Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0019340	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARVEST HOME GRAFTON	**1706 WASHINGTON ST , GRAFTON, Wisconsin, 53024**

(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) COMPLETION DATE
N0000	Initial Comments On 09/02/2026, Surveyor conducted two (2) complaint investigations at Harvest Home Grafton. Additional information was gathered through 09/03/2026. As a result of the survey 1 of 2 complaints was substantiated, resulting in 1 deficiency. Census: 13	N0000		
N0388	Implement, follow the individual service plan 83.35(3)(c) Implementation. The CBRF shall implement and follow the individual service plan as written. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on record review, and interview, the provider did not ensure the individual service plans (ISPs) for Resident 1 was implemented and followed as written. Resident 1's ISP directed staff to assist Resident 1 with transferring with a Hoyer and two staff. Findings include: On 07/30/2026, the Department received a complaint alleging Resident 1 had bruise of unknown origin. On 09/02/2026, Surveyor requested Resident 1's record from LPN A and Director of Operations (DOO) B. Resident 1's record identified the following: -Resident 1 was admitted to the facility on 04/07/2025 with diagnosis' including dementia, Alzheimer's disease and depression. -Resident 1's ISP dated 05/07/2026 documented:	N0388		

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

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N0388	Continued from page 1 *Transferring - Staff Assistance - Hoyer - Instructions "Resident requires two staff and a Hoyer for all transfers. Resident non weight bearing. Resident has a broda chair." *Staff charting - 05/26/2026 "Residents right knee appeared to be swollen and painful. Hospice completed a visit Monday d/t right knee pain." On 09/02/2026 at 11:45 AM, Surveyor interviewed LPN A and DOO B. LPN A stated they investigated Resident 1's bruise of unknown origin. The investigation showed: *On 05/27/2026 DOO B interviewed Caregiver C. Caregiver C stated s/he was not aware of a fall but did confirm s/he did transfer Resident 1 by his/herself with the Hoyer. *On 05/26/2026, DOO B interviewed Caregiver D and s/he confirmed when s/he walked into Resident 1's room, Resident 1 was already transferred into bed. Caregiver D stated when s/he entered the room Caregiver C asked him/her to look at Resident 1's right knee. *On 05/26/2026, DOO B interviewed Caregiver E. Caregiver E stated s/he saw Caregiver C take Resident 1 from the dining room after lunch to his/her room. Caregiver E stated s/he headed to Resident 1's room to help but the door was locked. Caregiver E stated s/he went to help another resident and then received a call over the walkie talkie saying you need to come to Resident 1's room and look at his/her knee. Surveyor requested Caregiver C's record. Caregiver C received disciplinary action on 06/04/2026 for "Failure to know and follow proper procedures for lifting, transferring and/or other potentially hazardous tasks associated with job performance." "Using equipment or supplies in an unsafe manner." Caregiver C was reeducated on proper procedures for lifting and transferring residents using proper devices per care plan. On 07/09/2026, Caregiver C was terminated - management was informed that Caregiver C improperly transferred a resident by lifting him/her around the waist instead of using the designated sit-to-stand lift. Caregiver C had	N0388		

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N0388	Continued from page 2 previously been counseled regarding this same issue on 06/042026. Performing unsafe transfers is a direct violation of the Standards of Conduct, which states: "Failure to know and follow proper procedures for lifting, transferring, and/or other potentially hazardous tasks associated with job performance." The provider did not implement Resident 1's ISP as written.	N0388		