/her due to safety.

At approximately 10:22 a.m., Surveyor interviewed Caregiver G. Caregiver G reported that since s/he has been working with the provider a couple of weeks ago, staff have never transferred Resident 1 to the toilet and that Resident 1 was totally dependent on staff for brief changes for all his/her toileting needs. Caregiver G reported s/he was concerned that staff on other shifts, particularly with the overnight (NOC) shift, were not checking Resident 1's brief and changing him/her. Caregiver G reported that during his/her morning rounds yesterday, s/he discovered Resident 1 was in his/her recliner with feces on his/her hands, recliner, and hoyer sling. Caregiver G reported that the feces appeared to be "caked on" and like Resident 1 had been sitting soiled for hours. Caregiver G reported that s/he reported these concerns to Executive Director A. Caregiver G reported that Resident 1 was a known fall risk and that s/he attempts to self-transfer even though s/he requires a hoyer lift for all transfers. Caregiver G reported that Resident 1 did not reliably use his/her call light to request assistance.

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N 389	Continued From page 3 On 03/20/2024, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider on 11/28/2023 with diagnoses including major depressive disorder and unspecified paraplegia. Resident 1 was documented as having an activated power of attorney for healthcare (POA). Surveyor reviewed Resident 1's incident reports from 11/28/2023 - 03/20/2024, where staff documented Resident 1's falls. Surveyor observed the following 6 entries which documented 6 falls in that timeframe, with staff also documenting the updated intervention to Resident 1's ISP after each fall: 1) 11/28/2023 (7:00 p.m.): "On 11/28/23 Around 7pm resident was found sitting on bathroom floor when staff entered apartment...New Action added to ISP: Educate and remind resident of potential fall hazards." 2) 12/30/2023 (11:00 a.m.): "On 12/30/23 around 11am staff heard resident yelling upon entering room staff observed resident laying on [his/her] floor in front of [his/her] wheelchair...New Action added to ISP: Remind to use assistive devices and to use call pendant for assistance if needed." 3) 01/24/2024 (1:49 a.m.): "On 1/24/24 at approximately 0149, resident had an unwitnessed fall in room...During rounds, care staff observed resident sitting on the floor, upright on buttocks in front of recliner facing towards the bed...Resident stated [s/he] was attempting to get in [his/her] wheelchair, when it rolled away from [him/her], resulting in sliding out of recliner to floor...New Action added to ISP: Resident educated on safety awareness." 4) 01/26/2024 (8:00 p.m.): "On 1/26/2024,	N 389		

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resident was in the dining room eating dinner and appeared to be in good spirits. Resident was taken back to [his/her] room in a wheelchair to watch TV at approximately 1800. On 1/26/2024 at 2000, resident alerted staff. Upon entering, staff observed resident in the bathroom; resident was in between the wall and the tiolet[sic]; [his/her] feet were angled towards the shower. Resident's forearm was observed in between the wall and tiolet[sic] grab bar. Residents[sic] hand was ashen and appeared 'darker' in color compared to other hand. Resident's arm visably[sic] deformed. Resident was yelling out; 'Help, it hurts.' Resident was lowered to the ground safely and arm was stabilized until parametics[sic] arrived. 911 called and resident was sent to [local hospital] for further evaluation. Resident was evaluated in the emergency room and was admitted to the hospital..." There was no new action added to Resident 1's ISP per the incident report, however, Surveyor reviewed Resident 1's current ISP, last revised on 03/20/2024, and observed the following related information under the "Falls" heading: "Post Fall 1/26/24: Resident will be transferred with Hoyer lift."

5) 02/10/2024 (7:30 a.m.): "On 2/10/24, resident had an unwitnessed fall in room. Care staff were rounding as first shift began and observed resident laying on floor on right side. Resident was located near the dresser with the TV on top. Wheelchair was located a couple feet away from resident. Writer observed 3 contusions to head. 2 located next to each other on left side of head (upper forehead). The third located on right side of head (upper forehead). Resident has a minor laceration to lower lip (near left side of mouth). Resident stated [s/he] fell getting out of bed. Resident [complained of] head pain, right leg pain, and right shoulder pain...New Action added

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to ISP: Resident is to change from [overnight (NOC)] shift get up to [morning (AM)] get up."

6) 03/07/2024 (7:00 a.m.): "On 3/7/24 around 7 AM during am rounds staff heard yelling from apartment. Upon entering apartment staff observed resident Laying[sic] on the floor on [his/her] right side in front of [his/her] recliner & recliner in stand up position. Resident had [his/her] pendant off of [him/her] laying on the ground in back of [him/her]...New Action added to ISP: Keep recliner in low position at all times and reclined when resting or sleeping."

Surveyor observed that the interventions documented in the above 6 incident reports were also documented in Resident 1's ISP, except for information regarding his/her fall on 02/10/2024. While reviewing Resident 1's ISP, Surveyor observed the following information:

- Under the "Transferring" heading: "Resident is a Hoyer Lift Transfer. Staff provide total assistance with transfers using Hoyer. I use the small/medium/large size sling." This intervention was documented as being initiated on 02/09/2024.

- Under the "Bladder" heading: "INCONTINENT: I am incontinent of bladder. Staff assist me with using the toilet. Staff provide peri-care with toileting and after each incontinence episode..." This intervention was documented as being initiated on 11/21/2023 (around Resident 1's admission) and revised on 02/07/2024.

- Under the "Bowels" heading: "INCONTINENT: I am incontinent of bowel. Staff assist me with using the toilet. Staff provide peri-care with toileting after each incontinence episode." This

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intervention was documented as being initiated on 11/21/2023 (around Resident 1's admission) and revised on 02/07/2024.

- Under the "Falls" heading (besides the interventions documented in the ISP as documented above): "I am at risk for falls and am on the falls management program. Fall interventions include: staff report a change in behaviors/mood/sleep, handrail support in bathroom, promote adequate hydration, adequate lights in apartment, keep eyewear within reach, encourage to wear glasses, and appropriate footwear." These interventions were documented as being imitated on 11/21/2023 (around Resident 1's admission).

- Under the "Wellness Checks" heading: "END OF SHIFT: Staff check on me at the end of their shift." This intervention was documented as being initiated on 11/21/2023 (around Resident 1's admission) and revised on 03/02/2024.

- Under the "Pendant Utilization" heading: "I independently utilize my pendant to call for staff assistance as needed." This intervention was documented as being initiated on 11/21/2023 (around Resident 1's admission) and revised on 02/07/2024.

Surveyor reviewed Resident 1's hospital report from his/her hospitalization after his/her fall on 01/26/2024. An orthopedic surgeon consultation note, dated 01/27/2024, documented that the consult was due to a "left both-bone forearm fracture" as well as the following: "Radiographs were reviewed and show fracture of the radius and ulna. There is significant shortening of the radius. There was comminution [bone broken in 2 or more places] of the ulna."

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N 389	Continued From page 7 Surveyor reviewed Resident 1's progress notes from 01/20/2024 - 03/20/2024, which documented that Resident 1's hospitalization lasted from 01/26/2024 until 02/07/2024. At approximately 1:15 p.m., Surveyor interviewed Quality Specialist C and Director of Nursing B. Director of Nursing B confirmed that while Resident 1 uses his/her call light, s/he does not always use it reliably to request assistance. Director of Nursing B reported that Resident 1 does not transfer to the toilet and has not transferred to the toilet since s/he was last hospitalized around February 2024. Director of Nursing B reported that Resident 1 is totally dependent on staff for brief changes. When asked if Resident 1's brief was checked more than once per shift (per his/her ISP) Director of Nursing B reported that staff are expected to round on Resident 1 and check his/her brief while offering meals to him/her as well, but confirmed that this wasn't documented in his/her ISP. Director of Nursing B acknowledged Surveyor's concern that based on Resident 1's ISP, staff were directed to check on Resident 1 only once per shift. Director of Nursing B confirmed that Resident 1 was a hoyer lift for all transfers, and prior to that, relied on the EZ-stand for all transfers. At approximately 1:46 p.m., Surveyor interviewed Executive Director A, Director of Nursing B, Quality Specialist C, and Regional Operations Director D. Executive Director A reported s/he was unaware of any care concerns brought up by staff regarding Resident 1's cares. In discussing Resident 1's post-fall interventions, all acknowledged Surveyor's concern that fall prevention intervention and call light use	N 389		

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reminders, as documented interventions after Resident 1's first 3 falls, did not appear to address Resident 1's fall prevention needs as s/he was reported by staff to attempt to self-transfer and not reliably use his/her call light. All acknowledged Surveyor's concern that the hoyer lift use for transfers, as documented with Resident 1's post-fall intervention after his/her fourth fall, did not appear to address Resident 1's fall prevention needs as s/he was already requiring assistance by staff for transferring (with EZ stand use) and his/her falls were not related to him/her transferring with staff. All 3 acknowledged Surveyor's concern that it was not clear how changing Resident 1's get-up time, as documented in his/her post fall intervention after his/her fifth fall, would alleviate his/her fall risk as it related to him/her attempting to self-transfer. Other than reporting understanding of Surveyor's concerns that Resident 1's ISP was not updated to reflect fall risk mitigation strategies appropriate to his/her needs, nothing further was said. Quality Specialist C asking Surveyor if s/he knew of additional fall risk mitigation interventions.

At approximately 3:45 p.m., Surveyor interviewed POA H, who was Resident 1's documented activated POA. POA H reported that Resident 1 was still being transferred to the toilet for toileting, even after his/her hospitalization. POA H reported that on 02/13/2024, s/he was visiting Resident 1 and had observed staff assisting him/her to the toilet.

At approximately 4:07 p.m., Surveyor interviewed Caregiver I. Caregiver I reported that s/he was working on 01/26/2024 during one of Resident 1's falls. Caregiver I reported that staff were called to Resident 1's room and s/he was in his/her bathroom. Caregiver I reported that it looked like

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N 389	Continued From page 9 s/he had tried to go to the bathroom by him/herself. Caregiver I reported that s/he does not transfer Resident 1 to the toilet and only transfers him/her to his/her bed for brief changes. Caregiver I reported that s/he didn't think Resident 1 was transferred to the toilet since around the time s/he returned to the provider from the hospital.	N 389		