STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018636	A. BUILDING: _____ B. WING _____	C 10/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOW VIEW MANOR	920 WEST 5TH STREET NEILLSVILLE, WI 54456

(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 09/07/2023, Surveyors conducted a 2 complaint investigation and self-report review at Meadow View Manor. Data collection continued through 10/13/2023. Two of 2 complaints were substantiated. Two deficiencies were identified. Census: 6	N 000		
N 348	83.32(3)(d) Rights of Residents: Free from mistreatment In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Freedom from mistreatment. Be free from physical, sexual and mental abuse and neglect, and from financial exploitation and misappropriation of property. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Resident 1 was free from neglect. On 8/29/2023, Caregiver A left Resident 1 unsupervised in the shower with the water running for an unknown period. Resident 1 obtained second degree burns to approximately 25% of his/her body. Findings include: The facility is licensed as a Class CNA (non-ambulatory) community based residential facility (CBRF) able to serve up to 8 residents	N 348		

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

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N 348	Continued From page 1 within the client groups emotionally disturbed/mental illness, correctional clients, traumatic brain injury, developmentally disabled and physically disabled. Neglect, as defined in Wisconsin Statue 46.90(1)(f), is the failure of a caregiver to try to secure or maintain adequate care, services, or supervision for an individual, including food, clothing, shelter, or physical or mental health care. Neglect can be an act, omission, or course of conduct and creates significant risk or danger to the individual's physical or mental health. On 8/30/2023, the department received two complaints stating Resident 1 sustained "severe and possibly life threatening" burns after being left in the shower unsupervised. On 8/30/2023, the department received a self-report stating that on 8/29/2023, Resident 1 was burned after Caregiver A stepped away for possibly 5-10 minutes to get towels, leaving Resident 1 in the shower unattended. Emergency medical services were called and transported Resident 1 to the emergency room (ER). On 09/07/2023 at approximately 9:45 AM, Surveyors toured the facility with Licensee C. During the tour, Licensee C stated that Resident 1 was now deceased. Licensee C did not indicate a known cause of death but stated it was a quality-of-life issue. Licensee C indicated Caregiver A, who showered Resident 1 when the burns occurred, was still on a leave of absence and an internal investigation was completed. On 09/07/2023 at approximately 10:15 AM, Surveyor reviewed Resident 1's records.	N 348		

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N 348	Continued From page 2 Resident 1 was admitted to the provider on 02/03/2014, with diagnoses of legally blind due to retinal detachment, cerebral palsy, chronic constipation, mental retardation, and baclofen intrathecal infusion pump for muscle spasticity. Resident 1 had a guardian. Resident 1's Individual Service Plan (ISP), dated 01/01/2023, indicated the following: Resident 1 required total assistance with all activities of daily living (ADLs) including eating, dressing, transferring, and bathing. Resident 1 used a shower chair and was to be showered at least 3 times per week. Resident 1 was to be transferred via sit-to-stand lift with a special sling by 1 staff person or with a Hoyer lift when needed. In case of an emergency, Resident 1 would be pivot transferred by one staff person and a gait belt. Resident 1 would stiffen up or flail his/her arms when triggered and would throw him/herself out of his/her wheelchair and/or recliner. Resident 1 had overall body tightness and spastic paralysis with limited range of motion in his/her legs and arms. Resident 1 had limited verbal skills and was legally blind. Resident 1 needed 24-hour care and supervision due to physical and cognitive diagnoses. Resident 1's record included an incident report, dated on 08/29/2023, documenting the following: "Staff had assisted [Resident 1] with undressing and transferring into the shower chair that has locking wheels. Staff rolled [Resident 1] into the shower by moving [his/her] shower chair and locked the wheels for [his/her] safety. [Caregiver A] stated that [s/he] turned the water on and tested it to make sure it was the proper temperature and completed showering cares with no incidences.	N 348		

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[Caregiver A] stated that [s/he] stepped away from [Resident 1] to get more towels and was possibly gone for 5-10 minutes. [Caregiver A] stated that when [s/she] returned with the towels, [s/he] found [Resident 1] had burns to [his/her] chest from the water. [Caregiver A] immediately turned the water off and covered [Resident 1] with a light towel, and called the other staff member, [Caregiver B], into the shower for assistance.

[Caregiver A] contacted [Nurse Director (ND) D] for assistance and guidance. [ND D] instructed [Caregiver A] to call 911 for immediate medical attention."

The ambulance report, dated 08/29/2023, indicated a call was received at 9:43 AM from the provider on 08/29/2023. The report indicated that upon emergency personnel's arrival, Resident 1 was sitting in a shower chair in the shower with second degree burns to his/her chest, lower abdomen, and pelvic area. A hydrogel sheet was applied to the burn area and emergency personnel were unable to get Resident 1's vital signs due to his/her cold extremities and his/her arms were jerking and clenching. The burns were over approximately 28% of Resident 1's body.

Medical notes, dated 08/29/2023, indicated Resident 1 was air lifted to another hospital to treat second degree burns to 22% of his/her body on the anterior torso, genitalia, upper inner thighs, bilateral buttocks, right elbow, and right wrist. Resident 1 also had burn related hypovolemic shock. Resident 1 was transferred to a burn unit due to the extent of his/her burns.

Medical notes, dated 08/29/2023, indicated Resident 1 was admitted to the burn unit for 26% TBSA (total body surface area) partial thickness

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burns to his/her chest, right hand, right elbow, left flank, abdomen, groin, genitals, and buttocks. Resident 1 was taken immediately to the operating room and underwent debridement of his/her wounds. The notes stated, "This case presents a unique situation in that [his/her] burns are severe but survivable, however it is likely [s/he] will need excision and grafting for all of them and given the inability to assess [his/her] pain well, [s/he] will likely have a significant amount of pain and stress related to the injury and potential future surgeries as well as complications such as scar contractures. We are unable to communicate what we are doing to [him/her] for [his/her] cares, which also is likely very stressful for [him/her]." The notes stated, "[Resident 1] was not responding well to treatments and prognosis was poor. When family was contacted it was decided that [s/he] would be best served by comfort care. We treated [him/her] pain with IV (intravenous) pain medications and made [him/her] comfortable while withdrawing life extending cares. [Resident 1] passed away at 3:38 am on 9/2/2023."

The discharge summary, dated 09/02/2023, stated, "The patient unfortunately passed away due to the severity of [his/her] burns. We made [him/her] as comfortable as we could in-line with the wishes of [his/her] family."

The preliminary autopsy report indicated Resident 1 was pronounced dead on 09/02/2023 at 3:38 AM. The report indicated Resident 1's death was from the second-degree burns involving approximately 25 % of his/her total body surface. The report indicated Resident 1 also had bilateral pleural effusions, peritonitis with ischemic changes of the cecum, and nephrosclerosis, uterine leiomyoma. The histology and toxicology

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tests were still pending.

The tub bath and shower policy and procedure indicated staff were to obtain towels and supplies prior to bathing a resident. The policy and procedure indicated staff were to check the water temperature to ensure it did not exceed 105 degrees Fahrenheit. The policy and procedure did not indicate if staff should stay with a resident the entire length of bathing.

The abuse, neglect prohibition policy and procedure indicated staff leaving a resident alone when supervision was required would be considered neglect.

At approximately 10:20 AM, Surveyor interviewed Caregiver E. Caregiver E stated s/he had showered Resident 1 multiple times. Caregiver E stated it was protocol to stay with Resident 1 during shower cares. Caregiver E that stated if staff needed a towel during a resident shower, they were located just across the hallway in a closet.

At approximately 10:32 AM, Surveyor interviewed ND D. ND D stated that it was protocol for staff to stay with residents during shower cares or staff were to turn the water off before stepping out. ND D stated that Resident 1 could not move his/her limbs well due to contractures. ND D stated Resident 1 needed full assistance with all aspects of shower cares. ND D stated Resident 1 could vocalize if in pain but was not during the incident.

On 09/07/2023 at 9:00 AM, Surveyor interviewed Police Officer (PO) F. PO F stated s/he was still working through his/her investigation, and it was looking probably criminal in nature due to neglect. PO F stated Caregiver A had left Resident 1

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N 348	Continued From page 6 unattended while showering him/her and a thorough death investigation was conducted with Resident 1's death. PO F stated s/he had interviewed Caregiver A on 09/04/2023 and Caregiver A reported s/he left Resident 1 in the shower room to grab a towel on the other side of the facility. PO F stated Caregiver A ended up taking time to fold laundry and put it away before returning to Resident 1 in the shower. On 09/14/2023 at 10:00 AM, Surveyor interviewed PO F while reviewing the provider's documentation s/he had on hand at the police department and PO F's preliminary police report. PO F stated the 911 call came in at 9:40 AM on 08/29/2023 from the provider. PO F stated his/her interviews concluded Resident 1's shower began at approximately 9:00 AM at the facility. PO F stated the preliminary reports found Caregiver G had arrived at the facility around 9:30 AM and spoke with Caregiver A and Caregiver B while Resident 1 was still in the shower. PO F stated that after Caregiver G left the facility to go next door, Caregiver A went back to check on Resident 1 and found him/her with the burns. PO F stated per the pathologist, Resident 1's presentation of the burns indicated s/he had most likely been burned due to a steady prolonged water exposure. PO F stated Resident 1 could have potentially been left in the shower with the water running for 20 to 30 minutes after s/he had already been washed up. The provider did not ensure Resident 1 was free from neglect when Caregiver A left Resident 1 unsupervised in the shower for 20 to 30 minutes on 08/29/2023. Resident 1 obtained second degree burns to approximately 25% of his/her body and died in the burn unit on 09/02/2023.	N 348		

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N 358	Continued From page 7	N 358		
N 358	83.32(3)(n) Rights of Residents: Safe environment In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Safe environment. Live in a safe environment. The CBRF shall safeguard residents from environmental hazards to which it is likely the residents will be exposed, including both conditions that are hazardous to anyone and conditions that are hazardous to the resident because of the residents ' conditions or disabilities. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure the environment was safeguarded from conditions that are hazardous to residents. On 8/29/2023, Resident 1 sustained second degree burns to approximately 25% of his/her body after being left unsupervised in the shower for an unknown amount of time. Findings include: The facility is licensed as a Class CNA (non-ambulatory) community based residential facility (CBRF) able to serve up to 8 residents within the client groups emotionally disturbed/mental illness, correctional clients, traumatic brain injury, developmentally disabled and physically disabled. On 8/30/2023, the department received two complaints stating Resident 1 had sustained "severe and possibly life threatening" burns after being left in the shower unsupervised. On 08/30/2023, the department received a	N 358		

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self-report indicating that on 08/29/2023, Resident 1 was burned after Caregiver A stepped away for possibly 5 to 10 minutes to get towels, leaving Resident 1 in the shower unattended. Emergency medical services were called and transported Resident 1 to the emergency room (ER).

On 09/07/2023 at approximately 9:55 AM, Surveyor observed the boiler room in the facility basement where the water heater was located. Licensee C stated that right after the incident, they had a service agency come out to inspect the water system. Licensee C stated it appeared an incorrect mixing valve was installed at the last visit from the servicing agency in April 2023. Licensee C stated that s/he regularly tests the water temperature and records readings in the facility logbook.

Resident 1's record included an incident report, dated on 08/29/2023, that documented the following:
"Staff had assisted [Resident 1] with undressing, and transferring into the shower chair that has locking wheels. Staff rolled [Resident 1] into the shower by moving [his/her] shower chair and locked the wheels for [his/her] safety. [Caregiver A] stated that [s/he] turned the water on and tested it to make sure it was the proper temperature and completed showering cares with no incidences.

[Caregiver A] stated that [s/he] stepped away from [Resident 1] to get more towels and was possibly gone for 5-10 minutes. [Caregiver A] stated that when [s/he] returned with the towels, [s/he] found [Resident 1] had burns to [his/her] chest from the water. [Caregiver A] immediately turned the water off, and covered [Resident 1]

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N 358	Continued From page 9	N 358		

with a light towel, and called the other staff member, [Caregiver B], into the shower for assistance.

[Caregiver A] contacted [Nurse Director (ND) D] for assistance and guidance. [ND D] instructed [Caregiver A] to call 911 for immediate medical attention."

The discharge summary, dated 09/02/2023, stated, "The patient unfortunately passed away due to the severity of [his/her] burns. We made [him/her] as comfortable as we could in-line with the wishes of [his/her] family."

The preliminary autopsy report indicated Resident 1 was pronounced dead on 09/02/2023 at 3:38 AM. The report indicated Resident 1's death was from the second-degree burns involving approximately 25 % of his/her total body surface. The report indicated Resident 1 also had bilateral pleural effusions, peritonitis with ischemic changes of the cecum, and nephrosclerosis, uterine leiomyoma. The histology and toxicology tests were still pending.

The temperature log, dated 07/26/2023, indicated four water temperature readings were at 115 degrees Fahrenheit and 117 degrees Fahrenheit within the building. The shower room temperature was 110 degrees Fahrenheit. Surveyor did not receive the August 2023 water temperature log.

A service agency report, dated 11/11/2022, indicated the water system had been inspected and some water heater parts were replaced along with a pipe repair done.

A service agency report, dated 04/21/2023, indicated the water system had been inspected

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N 358	Continued From page 10 and a new indirect storage tank was installed. A service agency report, dated 09/09/2023, indicated a mixing valve was replaced for an anti-scald mixing valve. A master plumber report through the police department, dated 09/05/2023, indicated that the time of inspection, the water heater system appeared to be functioning properly and was set below the allowable maximum temperature for supplied hot water of 115 degrees Fahrenheit. The report stated, "A possible equipment malfunction happened earlier." The tub bath and shower policy and procedure indicated staff were to obtain towels and supplies prior to bathing a resident. The policy and procedure indicated staff were to check the water temperature to ensure it did not exceed 115 degrees Fahrenheit. "Exposure to hot water is a potential environmental danger for clients. Elderly clients and clients with mental and physical disabilities may have neurological conditions that prevent instant recoil from hot water. Because these individuals do not instantly react to dangerous temperature levels, they are at particular risk for injury. Hot water can cause scalding, e.g., second and third degree burns in which the skin blisters and swells. In such instances, skin does not return to normal and forms scar tissue upon healing. These burns may lead to permanent disability. Sustained contact with dangerously hot water can result in second and third-degree burns according to the following thresholds: 110° Fahrenheit 13 Minutes	N 358		

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120° Fahrenheit 10 Minutes
127° Fahrenheit 1 Minute
130° Fahrenheit 30 Seconds
140° Fahrenheit 6 Seconds
158° Fahrenheit 1 Second."
(Source: DQA publication P-01942, Hot Water Temperatures in Adult Family Homes, 08/2017)

On 09/07/2023 at 9:00 AM, Surveyor interviewed Police Officer (PO) F. PO F stated s/he was still working through his/her investigation. PO F stated s/he got 117 degrees Fahrenheit for the shower water temperature when at the facility. PO F stated they contacted a master plumber to look at the facility's water system. PO F stated the master plumber indicated the mixing valve was operating at 110 degrees Fahrenheit. PO F stated the provider had their own plumbers on site to fix the mixing valves.

On 09/14/2023 at 10:00 AM, Surveyor interviewed PO F while reviewing the provider's documentation s/he had on hand at the police department and PO F's preliminary police report. PO F stated the mixing valve should not have made a difference since it was set at 110 degrees Fahrenheit. PO F stated that if the mixing valve had failed, the water temperature could have increased to more than 130 degrees Fahrenheit since this was the temperature the water heater was set at.

On 10/13/2023 at 12:06 PM, Surveyor received an email from Licensee C which stated, "I had the hot water system inspected by a different plumber on Monday 10/9/23. [S/He] found that the scald proof system was missing a component that is required for CBRF code, and it is key to providing protection. The system was missing the automatic high temperature shut off valve. The

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N 358	Continued From page 12 mixing valves at the hot water tank, shower and sink do not automatically adjust, and require a constant temperature to provide protection. Without the high temperature valve the boiler can spike the hot water temperature and all hot water temperatures will increase throughout the facility. The plumber said there are other aspects of the system that need to change to bring it up to DSPS (Department of Safety and Professional Services) codes. The required parts have been ordered by [him/her], and [s/he] stated that they should be here and be installed by next week. Currently, water temperatures are being checked daily to ensure resident safety until the system is fixed." The provider did not ensure the environment was safeguarded from conditions that are hazardous to residents. The facility water system was not in compliance with DHS 83, which led Resident 1 to sustain second degree burns to approximately 25% of his/her body on 08/29/2023 when left in the shower for 20 to 30 minutes unsupervised by staff. Resident 1 died in the burn unit on 09/02/2023.	N 358		