

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>0014824</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>06/04/2014</b>
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NAME OF PROVIDER OR SUPPLIER  <b>BETHESDA LUTHERAN COMMUNITIES - STON</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1421 STONERIDGE DRIVE WATERTOWN, WI 53094</b>
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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
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M 000	INITIAL COMMENTS  Surveyor: 14940  On June 2, 2014, the Bureau of Assisted Living, Southern Regional Office conducted an onsite, self report review at Bethesda Lutheran Communities - Stoneridge, located at 1421 Stoneridge Drive, Watertown, WI.  One citation of noncompliance is being issued.	M 000		
M 570	88.10(3)(l) Safe Physical Environment  Safe physical environment. To a safe environment in which to live. The adult family home shall safeguard residents who cannot fully guard themselves from environmental hazards to which they are likely to be exposed, including conditions which would be hazardous to anyone and conditions which would be or are hazardous to a particular resident because of the resident's condition or handicap.  This Rule is not met as evidenced by: Surveyor, 14940  Based on observation, interview, and record review, the Licensee did not provide a safe environment for a resident with a history of unsupervised mobility concerns.  Resident 1 was admitted to the facility on May 6, 2014 with a history of 'wandering' without supervision of caregivers while residing at a different location.	M 570	<p><b>SEP 05 2014</b> Southern Regional Office Madison WI</p> <p>A lock was installed on 5/9/14 the basement stairs. Completed</p> <p>An automatic self closure 5/13/14 mechanism was installed on the door to the basement stairs. Completed</p> <p>The community will 5/16/14 complete post safety screens on all current individuals who reside in the community and update the ISP as needed with any identified safety concerns. This was completed via the safety sections of the Annual Strengths and Needs and Risk Assessment Tool. This is ongoing for any</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Wanda Altrutter TITLE: Area Director (X6) DATE: 9-4-14

Wisconsin Department of Health Services

STARTED at the DEPARTMENT of HEALTH SERVICES  
4000 W. WISCONSIN ST. MILWAUKEE, WI 53238

0014824

08/04/2014

1421 STONERIDGE DRIVE  
WATERTOWN, WI 53084

BETHESDA LUTHERAN COMMUNITIES STOP

REGULATORY OR OTHER CERTIFICATION APPROVAL

WISCONSIN INITIAL COMMENTS

Surveyor 14840

9/16/14

On 08/02/2014 the Home of Assisted Living Southern Regional Office conducted an unannounced self-report review at Bethesda Lutheran Communities - Stoneridge located at 1421 Stoneridge Drive, Watertown, WI.

One citation of non-compliance is being issued.

M 570 88 10-11(g) Safe Physical Environment

Safe physical environment: "The safe environment in which to live. The adult family home shall safeguard residents who cannot fully guard themselves from environmental hazards to which they are likely to be exposed including conditions which would be hazardous to anyone and conditions which would be of a hazardous to a particular resident because of the resident's condition or handicap."

The RLS is not met as evidenced by Surveyor 14840

Based on observation when we did a second review that we consider the home provides a safe environment for a resident with a history of unsupervised mobility concerns.

Resident 1 was admitted at the facility on May 9 2014 with a history of wandering without supervision of caregivers while residing at a residential location.

STATE FORMAL

*[Signature]*

*[Signature]*

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M 570	<p>Continued From page 1</p> <p>On May 9, 2014, Resident 1 fell down the home's basement steps while in a wheelchair.</p> <p>The findings are as follows:</p> <p>On May 13, 2014, the Department received the facility's self report. The report includes, "At 6:33 P.M. on May 9, 2014, (Area Director A) received a phone call that (Resident 1) (one of the people we support) living at Bethesda Lutheran Communities AFH (Adult Family Home) at 1421 Stoneridge Drive had fallen down the basement stairs while in (Resident 1's) wheelchair. (Resident 1) had been in the living room for devotions but was propelling her/himself in (Resident 1's) wheelchair back and forth between the living room and dining room. (The basement stairs (are) in a hallway off of the dining room.) A few minutes later the (caregiver) heard a loud crash and ran to the basement stairs to find (Resident 1) at the bottom, still in (Resident 1's) wheelchair. Immediately after the fall, staff unbuckled (Resident 1's) seatbelt and removed (Resident 1's) wheelchair. One (caregiver) stayed with (Resident 1) while the other called 911 and the Program Manager. (Resident 1) was transported to Watertown Regional Medical Center via EMS (ambulance) and the Med-Flight to Aurora Summit Hospital. (Resident 1) sustained two lacerations to (Resident 1's) face, a nasal sinus fracture and several bone fractures in one hand. According to the ER (emergency room) physician the head CT (computerized tomography) did not show any recent brain trauma. However, as the evening progressed, (Resident 1) was unable to sustain a good BP (blood pressure) on his/her own. The physician suspected that (Resident 1) vomited post-fall which may have caused an airway blockage and</p>	M 570	<p>new admissions and annually for those currently residing at this home. Monitored by Area Director (AD)</p> <p>The community will complete pre/post admission safety screens on individuals who admit to this community to ensure safety needs are timely identified and an individualized plan is developed to address the concerns. The Annual Strengths and Needs and Risk Assessment Tool has been revised. This tool will be used as the pre admission screen, the post admission screen and annually to identify safety concerns. To be monitored by the AD. Ongoing.</p> <p>During the initial 28 days in a new home environment the Annual Strength and Needs and Risk Assessment Tool will be completed. Any information that is contrary to the Pre-assessment will be addressed immediately. This</p>	<p>9/12/14</p> <p>8/29/14</p>



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M 570	<p>Continued From page 3</p> <p>basement door was not locked.</p> <p>Program Manager A, Manager B, and Surveyor 14940 toured the home, including Resident 1's former bedroom and the basement staircase.</p> <p>Resident 1's bedroom door included a lever style door knob. The door leading to the basement staircase included a lever style door knob and the door opens out into the hallway. The staircase contains 13 steps to a landing. A section of the wall included a black scrape. Manager B said the black mark was made by Resident 1's wheelchair as Resident 1 fell down the staircase. Manager B said she was at the home during the day of Resident 1's fall down the stairs. She had been in the basement working during the day and had made many trips up to the first floor level. Manager B said she was positive she shut the door behind her before leaving the home prior to Resident 1's fall.</p> <p>Program Manager A and Manager B told Surveyor 14940 the door leading to the basement staircase is now equipped with an automatic, self closing mechanism and a locked, lever door knob that can only be opened with a key. Both changes were made after Resident 1's fall and were observed by Surveyor 14940.</p> <p>Program Manager A and Manager B discussed the incident involving Resident 1 with Surveyor 14940. The Managers told Surveyor 14940 that Caregivers D and E were working the late afternoon and evening shift of May 9, 2014. While Caregiver E was conducting part of an activity in the home's living room, Caregiver D</p>	M 570	<p>All safety modifications by the maintenance staff as noted in the environment check completed on 5/10/14 are corrected. 8/5/14</p> <p>Door chimes to front entrance door and door leading to garage installed. Completed 8/15/14</p> <p>Root Cause Analysis developed in consultation with Vivage Quality Health Partners, namely Cynthia Haskell, a qualified professional not affiliated with Bethesda Lutheran Communities. Completed 8/19/14; report received 9/2/14. 8/19/14</p> <p>Monthly preventative maintenance check on self-locking mechanism added to maintenance checklist. (see attached) Home's maintenance person will complete monthly. See September's as attached. AD will ensure completion by monitoring the checklist. 8/29/14</p>	
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M 570	<p>Continued From page 4</p> <p>used the bathroom. During this time, Resident 1 propelled the wheelchair to the basement door, opened it, and fell down the steps. Program Manager A said Resident 1 was able to reach the basement door, open it, and fall down the steps within a matter of moments after leaving the activity in the living room. Caregiver D was still in the bathroom when Resident 1 fell down the steps.</p> <p>Both the local police and the facility investigated the incident, where both Caregiver D and Caregiver E said the basement door was shut prior to the incident on May 9, 2014.</p> <p>Manager B said Resident 1 was very interested in his/her environment, something Resident 1 liked to do at Resident 1's previous residence. Prior to moving to the home, Resident 1 was found in an unoccupied bedroom, sleeping in Resident 1's wheelchair. Up until moving to the home, caregivers were to check Resident 1's location every 15 minutes because Resident 1 would maneuver around the previous facility to areas Resident 1 was not allowed without supervision.</p> <p>Program Manager A, Manager B, and Surveyor 14940 reviewed Resident 1's record, as provided by the Managers.</p> <p>Resident 1 was admitted to the facility on May 6, 2014 with diagnoses and history of Profound Mental Retardation, Right Hemiplegia (paralysis) with Atrophied Upper and Lower Extremity, and Visual Impairments.</p> <p>Program Manager A said Resident 1 help Resident 1's right hand to Resident 1's chest related to Hemiplegia.</p>	M 570	<p>Automatic self closure and lock installed on laundry room door per recommendation of review by Vivage. Completed 8/29/14</p> <p>Monthly preventative maintenance check on door chimes functionality and operability of batteries added to maintenance checklist. (See attached) Home's maintenance person will complete monthly; AD will ensure completion by monitoring the checklist. 8/29/14</p> <p>Door chime added to basement door as further preventative measure. Completed 9/3/14</p> <p>Direct Support Staff will inspect the basement door daily to ensure the door is locked and latching properly. This will be monitored by staff entering the checks for the doors (basement, laundry room, garage and front) in the Extended Care Professional (ECP) system which is our 9/3/14</p>	
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M 570	<p>Continued From page 5</p> <p>Program Manager A said a preadmission assessment had not been completed prior to Resident 1's admission on May 6, 2014. Program Manager A said the organization now has a new policy to ensure preadmission assessments are completed prior to a Resident's 'move-in' date.</p> <p>An Individualized Program Plan, dated January 16, 2014 (approximately 4 months prior to Resident 1's admission to the home) includes "Any alternate setting would need to accommodate my wheelchair, desire to "roam" - plenty of open areas," and "...supervision due to high risk for falls, history of attempts to ambulate on own."</p> <p>A 'New Admission/Re-Admission Assessment/Information Form' dated January 22, 2014, received by Surveyor 14940 from Program Manager A on June 4, 2014, includes "Risk Issues: Falling Elopement Evacuation - 15 min (minute) checks, - Considered at high risk for falls" and "Uses wheelchair for mobility."</p> <p>An Individualized Service Plan, dated January 29, 2014 (approximately 4 months prior to Resident 1's admission to the home) includes, "History of wandering/elopement: Yes (checked) If yes, what is the prevention plan: (Resident 1 has) a 15 minute check in place that staff will use to make sure they know where (Resident 1 is) at all times."</p> <p>An Individualized Service Plan (ISP) Assessment, dated May 9, 2014 (the day of Resident 1's fall) includes information related to Resident 1's high risk for falls. The assessment does not address Resident 1's history of 'wandering' and/or need for supervision (including 15 minutes checks).</p>	M 570	<p>electronic monitoring system. The Program Manager will get an alert if the AM staff have not completed this check. ECP will cue staff that this needs to be done.</p>	

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M 570	Continued From page 6  Summary: Resident 1 was admitted to the facility on May 6, 2014 with a history of 'wandering' without supervision of caregivers while residing at a different home. On May 9, 2014, Resident 1 fell down the home's basement steps while in a wheelchair. Resident 1 died shortly after this incident.	M 570		
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