

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0014427	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/18/2013
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NAME OF PROVIDER OR SUPPLIER ARTISAN FOND DU LAC HOUSE (THE)	STREET ADDRESS, CITY, STATE, ZIP CODE 154 S PIONEER PARKWAY FOND DU LAC, WI 54935
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(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 Surveyor: 10902 On 6/12/13 with information gathered through 6/18/13, the investigation of 2 complaints was conducted at Artisan Fond du Lac House. Two citations were issued.	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: Surveyor: 10902 Based on record review and verified by interview, the facility did not investigate injuries of unknown source for Resident 1. From 3/1/13 through 5/6/13 Resident 1's record documented 4 times that she had injuries/bruises. The record did not contain the cause or investigation of the injuries. Administrator A verified that investigations had not been completed and did not lead to a plan to protect Resident 1 from further injury. Findings include: Resident 1	N 161		

For long term care providers, a plan of correction is required for class A, B, & C violations.
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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N 161	<p>Continued From page 1</p> <p>On 5/14/13 and 6/10/13 the Department received complaints about the facility's program services, resident behaviors and facility practices.</p> <p>On 6/12/13 Surveyor 10902 investigated the complaints, reviewed Resident 1's record and noted the following:</p> <p>-3/1/13 "Resident Notes"--...toenail is slightly blackened on inner edge and top of toe, her right forearm has a 2" x 3" bruise...</p> <p>-4/13/13 "Skin Evaluation"--Bruise on top of right foot. "Evaluation:"=Blank</p> <p>-4/15/13 "Skin Evaluation"--...bruise on top of right foot. Didn't see an accident report. "Evaluation:"=Blank</p> <p>-5/6/13 "Resident Notes"--...has 3 red marks on her left ankle bone along with 2 bruises one on her back and one on side of her head...</p> <p>On 6/12/13 per interview with Surveyor, Administrator A verified that the facility had not conducted investigation of Resident 1's bruises of unknown origin.</p>	N 161		
N 381	<p>83.35(1)(a) Pre-admission and ongoing assessments.</p> <p>Scope. The CBRF shall assess each resident ' s needs, abilities, and physical and mental condition before admitting the person to the CBRF, when there is a change in needs, abilities or condition, and at least annually. The assessment shall include all areas listed under par. (c). This requirement includes individuals receiving respite care in the CBRF. For</p>	N 381		

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N 381	<p>Continued From page 2</p> <p>emergency admissions the CBRF shall conduct the assessment within 5 days after admission.</p> <p>This Rule is not met as evidenced by: Surveyor: 10902</p> <p>Based on record review and verified by interview, the facility did not do assessments for 2 Residents (1 and 2) of a sample of 2.</p> <p>Resident 1 fell 5 times in 7 weeks: 3/15/13, twice on 4/19/13, 4/20/13, 5/1/13. Each fall resulted in injuries: skin tear, bruises, hit head twice and a hip injury. Ongoing and change of condition assessments were not completed by the facility. Resident 1 expired on 5/10/13 under the care of Hospice.</p> <p>Resident 2 was "agitated" and refused medications. She fell twice in 3 weeks: 3/15/13 and 4/2/13. With the 4/2/13 fall she stated that she hit her head and was sent to ER. She returned to the facility with diagnoses of "bleeding in her brain" and she was admitted to Hospice. Her balance decreased and her behaviors increased. Ongoing and change of condition assessments were not completed by the facility. Resident 2 expired on 5/10/13.</p> <p>Findings include:</p> <p>On 5/14/13 and 6/10/13 the Department received complaints about the facility program services, resident behaviors and facility practices. On 6/12/13 with information gathered through 6/18/13, Surveyor 10902 investigated these concerns through record review and interviews and noted the following:</p>	N 381		

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N 381	<p>Continued From page 3</p> <p>Resident 1</p> <p>-3/15/13 "Resident Notes"--Resident had an unwitnessed fall today (at 8:10 pm), her chair pad alarm started sounding resident was sitting on the floor. There were two residents that witnessed the fall and said that (Resident 1) had gone over there and sat down on her own. Resident has a skin tear...</p> <p>-4/3/13 "Resident Notes"--Resident mobility has declined quickly, she now states she is in pain...</p> <p>-4/3/13 "Update to ISP (Individual Service Plan)"--Resident mobility has declined quickly, she now states she is in pain or short of breath whenever she uses her walker. It has become too heavy to operate. Staff will use wheelchair at all times for safety and comfort...</p> <p>-4/19/13 "Resident Notes"--Resident fell twice today bruising on left hip, arms, 2 on legs and hands...fever of 100.5...</p> <p>-4/19/13 "Incident Report"--Heard alarm sound to find resident on side on floor next to wheel chair in front room...</p> <p>-4/20/13 "Resident Notes"--...2 am...resident fell and hit head...meeting with hospice and facility to discuss fall prevention. What they decided was to have an outside service come in between 10 pm and 6 am to sit with her, so she doesn't have anymore falls. Since community (facility) and hospice do not provide 1:1 only until resident is stable. Resident is getting hospital bed which needs to be at the lowest setting...personal alarm and pad alarm...</p> <p>-4/20/13 "Incident Report"--...was in wheel chair,</p>	N 381		

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N 381	<p>Continued From page 4</p> <p>very restless she tried to shift sides and in process did sit up out of chair and bent forward and caught her own fall out of chair. But hit her head on the wall...</p> <p>-5/1/13 "Resident Notes"--Resident had a fall ...staff heard a noise and turned around to see her on the floor. She had fallen head first out of her wheel chair. They seen blood coming from left side of her along with discoloration, swelling, laceration to left side of her fore head...injury to her head and hip ...sent out to ER by ambulance...</p> <p>-5/1/13 "Hospice Note"--Dressing to forehead. (Family) reports 5 sutures. Also has dressing on left hand, 3rd & 4th fingers buddy wrapped.</p> <p>-5/2/13 "Hospice Note"--pain...right hip, upper thigh...multiple bruised areas, grimaces...Relies on staff for all cares.....there is a swollen, ...firm area upper right thigh...instructed staff to ice area, extremely warm...Also has multiple bruised areas...arms...</p> <p>-5/10/13 "Resident Notes"--Resident passed (died) this morning...</p> <p>Resident 2</p> <p>Resident Notes: -2/2013 ...agitation...Staff will make sure that resident will be kept apart from other residents at all times to prevent any out bursts...</p> <p>-2/27/13 Resident refused medications...said she was on strike until they let her go home...</p> <p>-3/15/13 ...heard resident was crying. Staff opened her door to find (Resident 2) sitting on her</p>	N 381		

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N 381	<p>Continued From page 5</p> <p>floor near the bathroom. Staff asked resident what had happened, resident replied that her shoes do not fit properly and made her trip. (Resident 2) also has a skin tear on her right forearm....called daughter about getting her a new pair of shoes...</p> <p>-3/24/13 ...daughter has brought in ...shoes...</p> <p>-4/1/13 "Incident Report" ...I was coming back from doing another resident's care when I heard (another resident) screaming help I ran to where she was when I found (Resident 2) laying on the floor crying. She said she hit her head...sent out to hospital/emergency room...</p> <p>-4/2/13 Around 8:00 pm 4/1/13 (Resident) had a fall...near the entrance door. A resident witnessed the fall and yelled for help when staff arrive they found (Resident) lying on the floor near the couch on her right side...resident stated...her knee went out and made her fall...stated she hit her head really hard and hurt her arm...sent to ER...hospital called the home and reported to staff that she had bleeding in her brain and is not doing well. Doctors requested (Resident) to be admitted to hospice...continues to ambulate independently...leans slightly since hospitalization...has personal alarms now for fall prevention..</p> <p>-4/2/13 After resident's fall, resident has been experiencing mobility issues. Resident has been leaning more to the left....Staff will do 1:1 assist....use gait belt...continues to ambulate independently without equipment...Has personal alarms now for fall prevention...</p> <p>-4/3/13 ...increase in agitation...Haldol (antipsychotic)...every 6 hours as needed for</p>	N 381		

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N 381	<p>Continued From page 6</p> <p>agitation...also Roxanol (Morphine-narcotic)...every 1 (one) hour prn (as necessary)...Lorazepam (anti-anxiety/sedation)...as needed....ABHR transdermal (combination drugs) as needed...still waiting for all drugs to come from pharmacy.</p> <p>-4/4/13 ...extremely agitated around 6:30 pm until 11:00 pm. Yelling at employee and other residents pushing and trying to hit staff. Staff did administer medications but did not affect resident...Hospice was called...gave resident morphine....finally fell asleep around midnight...</p> <p>-4/5/13 Resident up around 9 am. Continues to be agitated. Lakeland here (to) see resident after fall on 4/2/13....Resident agitated this evening but able to do 1:1 to redirect resident. She finally calmed down around 9 pm...</p> <p>-4/6/13 Resident became very upset once it was time to take medications. Refused multiple times. Resident's agitation increased when EMT came for another resident. Got upset because they didn't have time to sit and talk to her. Resident was also hitting pictures...grabbed the cordless phone and started throwing the phone against the wall and floor. Went into the kitchen-hit the coffee pot out of one of the staff hands. Staff redirected resident out of the kitchen. Then she walked up to a male resident and kicked him in the leg. Staff redirected resident away from the rest of the community....got her to take prn (as necessary medication) for anxiety...hospice nurse...adjusted her medications by prescribing haldol...Director and nurse left around 9 pm. Right after we left resident started becoming agitated again lasted until 11 pm...</p> <p>Hospice Notes:</p>	N 381		

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N 381	<p>Continued From page 7</p> <p>-5/5/13 ...decreased ability to ambulate...uncontrolled anxiety/agitation....became verbally abusive and was physically striking out at staff - patient very weak and unsteady - high fall risk - risk of self harm -teaching: (to staff) safety, prn med (medication) use, reapproach...</p> <p>-5/5/13 Monitor for signs and symptoms of anxiety/agitation/pain...be aware of safety/fall risk d/t (due to) increased behaviors and PRN medication use...*it is easier to keep someone comfortable if we treat pain/anxiety right away at the onset. She escalated very quickly today with behaviors and needed multiple does of medications....</p> <p>-5/6/13 ...patient increased weakness, unsteady...facial bruising...</p> <p>-5/23/13 Medical Examiner/Coroner Investigator Report: ...informed that the decedent had expired following a fall with a subsequent brain bleed. Medical records review indicate that the decedent had a fall while located at Artisan Assisted Living and Memory Center, was diagnosed with a multiple intracranial hemorrhages...She expired at the facility on 5/10/13. Dr....signed the death certificate as natural due to subarachnoid (brain) bleed.</p> <p>On 6/12/13 per interview with Surveyor, Administrator A verified that assessments related to Resident 1 and 2's falls/continued fall risk had not been completed. Administrator A also verified that behaviors, multiple medication use, pain and diversion activity needs were not assessed to increase comfort and increase safety for Resident 1 and Resident 2.</p>	N 381		

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N 381	Continued From page 8 On 6/12/13 at the daily exit, attended in person by Surveyor, Administrator A, Interim Director of sister facility B, and via speaker phone, Chief Operation Officer C and Regional Director of Operations D, -they explained that the company does have comprehensive assessment forms that will address the residents' needs and that they have just begun the implementation process.	N 381		

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