STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020466	A. BUILDING: _____ B. WING _____	C 01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADAVA CARE OF PEWAUKEE CBRF	1109 CECELIA DRIVE PEWAUKEE, WI 53072

(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 01/08/2025, with information obtained through 01/24/2025, the Bureau of Assisted Living, Southern Regional Office, conducted a complaint investigation at Adava Care of Pewaukee CBRF, a community-based residential facility (CBRF) located in Pewaukee, WI. As a result of the survey, 1 deficiency was identified. The complaint was unsubstantiated. Census: 11	N 000		
N 161	83.12(3)(a) Investigate injuries of unknown source. Investigating injuries of unknown source. A CBRF shall investigate any of the following: 1. An injury that was not observed by any person. 2. The source of an injury to a resident that cannot be adequately explained by the resident. 3. An injury to a resident that appears suspicious because of the extent of the injury or the location of the injury on the resident. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that an investigation into bruising of unknown source on Resident 1's thigh(s), of which s/he was not able to explain, was investigated. Findings include: On 01/08/2025, at approximately 9:33 a.m., Surveyor interviewed Administrator A regarding Resident 1's needs. Administrator A reported that Resident 1 was verbal but could not be	N 161		

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

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understood. At this time, while requesting various records, Surveyor requested documentation of all investigations the provider completed for injuries of unknown source for any residents.

At approximately 10:30 a.m., Administrator A confirmed s/he only had 1 investigation, which related to an incident of bilateral shin bruising that was discovered on Resident 1 back on 11/05/2024. Administrator A confirmed s/he had no other investigations of injuries of unknown source.

At approximately 10:59 a.m., Surveyor attempted to interview Resident 1. Resident 1 was unable to answer Surveyor's questions appropriate to context, including yes/no questions. Surveyor was unable to establish reliable non-verbal communication with Resident 1, such as shaking head yes/no.

In reviewing the investigation documents provided by Administrator A, Surveyor reviewed a document that was not labeled with a date or time but appeared to be a narrative of an event. The statement's author was identified as Caregiver C. The statement documented, "So yesterday our resident [Resident 1]] fall [sic] in common area and we call [Resident 1's legal representative] so follow the protocol . [sic] that's [sic] happen close 6;30 [sic] pm and [legal representative] came in after 9;40 [sic] pm and investigating. [S/he] ask a lot [sic] of question [sic] to me and my other co worker too then [s/he] go in front and asking question [Associate Administrator B] too.after [sic] that our 3rd shift here i [sic] am counting with them and leaving but [legal representative] want to show us something then me and [Associate Administrator B] go [Resident 1] room together then [legal representative] showing us [his/her]

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bsuice [sic] and asking how that happen..."

At approximately 11:51 a.m., Surveyor interviewed Associate Administrator B about the above statement. Associate Administrator B reported that the incident above was not the same bruising that was discovered on 11/05/2024, but occurred on a day that Resident 1 had a fall. Associate Administrator B reported that the bruise Resident 1's legal representative showed him/her and Caregiver C was located on Resident 1's inner thigh.

At approximately 1:37 p.m., Surveyor reviewed an incident report for Resident 1, provided by Associate Administrator B. Associate Administrator B reported that the report was related to the same fall referenced in Caregiver C's statement. The report documented that on 12/01/2024 at 6:54 p.m., "medpasser heard resident say 'oh [expletive]' when medpasser looked, [s/he] seen resident on the floor on [his/her] bottom in the common area. No noticeable injuries." A body chart within the report was blank, indicating no observed injuries to Resident 1's body. Surveyor observed that the manner of how Resident 1 fell (being found on his/her bottom) did not correlate with any involvement to his/her inner thigh bruising.

On 01/08/2025, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider on 10/10/2024 with diagnoses including unspecified psychosis, Alzheimer's disease, hemiplegia and hemiparesis status post cerebral infarction affection left dominant side, and failure to thrive. Resident 1 was documented as having an activated power of attorney for healthcare. Resident 1's initial assessment, dated 10/10/2024, documented that s/he had difficulty

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communicating, required regular prompting due to confusion and disorientation, and had no skin issues. Resident 1's current individual service plan (ISP), dated 10/10/2024, documented that staff assisted Resident 1 with reorientation and redirection as well as assistance to ensure communication needs/wishes were met.

On 01/10/2025, Surveyor reviewed "Resident Service Notes" for Resident 1 from 10/10/2024 (his/her admission date) through 01/07/2025, provided by Associate Administrator B. Surveyor observed the following entry dated 11/23/2024: "While I was putting [him/her] back into bed after toileting [him/her] and I noticed a greenish color bruse [sic] in [his/her] inner thigh of [his/her] left leg." Surveyor observed that this entry was made approximately 1 week prior to the fall Resident 1 experienced on 12/01/2024.

Another entry on 11/30/2024 by Associate Administrator B documented, "When giving resident a shower this AM, writer noticed a quarter-size bruise on residents inner left thigh. At first it looked like a shadow but after looking @ it again you can see it was a newer looking bruise. Writer notified [his/her] case manager via email. Writer also notified the Admin." No other entries were made regarding the bruise or any follow up assessment or investigation that was done into its source.

On 01/24/2025, Surveyor reviewed outside medical records obtained for Resident 1, which included a visit note from a visit Resident 1 had with his/her medical provider on 12/31/2024. The note documented that Resident 1 presented to the clinic with his/her legal representative, Power of Attorney (POA) D, "for concerns about bruising." The report documented that on

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N 161	Continued From page 4 12/01/2024, POA D had concerns about a bruise that was reported and observed by him/her on his/her inner right thigh, approximately quarter-sized. On 01/24/2025, at approximately 2:46 p.m., Surveyor interviewed Administrator A and Regional Director of Operations E. Both acknowledged Surveyor's concern about the lack of investigation done into Resident 1's thigh bruising after it was observed by staff. Regional Director of Operations E reported that changes were being made in how this sort of tracking/monitoring would be done by staff. Regional Director of Operations E reported that resident service notes would be reviewed daily for any changes so that changes documented could be appropriately followed up on.	N 161		