

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0016972	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/25/2022
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NAME OF PROVIDER OR SUPPLIER CLIFDEN COURT NORTH	STREET ADDRESS, CITY, STATE, ZIP CODE 6801 W LOOMIS RD GREENDALE, WI 53129
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N 000	Initial Comments On 08/24/2022, Surveyor completed 3 complaint investigations at Clifden Court North. As a result, 3 deficient practices were identified and 3 complaints were substantiated. Census: 17	N 000		
N 169	83.12(5)(a) Notification: incident, injury, changes. The CBRF shall immediately notify the resident's legal representative and the resident's physician when there is an incident or injury to the resident or a significant change in the resident's physical or mental condition. This Rule is not met as evidenced by: Based on record review and interview, the provider did not notify Resident 1's legal representative when Resident 1 sustained an injury and was sent to the hospital for treatment. Findings include: On 05/26/2022 and 06/21/2022, the Department received complaints alleging the provider did not notify a resident's responsible party when a resident sustained an injury and was sent to the hospital. On 08/24/2022, at approximately 1:00 PM, Surveyor reviewed Resident 1's record and identified the following:	N 169		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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N 169	<p>Continued From page 1</p> <p>Resident 1 was admitted on 02/02/2022. Resident 1's resident information sheet, dated 02/23/2022, identified Resident 1's power of attorney for health care (POAHC) was activated.</p> <p>Resident 1's Statement of Incapacity for the POAHC was signed and dated on 01/03/2022 and 01/21/2022.</p> <p>A witness statement, from the incident on 05/18/2022, where Resident 1 sustained a fall with injuries including fractures, signed by Caregiver C, stated, "I attempted several times to get access [sic] to the computer to contact [Resident 1] family but the computer was down. I wasn't [sic] able to print off an information or view any information on the computer."</p> <p>An investigation report, dated 05/23/2022, conducted by the Former Executive Director B, stated, "[Caregiver C] looked in ECP (Medication pass system that has resident face sheet) the system was not bringing up the face sheet so [s/he] could not call the family about the fall at that time."</p> <p>On 08/24/2022, at approximately 3:45 PM, Surveyor interviewed Executive Director (ED) A regarding the provider's notification process. ED A reported s/he could not speak to the incident as it occurred prior to the current management staff. ED A reported the current notification process was staff or management would notify the resident's primary contact (designated responsible party) and physician at the time of the incident, after the emergency was handled.</p> <p>On 08/24/2022, at approximately 4:30 PM, Surveyor interviewed POAHC D via e-mail. POAHC D confirmed s/he was not notified by the</p>	N 169		

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N 169	Continued From page 2 provider when Resident 1 was hospitalized.	N 169		
N 389	<p>83.35(3)(d) Service plans updated annually or on changes</p> <p>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.</p> <p>This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 1 resident's Individual Services Plan (ISP) was reviewed and updated with changes and/or annually. Resident 2's ISP was due for an annual update in 03/2021 and was not updated. Resident 2's ISP was not updated when Resident 2 had falls.</p> <p>Findings include:</p> <p>On 06/21/2022, the department received a complaint a resident fell and sustained a broken hip.</p> <p>On 08/24/2022, at approximately 2:02 PM, Surveyor reviewed Resident 2's record. Resident 2 was admitted to the facility on 02/05/2020.</p>	N 389		

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N 389	Continued From page 3 Resident 2's ISP was dated 03/05/2020. Resident 2's ISP was due for annual update in 03/2021 and was not updated. Resident 2 sustained a fall on 09/23/2021. Resident 2's's ISP was not updated. On 11/09/2022, Resident 2 fell and was admitted to the hospital with a broken hip. On 08/24/2022, at approximately 3:45 PM, Surveyor interviewed Executive Director (ED) A. ED A reported s/he was not with the facility at that time. ED A and the current management team were recently hired to manage the facility. ED A confirmed s/he was aware of the code requirement for ISP updates. ED A reported the management company was implementing strategies to ensure the provider was in compliance with the code requirements.	N 389		
N 415	83.37(2)(d) Documentation of medication administration. Documentation of medication administration. As required under s. DHS 83.42(1)(o), at the time of medication administration, the person administering the medication or treatment shall document in the resident record the name, dosage, date and time of medication taken or treatments performed and initial the medication administration record. Any side effects observed by the employee or symptoms reported by the resident shall be documented. The need for any PRN medication and the resident ' s response shall be documented. This Rule is not met as evidenced by: Based on record review and staff interview, the provider did not ensure each person	N 415		

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N 415	<p>Continued From page 4</p> <p>administering medications to residents, initial the medication administration record to identify the name, dosage, date and time each medication administered for 1 of 1 resident. Resident 1's medication administration record (MAR) from February 2022 to May 2022 were missing staff initials from multiple administration dates and times for Resident 1's prescribed eye drops.</p> <p>Findings include:</p> <p>On 06/21/2022, the Department received a complaint alleging a resident did not consistently receive her/his prescribed eye drops.</p> <p>On 08/24/2022 at approximately 11:15 a.m., Surveyor reviewed Resident 1's record and identified the following:</p> <p>Resident 1 was admitted on 02/02/2022, with diagnoses including glaucoma, combined forms of age-related cataract and dry eye syndrome.</p> <p>Resident 1's individual service plan, dated 05/23/2022, indicated Resident 1 required staff assistance/administration of medications.</p> <p>Resident 1's medication administration record (MAR) for February 2022 through May 2022 indicated Resident 1 received prescription eye drops twice per day.</p> <p>1. Dorzolamide Hydrochloride 2% eye drops, instill 1 drop in left eye 2 times per day (8:00 AM and 8:00 PM). Missed documentation for the 8:00 AM dose between 02/06/2022 to 05/20/2022 were observed on the following dates: 04/04/2022, 04/08/2022, 04/09/2022, 04/10/2022, 04/11/2022, 04/14/2022, 05/01/2022, 05/05/2022, 05/06/2022,</p>	N 415		

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N 415	<p>Continued From page 5</p> <p>05/11/2022, 05/12/2022, 05/14/2022, 05/17/2022, and 05/19/2022. Total of 14 missed documentation doses.</p> <p>Missed documentation for the 8:00 PM dose between 02/06/2022 to 05/20/2022 were observed on the following dates: 03/01/2022, 03/03/2022, 03/04/2022, 03/05/2022, 03/06/2022, 03/07/2022, 03/08/2022, 03/09/2022, 03/10/2022, 03/11/2022, 03/14/2022, 03/15/2022, 03/18/2022, 03/19/2022, 03/20/2022, 03/23/2022, 03/24/2022, 03/25/2022, 03/28/2022, 03/29/2022, 03/31/2022, 04/01/2022, 04/03/2022, 04/04/2022, 04/08/2022, 04/23/2022, 05/04/2022, 05/07/2022, 05/12/2022, 05/13/2022, 05/16/2022, 05/19/2022, and 05/20/2022.</p> <p>Total of 33 missed documentation doses.</p> <p>2. Latanoprost 0.005% drops, instill 1 drop in both eyes at bedtime (8:00 PM). Missed documentation for the 8:00 PM dose between 02/06/2022 to 05/20/2022 were observed on the following dates: 03/01/2022, 03/03/2022, 03/04/2022, 03/05/2022, 03/06/2022, 03/07/2022, 03/08/2022, 03/09/2022, 03/10/2022, 03/11/2022, 03/14/2022, 03/15/2022, 03/18/2022, 03/19/2022, 03/20/2022, 03/23/2022, 03/24/2022, 03/25/2022, 03/28/2022, 03/29/2022, 03/31/2022, 04/01/2022, 04/03/2022, 04/04/2022, 04/08/2022, 04/23/2022, 05/04/2022, 05/07/2022, 05/12/2022, 05/13/2022, 05/16/2022, 05/19/2022, and 05/20/2022.</p> <p>Total of 33 missed documentation doses.</p> <p>On 08/24/2021, approximately 3:45 PM, Surveyor interviewed Executive Director (ED) A and Vice President of Operations (VPO) E regarding Resident 1's MARs not containing initials of the</p>	N 415		

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N 415	Continued From page 6 staff on the dates the medications were administered. ED A and VPO E confirmed the MARs contained blank dates when Resident 1's eye drops were to be administered. ED A reported there was a new management team and could not speak to the reason the MARs contained blank dates. VPO E reported the current management team implemented new safeguards regarding medication administration and documentation. VPO E reported the new medication documentation system alerted management/leads if the prescribed medication was not initialed by staff at the time of administration.	N 415		