| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0014922 | A. BUILDING: _____ B. WING _____ | C 11/27/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CARE PARTNERS ASSISTED LIVING EAU CLAIRE EA | 3325 BIRCH STREET EAU CLAIRE, WI 54701 |

| (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<br><br>On 11/27/2024, Surveyor conducted two complaint investigations at Care Partners Assisted Living Eau Claire East.<br><br>One of 2 complaints was substantiated.<br><br>One deficiency was identified.<br><br>Census: 32 | N 000 | | |
| N 388 | 83.35(3)(c) Implement, follow the individual service plan<br><br>Implementation. The CBRF shall implement and follow the individual service plan as written.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the provider did not ensure Resident 1's individual service plan (ISP) was followed as written.<br><br>Findings include:<br><br>On 07/18/2024, the Department received a complaint regarding resident care.<br><br>On 11/27/2024, Surveyor reviewed Resident 1's record, including the ISP and incident reports.<br><br>Resident 1 had an admission date of 06/03/2024 and had the following diagnoses: osteoporosis, vitamin D deficiency and hypothyroidism.<br><br>Resident 1's ISP had an original date of 07/03/2024 and was updated on 07/11/2024 after Resident 1 had a fall with injury. The ISP stated Resident 1 required full assistance with dressing, bathing, and toileting, and will ring when s/he needs to use the restroom. Resident 1 was | N 388 | | |

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0014922 | A. BUILDING: _____ B. WING _____ | C 11/27/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CARE PARTNERS ASSISTED LIVING EAU CLAIRE EA | 3325 BIRCH STREET EAU CLAIRE, WI 54701 |

| (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 388 | Continued From page 1 | N 388 | | |

assessed for evacuation capabilities and the ISP identified Resident 1 was able to safely evacuate with 2-assist to transfer with 1-assist to push the wheelchair.

Surveyor reviewed the daily "Kardex" for Resident 1 for the month of July. The Kardex is an internal document used to show each resident's current care needs and staff are required to initial the Kardex each shift. The July Kardex indicated Resident 1 required "assist of 2 for transfers" and a "sit-to-stand 2-person pivot transfer" for toileting.

Surveyor reviewed an incident report, dated 07/11/2024. The incident report stated Caregiver B assisted Resident 1 to standing position from the toilet when Resident 1's knee buckled, and his/her foot got stuck. Caregiver B lowered Resident 1 to the floor while waiting for another staff to assist. Resident 1 sustained torn skin on his/her foot and ankle, was bleeding, and required surgery to repair the fracture in his/her ankle. The incident was reported by the provider to the Department, as required.

On 11/27/2024 at approximately 1:30 PM, Administrator A stated Resident 1 was a 2-person assist with mobility and transferring. Administrator A informed Surveyor Caregiver B was working and did not follow Resident 1's ISP at the time of the fall because Resident 1 told Caregiver B s/he could transfer him/her alone. Administrator A further stated Caregiver B received a disciplinary action for the incident.

Surveyor reviewed the disciplinary action form, dated 07/11/2024. The disciplinary action form stated Caregiver B did not follow Resident 1's care plan/Kardex and provided 1-assist cares on

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0014922 | A. BUILDING: _____ B. WING _____ | C 11/27/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CARE PARTNERS ASSISTED LIVING EAU CLAIRE EA | 3325 BIRCH STREET EAU CLAIRE, WI 54701 |

| (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 388 | Continued From page 2<br>a resident that required 2-assist, which resulted in injury to the resident. The disciplinary action form was dated and signed by Administrator A and Caregiver B on 07/11/2024. | N 388 | | |