STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016733	A. BUILDING: _____ B. WING _____	R 12/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE POINTE VILLA ASSISTED LIVING	190 LAKE POINTE DRIVE OSHKOSH, WI 54904

(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 12/10/2024, Surveyors conducted a verification visit at Lakepoint Villa Assisted Living. One (1) of 2 deficiencies was uncorrected and 1 new citation identified. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census: 18	{N 000}		
{N 389}	83.35(3)(d) Service plans updated annually or on changes 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. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Resident 2's individual service plan (ISP) was updated based on assessment to meet his/her needs for fall prevention. Between 10/01/2024 and 11/28/2024, Resident 2 experienced 8 falls. Resident 2's ISP dated 09/30/2024, was not updated to identify	{N 389}		

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

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{N 389}	Continued From page 1 interventions to mitigate his/her risk of falls. This is a repeat deficiency. See Statement of Deficiency XEPV11, dated 07/15/2024. Findings include: Surveyor reviewed Resident 2's complete record on 12/10/2024 at approximately 12:30 pm. Resident 2 was admitted to the facility on 11/08/2021 with diagnoses including bipolar disorder, major depressive disorder, idiopathic progressive neuropathy, personality change due to known physiological condition and disorder of the brain, unspecified. The most current ISP signed and dated 09/30/2024 by resident's POA and facility staff read in part, " ... the resident was educated on the importance of waiting for staff to arrive before standing up to transfer...resident has bed alarm, alarm to be placed out of reach for resident to prevent from shutting off, door open at all times ...Resident is to have chair alarm at all times when in wheelchair, should be connected to shirt ...was re educated [sic] on the importance of using the call light for assistance and to not think [s/he] is trouble at all." Surveyor noted that there were 8 falls recorded after the ISP was signed on 09/30/2024. The record did not contain post fall assessments and there were no updates to the ISP after 09/30/2024. Documentation of falls in observation and incident reports: - 10/01/2024 8:30 AM - " ...Resident had a fall in [his/her] room. ... Resident was sitting on [his/her] butt by [his/her] bed ...Resident states that [s/he] missed The wheelchair and landed on [his/her] butt. - 10/03/2024 9:15 AM - " ...Resident had a fall in	{N 389}		

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{N 389}	Continued From page 2	{N 389}		

[his/her] room during a transfer. [S/he] pulled [his/her] cord while falling Staff walked in right away and seen [sic] [him/her] laying on [his/her] side trying to slowly get up off the floor ..."
- 10/12/2024 7:30 AM- " ...Resident had a fall in the bathroom. caregiver J told Med tech that resident fell while [s/he] was drying resident off after [his/her] shower ..." The report also read, "What interventions were added to the service plan if any - Will look into possibly getting a non-slip grip for the shower floor."
- 10/24/2024 6 PM - " ...Resident pushed [his/her] call button that was around [his/her] neck, Med passer asked what happened. Resident stated [s/he] was reaching for popcorn on the floor and [s/he] fell out of [his/her] w/c. ...What interventions were added to the service plan if any - All interventions are put in place correctly."
- 11/04/2024 10:00 AM - " ...resident alarms were going off when staff walked in, they found [him/her] sitting on the floor by the bed. ...What interventions were added to the service plan if any - all interventions are appropriate for this"
- 11/17/2024 8:24 PM - " ...Staff heard a loud band [sic] and went into resident's bathroom and found [him/her] laying face down on [his/her] bathroom floor. Staff asked resident what happened and [s/he] said "I dropped it and was reaching for it and fell". Staff found the tube of polident [sic] on the floor by the sink ..."
- 11/23/2024 8:30 PM - " ...When writer entered residents [sis] room resident was laying on [his/her] stomach with [his/her] head towards [his/her] closet and [his/her] body by the foot of the bed. When writer asked what happened, resident stated [s/he] was trying to pick [his/her] shoe off of the ground ...' No incident report noted for this incident.
- 11/28/2024 9:45 AM - " ...MT (med tech) and CG (caregiver) were helping resident transfer

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{N 389}	Continued From page 3	{N 389}		

from bed to chair when residents legs gave out and [s/he] fell on [his/her] right knee and left foot ...MT (med tech) and CG (caregiver) got resident up and into WC (wheel chair.)" "What interventions were added to the service plan if any? :: (Left blank)"

Surveyors interviewed Resident 2 on 12/10/2024 at 10:35 AM. Resident 2 was seated in his/her room in a wheelchair. Resident 2 states that s/he has pain in both feet due to hurting them after falls. Resident 2 showed surveyors the braces that were on both feet and stated one ankle was fractured and the other was sprained. Surveyors asked Resident 2 about the call button around his/her neck. S/he stated that s/he could press that when they needed anything and the aides would come in the room to assist. Surveyors observed a sign on transfer pole next to the bed reminding [him/her] to call for help before transferring. At approximately 1:00 PM surveyor entered Residents 2's room with Resident 2's Power of Attorney (POA I). Surveyor observed a bed alarm. POA I stated that the same alarm is used when resident is in bed or seated on his/her couch. POA I also stated Resident 2 should have a chair alarm clipped to his/her clothing when in the wheelchair. Surveyor and POA I then went to talk with Resident 2 in the common area. Surveyor observed the chair alarm clip was broken and not attached to Resident 2's clothing, rendering the alarm ineffective.

Surveyors interviewed POA I on 12/10/2024 at 12:05 PM. POA I confirmed Resident 2 had multiple falls in recent months. S/he said after the fall on 10/24/2024 Resident 2 sustained a fractured right ankle and during the fall on 11/28/2024 s/he sustained a sprained left ankle. POA I also explained Resident 2 experienced

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{N 389}	Continued From page 4	{N 389}		

recent changes in condition to include an increased tendency to self-transfer and increased irritability. POA I stated s/he was actively working with Resident 2's medical providers to identify the potential medical causes for the changes POA I confirmed that there was no new ISP discussed or signed since 09/30/2024.

Surveyors interviewed Assistant Exec Director D and Wellness Director K on 12/10/2024 at 1:30 PM. Assistant Exec Director D confirmed there were no post fall assessments completed and no updates to the ISPs following the falls noted above. Both Assistant Exec Director D and Wellness Director Y stated they are new in their respective roles and both plan to implement corrections to ensure ISPs are updated as required.

Surveyor note: According to the publication titled "Falls in Assisted Living Facilities" last revised 02/2022, "Falls resulting in serious injury or death continue to occur in assisted living settings. For this reason, the Division of Quality Assurance (DQA) is reminding assisted living providers of the need to identify residents at risk for falls and to implement strategies for falls prevention ...Once risks are identified, the resident's individual service plan (ISP) should contain approaches to prevent falls from occurring. The following are some examples of interventions ...anticipation of needs, including position changes and ambulation, toileting, food or fluids. Physical assistance with daily living activities. Supervision ...Every fall should result in a post-fall assessment to determine the cause of the fall and the need for additional or modified interventions. Comprehensive reporting information will identify the date, time, environmental status, and physical or mental

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{N 389}	Continued From page 5 condition of the person prior to the fall. Review of those assessments can also reveal a pattern associated with time, place, and staff present ...If a resident is not following a recommended safety plan, a re-assessment may be needed to identify alternative, more effective approaches. A risk engaged by a resident will not eliminate provider liability if there is a negligence that results in harm or if there is a violation of regulatory requirements." IN SUMMARY: Resident 2 experienced 8 falls between 10/01/2024 and 11/28/2024, Resident 2's ISP was not updated based on assessment to identify the frequency of falls or to identify new interventions to prevent future falls.	{N 389}		