STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017235	A. BUILDING: _____ B. WING _____	R-C 09/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MATTERHAUS	N109 W17000 AVA CIRCLE GERMANTOWN, WI 53022

(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 From 09/12/2023 through 09/14/2023, Surveyor conducted a verification visit and complaint investigation at Matterhaus, a CBRF in Germantown. Four deficiencies were identified. Statement of Deficiency (SOD) F5IE11, dated 04/25/2023, was corrected. The complaint was substantiated. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census: 25	{N 000}		
N 158	83.12(2)(a) Caregiver: Investigating abuse & neglect Investigating and reporting abuse, neglect, or misappropriation of property. Caregiver. 1. When a CBRF receives a report of an allegation of abuse or neglect of a resident, or misappropriation of property, the CBRF shall take immediate steps to ensure the safety of all residents. 2. The CBRF shall investigate and document any allegation of abuse or neglect of a resident, or misappropriation of property by a caregiver. If the CBRF ' s investigation concludes that the alleged abuse, or neglect of a resident or misappropriation of property meets the definition of abuse or neglect of a resident, or of misappropriation of property, the CBRF shall report the incident to the department on a form provided by the department, within 7 calendar days from the date the CBRF knew or should have known about the abuse, neglect, or misappropriation of property. The CBRF shall maintain documentation of any investigation.	N 158		

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

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N 158	Continued From page 1	N 158		

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure documentation was maintained when an investigation of abuse occurred. The provider did not maintain documentation of the investigation which concluded Caregiver C mistreated Resident 1.

Findings include:

On 09/12/2023, Surveyor conducted a complaint investigation alleging caregiver mistreatment occurred at the provider's facility.

On 09/12/2023 at approximately 9:00 a.m., Surveyor reviewed a self-report that stated Caregiver C was being verbally loud with Resident 1 and pushing Resident 1 in an aggressive, fast manner when s/he stopped abruptly, causing Resident 1 to fall from his/her wheelchair on 06/15/2023. The report stated Caregiver C was terminated for caregiver misconduct and verbal abuse.

On 09/12/2023 at approximately 10:00 a.m., Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider's facility on 05/05/2017 with diagnosis including vascular dementia. Resident 1's record included a hospital discharge summary that documented Resident 1 was seen on 06/15/2023 with a nosebleed, head injury, closed fracture nasal bone, facial contusion and contusion of the right wrist.

On 09/12/2023 at approximately 11:00 a.m., Surveyor interviewed Executive Director A. Executive Director A stated Resident 1 had an incident on 06/15/2023 which was initially

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N 158	Continued From page 2 reported as a fall, but after Resident 1's return from the hospital family inquired further about the injuries due to encouragement from a caregiver. Executive Director A stated s/he then interviewed caregivers present during the incident, 1 of which was Caregiver D and held a family meeting. Executive Director A stated upon completion of his/her investigation, Caregiver C was terminated for mistreatment and the self-report, which included the conclusion of the facility's investigation, was submitted to the department. Surveyor requested a timeline and documentation of Executive Director A's investigation, including caregiver interviews. Executive Director A stated s/he did not document the investigation and s/he was unable to provide a timeline of events. On 09/14/2023 at approximately 12:45 p.m., Surveyor interviewed Caregiver D. Caregiver D confirmed s/he worked on 06/15/2023 and witnessed Caregiver C's mistreatment of Resident 1. Caregiver D stated s/he recalled management contacting him/her regarding the mistreatment, but thought it was a few days after the incident occurred. The provider did not maintain documentation of the investigation following Caregiver C's mistreatment of Resident 1. Cross Reference: N0160 DHS 83.12(2)(c) Report To Law Enforcement And Coroner N0348 DHS 83.32(3)(d) Rights of Residents: Free From Mistreatment N0431 DHS 83.38(1)(g) Health Monitoring	N 158		
N 160	83.12(2)(c) Report to law enforcement and coroner	N 160		

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N 160	Continued From page 3 Investigating and reporting abuse, neglect, or misappropriation of property. Other reporting. Filing a report under sub. (1) or (2) does not relieve the licensee or other person of any obligation to report an incident to any other authority, including law enforcement and the coroner. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the obligation to report incidents to law enforcement was fulfilled. The provider did not report Caregiver C's mistreatment of Resident 1 to law enforcement. Findings include: On 09/12/2023, Surveyor conducted a complaint investigation alleging caregiver mistreatment occurred at the provider's facility. On 09/12/2023 at approximately 9:00 a.m., Surveyor reviewed a self-report that stated Caregiver C was being verbally loud with Resident 1 and pushing Resident 1 in an aggressive, fast manner when s/he stopped abruptly, causing Resident 1 to fall from his/her wheelchair on 06/15/2023. The report stated Caregiver C was terminated for caregiver misconduct and verbal abuse. On 09/12/2023 at approximately 10:00 a.m., Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider's facility on 05/05/2017 with diagnosis including vascular dementia. Resident 1's record included a hospital discharge summary that documented Resident 1 was seen on 06/15/2023 with a nosebleed, head injury, closed fracture nasal bone, facial contusion and contusion of the right wrist.	N 160		

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N 160	Continued From page 4 On 09/12/2023 at approximately 11:00 a.m., Surveyor interviewed Executive Director A. Executive Director A stated Resident 1 had an incident on 06/15/2023 which was initially reported as a fall, but after Resident 1's return from the hospital family inquired further about the injuries due to encouragement from a caregiver. Executive Director A stated s/he then interviewed caregivers present during the incident. Executive Director A stated upon completion of his/her investigation, Caregiver C was terminated for mistreatment and the self-report, which included the conclusion of the facility's investigation, was submitted to the department. On 09/12/2023 at 3:40 p.m., Surveyor followed up with Executive Director A to ensure that law enforcement had been updated regarding Caregiver C's mistreatment of Resident 1. On 09/13/2023 at approximately 12:00 p.m., Executive Director A followed up with Surveyor and stated law enforcement was not contacted by the provider. Executive Director A stated s/he told family they could file a police report if they wished and did not give a reason as to why the provider did not contact law enforcement. Cross Reference: N0158 DHS 83.12(2)(a) Caregiver: Investigating Abuse & Neglect N0348 DHS 83.32(3)(d) Rights of Residents: Free From Mistreatment N0431 DHS 83.38(1)(g) Health Monitoring	N 160		
N 348	83.32(3)(d) Rights of Residents: Free from mistreatment In addition to the rights under s. 50.09, Stats.,	N 348		

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N 348	Continued From page 5 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 mistreatment. Resident 1 was mistreated by Caregiver C on 06/15/2023. Findings include: On 09/12/2023, Surveyor conducted a complaint investigation alleging caregiver mistreatment occurred at the provider's facility. On 09/12/2023 at approximately 9:00 a.m., Surveyor reviewed a self-report that stated Caregiver C was being verbally loud with Resident 1 and pushing Resident 1 in an aggressive, fast manner when s/he stopped abruptly, causing Resident 1 to fall from his/her wheelchair on 06/15/2023. The report stated Caregiver C was terminated for caregiver misconduct and verbal abuse. On 09/12/2023 at approximately 10:00 a.m., Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider's facility on 05/05/2017 with diagnosis including vascular dementia. Resident 1's record included the following progress note: - 06/15/2023 2:45 p.m.: Resident had a witnessed	N 348		

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N 348	Continued From page 6	N 348		

fall in the hallway while staff was pushing him/her. Nose was swollen and bruised, small skin tear noted on right hand, small skin tear noted on right forearm, possible hematoma forming on right wrist, hematoma forming on forehead just above bridge of nose. Resident reported, "Everything hurts."
- 06/15/2023 4:00 p.m.: Family present to assess resident and applied pressure dressing to stop bleeding.
- 06/15/2023 6:00 p.m.: Cannot get nose to stop bleeding. Family transporting resident to ER.
- 06/16/2023 3:30 a.m.: Returned from ER at around 10:30 p.m. and staff were told resident had a broken nose. Resident continued to bleed heavily from his/her nose. Staff held pressure with ice. Resident had coughed and spit out blood. Resident had blood clot sticking out of his/her nose that was approximately 1 inch, which prevented staff from administering medication into resident's nostril. Resident was transferred back to the hospital and spit out a large amount of blood while exiting the facility.
- 06/16/2023 8:45 a.m.: Returned from the emergency room.
*No documentation of incident involving alleged abuse.

On 09/12/2023 at approximately 10:15 a.m., Surveyor reviewed a hospital discharge summary that documented Resident 1 was seen on 06/15/2023 with a nosebleed, head injury, closed fracture nasal bone, facial contusion and contusion of the right wrist. Surveyor reviewed pictures provided by Resident 1's family to Executive Director A on 06/19/2023 that showed bruising to Resident 1's forehead, right eye, left eye, nose and chest, along with a bandaged nose and dried blood to Resident 1's forehead and nose (Photo 1, Photo 2, Photo 3).

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N 348	Continued From page 7 On 09/12/2023 at approximately 11:00 a.m., Surveyor interviewed Executive Director A. Executive Director A stated Resident 1's incident on 06/15/2023 was initially reported as a fall, but after Resident 1's return from the hospital family inquired further about the injuries due to encouragement from a caregiver. Executive Director A stated s/he then interviewed caregivers present during the incident, 1 of which was Caregiver D. Executive Director A stated upon completion of his/her investigation, Caregiver C was terminated for mistreatment of Resident 1, which was summarized in his/her self-report. On 09/14/2023 at 12:45 p.m., Surveyor interviewed Caregiver D. Caregiver D stated s/he was working with Caregiver C on 06/15/2023. Caregiver D stated Resident 1 was "having a moment." Caregiver D stated Resident 1 tried to fight him/her and the other caregivers. Caregiver C stated Caregiver D grabbed Resident 1's wheelchair and pushed Resident 1 aggressively down the hall. Caregiver C stated Resident 1 yelled, "Stop ... Where are you taking me?" Caregiver C stated Resident 1 was being very mean and when the wheelchair stopped, Resident 1 "flew out of the chair." Caregiver C stated, "I'd never seen anything like that." On 07/15/2023, Resident 1 was mistreated by Caregiver C. Cross Reference: N0158 DHS 83.12(2)(a) Caregiver: Investigating Abuse & Neglect N0431 DHS 83.38(1)(g) Health Monitoring N0160 DHS 83.12(2)(c) Report To Law Enforcement And Coroner	N 348		

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N 431	Continued From page 8	N 431		
N 431	83.38(1)(g) Health monitoring. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident ' s highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Health monitoring. 1. The CBRF shall monitor the health of residents and make arrangements for physical health, oral health or mental health services unless otherwise arranged for by the resident. Each resident shall have an annual physical health examination completed by a physician or an advanced practice nurse as defined in s. N 8.02(1), unless seen by a physician or an advanced practice nurse as defined in s. N 8.02(1) more frequently. 2. When indicated, a CBRF shall observe residents ' food and fluid intake and acceptance of diet. The CBRF shall report significant deviations from normal food and fluid intake patterns to the resident ' s physician or dietician. 3. The CBRF shall document communication with the resident ' s physician and other health care providers, and shall record any changes in the resident ' s health or mental health status in the resident ' s record. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the physical and mental	N 431		

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health of 1 of 1 residents reviewed was monitored and documented in the resident's record. The physical and mental health of Resident 1 was not monitored or documented in his/her record after being mistreated by Caregiver C.

Findings include:

On 09/12/2023, Surveyor conducted a complaint investigation alleging physical abuse occurred at the provider's facility.

On 09/12/2023 at approximately 9:00 a.m., Surveyor reviewed a self-report that stated Caregiver C was verbally loud with Resident 1 and pushing Resident 1 in an aggressive, fast manner when s/he stopped abruptly, causing Resident 1 to fall from his/her wheelchair on 06/15/2023. The report stated Caregiver C was terminated for caregiver misconduct and verbal abuse.

On 09/12/2023 at approximately 10:00 a.m., Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider's facility on 05/05/2017 with diagnosis including vascular dementia. Resident 1's record included the following progress note:

- 06/15/2023 2:45 p.m.: Resident had a witnessed fall in the hallway while staff was pushing him/her. Nose was swollen and bruised, small skin tear noted on right hand, small skin tear noted on right forearm, possible hematoma forming on right wrist, hematoma forming on forehead just above bridge of nose. Resident reported, "Everything hurts."
- 06/15/2023 4:00 p.m.: Family present to assess resident and applied pressure dressing to stop bleeding.

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- 06/15/2023 6:00 p.m.: Cannot get nose to stop bleeding. Family transporting resident to ER.
- 06/16/2023 3:30 a.m.: Returned from ER at around 10:30 p.m. and staff were told resident had a broken nose. Resident continued to bleed heavily from his/her nose. Staff held pressure with ice. Resident had coughed and spit out blood. Resident had blood clot sticking out of his/her nose that was approximately 1 inch, which prevented staff from administering medication into resident's nostril. Resident was transferred back to the hospital and spit out a large amount of blood while exiting the facility.
- 06/16/2023 8:45 a.m.: Returned from the emergency room.
- 06/16/2023 10:15 a.m.: After Visit Summary from ER received. Resident prescribed Augmentin.
- 06/16/2023 2:15 p.m.: Exam done post ER visit. Nose fracture and continued bleeding. Bruising noted to face and arms. Resident appears comfortable.
- 06/19/2023 1:30 p.m.: Checked on resident due to his/her fall last week. Resident has bruising to bilateral eyes and nose. Resident verbally denies pain but is showing non-verbal signs of pain that family is noticing as well. Note that resident is acting per baseline but is more crabby than usually today - likely due to pain ... Received order for Tramadol 50 mg - Take 1 tab by mouth at bedtime for 3 days for acute pain and Tramadol 50 mg - Take 1 tablet every 6 hours as needed for pain.

*Documentation did not include record of abuse.

On 09/12/2023 at approximately 10:15 a.m., Surveyor reviewed a hospital discharge summary that documented Resident 1 was seen on 06/15/2023 with a nosebleed, head injury, closed fracture nasal bone, facial contusion and

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contusion of the right wrist. Surveyor reviewed pictures provided by Resident 1's family to Executive Director A on 06/19/2023 that showed bruising to Resident 1's forehead, right eye, left eye, nose and chest, along with a bandaged nose and dried blood to Resident 1's forehead and nose (Photo 1, Photo 2, Photo 3).

On 09/12/2023 at approximately 11:00 a.m., Surveyor interviewed Executive Director A. Executive Director A stated Resident 1's incident on 06/15/2023 was initially reported as a fall, but after Resident 1's return from the hospital family inquired further about the injuries due to encouragement from a caregiver. Executive Director A stated s/he then interviewed caregivers present during the incident, 1 of which was Caregiver D. Executive Director A stated upon completion of his/her investigation, Caregiver C was terminated for mistreatment and the self-report, which included the conclusion of the facility's investigation, was submitted to the department. Surveyor requested documentation of the abuse Resident 1 sustained and record of health monitoring following the abuse. Executive Director A stated documentation of the abuse included the self-report submitted to the department and health monitoring was included in the progress notes reviewed above. Surveyor reviewed progress notes with Executive Director A and shared concern that record did not document abuse that occurred, did not document monitoring of all injuries sustained and did not document monitoring of Resident 1's mental health after being the victim of mistreatment. Surveyor also shared concern that no documentation of Resident 1's physical health, including pain, was documented between 06/16/2023 and 06/19/2023 and that on 06/19/2023, Resident 1 was observed with

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non-verbal signs of pain. Executive Director A stated monitoring may have taken place in the caregiver task log. Executive Director A then logged into Resident 1's electronic record to review Resident 1's task log and medication administration record (MAR) and stated there was no additional documentation of monitoring Resident 1's physical and mental health. Resident 1's MAR indicated s/he received Acetaminophen 500 mg 2 tablets 3 times daily (Start Date: 04/21/2023), but did not receive any additional scheduled or as needed pain medication until Tramadol orders were received on 06/19/2023.

On 09/14/2023 at approximately 12:45 p.m., Surveyor interviewed Caregiver D. Surveyor asked Caregiver D if other caregivers were made aware of the mistreatment Resident 1 endured on 06/15/2023 and if caregivers were instructed to monitor him/her for the physical and mental affects. Caregiver D stated staff found out about the mistreatment by talking amongst themselves. Caregiver D stated there were no additional instructions related to the health monitoring of Resident 1.

Cross Reference: N0158 DHS 83.12(2)(a) Caregiver: Investigating Abuse & Neglect
N0160 DHS 83.12(2)(c) Report To Law Enforcement And Coroner
N0348 DHS 83.32(3)(d) Rights of Residents: Free From Mistreatment