

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0013336	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 10/09/2012
NAME OF PROVIDER OR SUPPLIER EMERITUS AT LEGACY GARDENS			STREET ADDRESS, CITY, STATE, ZIP CODE 1601 WHEELER RD MADISON, WI 53704		
(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: 14940 On September 4, 2012, the Bureau of Assisted Living, Southern Regional Office conducted an onsite, complaint investigation and verification visit of Statement of Deficiencies (SODs) 175M13 and QJWI11 at Legacy Gardens Assisted Living Community, 1601 Wheeler Road, Madison, WI. As a result of the verification visit of QJWI11 and the complaint investigation, six citations are being issued. One of the six citations issued is a repeat violation of compliance, initially issued in SOD QJWI11. As a result of the verification visit of 175M13, all citations are corrected. Surveyor: 21806	{N 000}			
N 165	83.12(4)(c) Reporting incidents with serious injury A CBRF shall send a written report to the department within 3 working days after any of the following occurs: Any incident or accident resulting in serious injury requiring hospital admission or emergency room treatment of a resident. This Rule is not met as evidenced by: Surveyor: 14940 Based on interview and record review, the facility did not send a written report to the Department after Resident 3 experienced a fall resulting in serious injury and hospitalization. Cross Reference: DHS 83.32(3)(i) Resident Rights	N 165			

For long term care providers, a plan of correction is required for class A, B, & C violations.

TITLE

(X6) DATE

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

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N 165	<p>Continued From page 1</p> <p>The findings are as follows;</p> <p>On July 19, 2012, the Department received a complaint including an allegation that Resident 3 had fallen at the facility.</p> <p>On August 29, 2012, Surveyor 14940 reviewed the Department's facility file. The Department did not receive a written report from the facility after Resident 3 experienced a fall resulting in serious injury and hospitalization.</p> <p>On September 4, 2012, the Department conducted an onsite visit at the facility, including a complaint investigation.</p> <p>On September 4, 2012, Resident Care Coordinator/Registered Nurse (RCC/RN) C and Surveyor 14940 reviewed Resident 3's record, including RCC/RN C's documentation related to Resident 3's falls on June 10, 2012. The documentation includes;</p> <p>Resident 3's Service Notes include the following documentation by RCC/RN C. RCC/RN C's documentation includes, "June 10, 2012 0620 (6:20 A.M.). On 6/10/12 resident had a fall. MA (Medication Assistant) went into room to give (Resident 3) A.M. meds (medications) - MA found resident on the floor next to (Resident 3's) recliner (and) heater. MA did ROM (range of motion) and called for assist. ROM (-) (negative) for deficit. MA asked resident what happened (and) resident stated (Resident 3) was going to the bathroom (and) fell. Resident did not have call pendant around (Resident 3's) neck. Resident remained in community - refused to go to hospital. Hands discolored . V.S. (vital signs) done (and) resident up in recliner. Small s/t (skin tear) on arm (and) abrasion on forehead.</p>	N 165			

For long term care providers, a plan of correction is required for class A, B, & C violations.

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N 165	<p>Continued From page 2</p> <p>Resident assisted (with) 2 staff to BR (bathroom) (and) then in recliner. Call pendant placed around residents neck (and) encouraged to call if (Resident 3) needs any help. @ (At) 10:15 (A.M.) MA went up to bandage L (left) knee skin tear (and) found resident on the floor by (Resident 3's) table. (Resident 3) stated that (Resident 3) was picking up (Resident 3's) call pendant (and) lost balance (and) fell again. Staff states that resident was drooling (and) L (left) side of body "didn't seem the same " - Resident was 2 person assist. VS = 96.6 (temperature)-84 (pulse) -18 (respirations) -122/58 (blood pressure). Resident was sent out to (local hospital) per (ambulance service) @ (at) 10:40 A.M. Was admitted to hospital".</p> <p>Surveyor 14940 received copies of Resident 3's hospital medical records, as a result of a hospital medical records request.</p> <p>Resident 3's hospital history and physical, dated June 10, 2012, includes, "(Resident 3) presenting with a Fall" and "(Resident 3) complains of a slight headache in (Resident 3's) left temporal area.."</p> <p>Resident 3 has "bruising over left temporal region."</p> <p>Resident 3 received a CT Scan of the head and X-rays of the elbow and knee. Resident 3 was admitted with diagnoses including "Subarachnoid bleed" and a contusion to elbow and knee.</p> <p>Resident 3's hospital discharge summary includes Resident 3 was admitted to the hospital from the facility on June 10, 2012 and discharged to a skilled nursing facility on June 12, 2012.</p> <p>On September 20, 2012, the Department received a certified copy of Resident 3's death certificate.</p> <p>The death certificate includes Resident 3's</p>	N 165			

For long term care providers, a plan of correction is required for class A, B, & C violations.

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N 165	Continued From page 3 immediate cause of death as "Complications Following Blunt Trauma of Head with Acute and Chronic Subdural Hematoma" and "Fell While Ambulating." The date and the location Resident 3's injury occurred is documented as "June 10, 2012" at "1601 Wheeler Rd, City of Madison, WI (Legacy Gardens Assisted Living Community)". Resident 3 died on July 23, 2012. On September 27, 2012, Surveyor 14940 conducted a telephone interview with Administrator A. Administrator A said she is responsible for sending reports to the Department. Administrator A told Surveyor 14940 that she did not report Resident 3's fall with injury and hospitalization to the Department because she didn't realize it was such a concern until after the fact. She didn't realize Resident 3's hospitalization had to do with a fall and/or head injury. Administrator A said Resident 3 received Hospice care related to general deterioration after Resident 3 was discharged from the facility.	N 165			
N 214	83.15(3)(a) Administrator shall supervise daily operation The administrator shall supervise the daily operation of the CBRF, including but not limited to, resident care and services, personnel, finances, and physical plant. The administrator shall provide the supervision necessary to ensure that the residents receive proper care and treatment, that their health and safety are protected and promoted and that their rights are respected. This Rule is not met as evidenced by: Surveyor: 14940	N 214			

For long term care providers, a plan of correction is required for class A, B, & C violations.

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N 214	Continued From page 4 Based on observation, interview, and record review, Administrator A does not ensure the residents receive proper care and treatment, that their health and safety are protected and promoted, and that their rights are respected. On September 4, 2012, Surveyor 14940 and Surveyor 18702 conducted an onsite, complaint investigation and verification visit. As a result of this onsite visit, six citations (including this noncompliance) are being issued in SOD QJWI12. The citations are as follows; 83.12(4)(c) Reporting Requirements The facility did not send a written report to the Department after Resident 3 experienced a fall resulting in serious injury and hospitalization. 83.32(3)(i) Resident Rights The facility did not ensure Resident 3 received prompt and adequate treatment following a fall at the facility resulting in injury. 83.35(1)(c) Assessment The facility did not assess the use of a slide and chain type lock installed to the external, top section of Resident 4's bathroom door. The lock prevents Resident 4 from entering the bathroom unassisted. This citation of noncompliance is a repeat violation, initially issued with Statement of Deficiency (SOD) QJWI11. 83.35(3)(a) Individual Service Plan Individual Service Plans for 2 of 2 sample residents (Resident 5 and Resident 6) with side	N 214			

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N 214	Continued From page 5 rails attached to their beds did not address the resident's need for and use of side rails. 12.04(2) Criminal Background Checks The facility did not ensure CBC (caregiver background check) requirements were met for 3 sample employees out of 35 total employees that have worked at the facility for more than 60 days.	N 214			
N 353	83.32(3)(i) Rights of Residents: Adequate treatment In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Prompt and adequate treatment. Receive prompt and adequate treatment that is appropriate to the resident ' s needs. This Rule is not met as evidenced by: Surveyor: 14940 Based on interview and record review, the facility did not ensure Resident 3 received prompt and adequate treatment following a fall at the facility resulting in injury. Prior to June 10, 2012, Resident 3 was capable of ambulating independently, was continent and able to toilet self, and was not known to have any bruises, abrasions, or skin tears. Resident 3 experienced memory issues. Resident 3 experienced an unwitnessed fall in Resident 3's room and was found by a caregiver/medication assistant at 6:20 A.M. on June 10, 2012. A caregiver observed changes in Resident 3's physical condition, including, but not limited to, an injury to Resident 3's forehead, Resident 3 required caregiver assistance with mobility and cares, and Resident 3 had been	N 353			

For long term care providers, a plan of correction is required for class A, B, & C violations.

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N 353	<p>Continued From page 6</p> <p>incontinent.</p> <p>Despite evidence Resident 3 had experienced a possible head injury and other physical changes as a result of this fall, facility staff did not seek emergency medical attention nor did on duty staff contact the facility's on-call management staff, a physician, or Resident 3's designated contact person.</p> <p>On June 10, 2012 at 10:15 A.M., a caregiver found Resident 3 on the floor in Resident 3's room following another unwitnessed fall. Resident 3 required assistance of two caregivers to get up from the floor and was unable to stand or sit without assistance. At this point, a caregiver called 911 for emergency medical care and contacted the facility's on-call management staff, and Resident 3's designated contact person was informed of both falls.</p> <p>Resident 3 was transported to a local hospital and admitted for care related to a Subarachnoid hemorrhage, bleeding between the brain and the membrane that surrounds the brain. Resident 3 was admitted to a skilled nursing facility and later died as result of "complications following blunt trauma of head with acute and chronic subdural hemorrhage".</p> <p>The findings are as follows;</p> <p>On July 19, 2012, the Department received a complaint including an allegation that Resident 3 had fallen at the facility.</p> <p>On September 4, 2012, the Department conducted an onsite visit at the facility, including a complaint investigation.</p> <p>On September 4, 2012, Surveyor 14940</p>	N 353			

For long term care providers, a plan of correction is required for class A, B, & C violations.

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N 353	<p>Continued From page 7</p> <p>interviewed Resident Care Coordinator/Registered Nurse (RCC/RN) C about Resident 3's needs, services, and falls at the facility.</p> <p>RCC/RN C told Surveyor 14940 that Resident 3 was able to ambulate independently and with stability prior to being sent to the hospital as a result of two falls on the morning of June 10, 2012. Resident 3 did not return to the facility following this hospitalization.</p> <p>RCC/RN C said she is not aware of other falls experienced by Resident 3 prior to June 10, 2012.</p> <p>RCC/RN C said Resident 3's Power of Attorney for Healthcare (POA-HC) H was designated to be contacted if and when Resident 3 experienced any changes in condition, including falls.</p> <p>RCC/RN C showed Surveyor 14940 where Resident 3's POA-HC H's contact information was located on Resident 3's medical record face sheet.</p> <p>RCC/RN C said she was not on duty within the facility when Resident 3's falls occurred over the weekend of June 10, 2012. RCC/RN C said she believes she was on-call that weekend and would have expected the caregivers to contact her following any resident fall or event (incident).</p> <p>RCC/RN C said she was not contacted after Resident 3's initial fall on the morning of June 10, 2012.</p> <p>RCC/RN C told Surveyor 14940 that she and Resident 3's POA-HC H should have been contacted after each of Resident 3's falls on June 10, 2012. RCC/RN C said it would be documented in Resident 3's record when and if Resident 3's POA-HC H was contacted for each fall on June 10, 2012.</p> <p>Surveyor 14940 asked RCC/RN C to explain the</p>	N 353			

For long term care providers, a plan of correction is required for class A, B, & C violations.

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N 353	<p>Continued From page 8</p> <p>facility's management coverage and responsibilities of the caregivers when a resident experiences an event, including a fall(s), over the course of a weekend.</p> <p>RCC/RN C told Surveyor 14940 that either RCC/RN C or the Wellness Coordinator are usually on-call during weekends. When a resident experiences a fall, or event, the caregiver should call the person on-call, fax the physician, and contact the resident's designated family member. RCC/RN C said a summary of the event, including when and whom was contacted, would be documented in a resident's event management document.</p> <p>Surveyor 14940 asked RCC/RN C to provide Resident 3's record, including documentation of Resident 3's events specific to falls for the past 6 months prior to and including June 10, 2012.</p> <p>RCC/RN C and Surveyor 14940 reviewed Resident 3's record, including two event management documents for Resident 3's falls on June 10, 2012, as provided by RCC/RN C. The documentation includes;</p> <p>Resident 3's most current individual service plan (ISP), as provided by RCC/RN C, includes; "Periods of confusion has increased from long term memory. (Resident 3) is very good at covering (Resident 3's) issue of memory loss"; "Resident has been evaluated and fall management is not applicable"; "No skin conditions"; "Resident has been evaluated and has the capacity for self care of toileting needs"; and "Resident has been evaluated and is independent in transferring." Resident 3's ISP includes "Dementia" in the 'Chronic/Short-term and Recurring Illnesses'</p>	N 353			

For long term care providers, a plan of correction is required for class A, B, & C violations.

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N 353	Continued From page 9 section. [*Documentation of Resident 3's initial fall on June 10, 2012*] * Resident 3's event management document includes the following sections and information: The documentation includes an event occurred on June 10, 2012 at 6:20 A.M. Resident 3's mental status was "Alert and oriented" and the event type was "Suspected fall - found on floor." The event description documentation, of the "event or incident" includes, "MA (Medication Assistant) was passing meds (medications) and went into residents room to give them. Found resident on the floor next to (Resident 3's) recliner and heater. MA did ROM (range of motion) and then called for assist. MA asked resident what happened and resident stated (Resident 3) was going to the bathroom and fell. Resident didn't have (Resident 3's) pendant on." The staff in charge at time of Resident 3's event was Caregiver/Medication Assistant E. The documentation includes, Resident 3 "Remained in the community (at the facility)" and Resident 3's "Injury/outcome: Discoloration". The documentation includes an explanation of "what immediate action was taken, "ROM (range of motion) done, VS (vital signs) done, (Physician I) and (Resident 3's POA-HC H) contacted at 1020 (10:20 A.M.) and 1005 (10:05 A.M.) respectively"; The documentation includes a description of the "Interventions/preventative measures (:) Resident was assisted in the bathroom, ADL's (activities of daily living) done and resident settled in recliner." The "Notifications" section includes documentation that Physician I was notified on June 10, 2012 at 10:20 A.M. and Resident 3's	N 353			

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N 353	Continued From page 10 POA-HC H was notified. The documentation includes, "Responsible party/family reaction: Nothing stated." The "Signature & (and) title of person completing this form" includes RCC/RN C's signature, dated June 11, 2012. These sections of the form were reviewed by Administrator A on June 14, 2012 and RCC/RN C on June 11, 2012, as signed. The "Event report investigation and summary of preventative measures" section documentation includes: Resident 3 was doing "Usual" activity; Resident 3 was "Oriented to: time event place and person"; Resident 3's skin condition documentation includes, "Discolorations and small s/t (skin tear) on arm from fall, also abrasion on right forehead" (This is a discrepancy compared with Caregiver E's documentation of Resident 3's injury which states "bruise to left side of forehead"); The documentation of what Resident 3 said had caused the event includes, "(Resident 3) was just going to the bathroom and (Resident 3) fell"; The documentation of "What immediate action was taken to prevent further incidents" includes, "Resident settled in recliner and given call button to use if (Resident 3) needed to get up again"; The documentation of "How was staff educated" includes, "Make frequent checks on resident." The "Preventative measures taken" documentation includes, "Placed on daily observation and monitoring worksheet for 72 hours." The "Investigation Summary" documentation includes no investigation was indicated. These sections of the form were reviewed by Administrator A on June 14, 2012 and RCC/RN C on June 11, 2012, as signed.	N 353			

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N 353	<p>Continued From page 11</p> <p>* Resident 3's "Event First Responder Worksheet", completed by Caregiver/Medication Assistant E, includes the following documentation of Resident 3's fall on June 10, 2012 at 6:20 A.M.; Resident 3 experienced an "alleged fall/witnessed fall" with skin area injury. Resident 3 was not sent to the hospital.</p> <p>Resident 3's POA-HC H was notified at 10:05 A.M. and Physician I was notified at 10:20 A.M. At the top of the page, the documentation includes, "RN (Former Facility RN) M notified at 10:33 A.M." The on-call facility management, a physician, and Resident 3's POA-HC H were contacted and/or informed of Resident 3's initial fall approximately four hours following that fall on June 10, 2012.</p> <p>* Resident 3's "Event (after hours) Physician Communication Form", completed by Caregiver/Medication Assistant E on June 10, 2012 at 3 P.M. and sent to Physician I, includes the following documentation;</p> <p>The form's instructions include, "This form is only to be used for after hours and non-emergency situations. Once completed, a copy of this form must be provided to the Executive Director for review."</p> <p>Caregiver/Medication Assistant E's written description of Resident 3's event includes, "MA (Medication Assistant) was passing resident 6:30 A.M. med (medication) this morning. Resident normally come open door for (Caregiver/Medication Assistant E), but when MA knocked on door Resident stated come in MA went into Resident room found (Resident 3) on floor next to (Resident 3's) recliner (sic)/heater. R.O.M. (range of motion) was done. MA notice L (left) knee skin tear, both hands/arms discoloration, bruise on L (left) side of forehead. MA then call for help, got resident off floor. MA</p>	N 353			

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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 353	<p>Continued From page 12</p> <p>then ask if (Resident 3) was in pain. Resident stated No, also ask if (Resident 3) would like to be sent out to hospital. Resident stated No. RA (Resident Assistant) finish getting Resident clean/change of clothes on got (Resident 3) comfortable in recyliner (sic). R.A. also brought up breakfast no further complaints." At the top of the page, the documentation includes, "RN (Former Facility RN) M notified at 10:33 A.M."</p> <p>[*Documentation of Resident 3's second fall on June 10, 2012*]</p> <p>* Resident 3's event management document includes the following sections and information: The documentation includes an event occurred on June 10, 2012 at 10:15 A.M. Resident 3's mental status was "Confused at times" and the event type was "Suspected fall - found on floor." The event description documentation, of the "event or incident" includes, "MA (Medication Assistant) went up to residents room to bandage skin tear from previous fall when they found resident on the floor by teh (sic) table. MA did ROM (range of motion). All bruises and s/t (skin tear) from first fall noted. No new skin issues. MA called for assistance. Resident was assisted off the floor onto the chair. MA asked Resident if (Resident 3) would like to go teh (sic) hospital and Resident stated yes. RA (Resident Assistant) also noticed when waiting on (ambulance service) that (Resident 3) had been drooling and it was very hard for resident to stand on (Resident 3's) own. Left side was weak." The staff in charge at the time of Resident 3's event was Caregiver/Medication Assistant E. The documentation includes, Resident 3 "ER (Emergency Room) visit" and Resident 3's "Injury/outcome: Abrasion".</p>	N 353			

For long term care providers, a plan of correction is required for class A, B, & C violations.

Wisconsin Department of Health Services

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N 353	<p>Continued From page 13</p> <p>The documentation includes an explanation of "what immediate action was taken, "(Resident 3's POA-HC H) was contacted 6/10/1025 (June 10, 2012 at 10:25 A.M.)";</p> <p>The documentation includes a description of the "Interventions/preventative measures (:)</p> <p>Resident sent to (local hospital) for eval (evaluation)."</p> <p>The "Notifications" section includes documentation that Resident 3's POA-HC H was notified. The documentation includes, "Responsible party/family reaction: Upset about being called so late. Felt she should have been called after first fall."</p> <p>The "Signature & (and) title of person completing this form" includes RCC/RN C's signature, dated June 11, 2012. These sections of the form were reviewed by Administrator A on June 14, 2012 and RCC/RN C on June 11, 2012, as signed.</p> <p>The "Event report investigation and summary of preventative measures" section documentation includes:</p> <p>Resident 3 was doing "Usual" activity;</p> <p>Resident 3 was "Oriented to: person";</p> <p>Resident 3's recent physical changes "Yes, was drooling and unable to stand well on the left side. Abrasion on R (right temporal area (This is a discrepancy compared to Caregiver/Medication Assistant E's documentation of Resident 3's injury which states "bruise to left side of forehead") ;</p> <p>Resident 3's skin condition documentation includes, "Discolorations on both arms and hands. Abrasion on R (right) temporal area (This is a discrepancy compared to Caregiver/Medication Assistant E's documentation of Resident 3's injury which states "bruise to left side of forehead") ";</p> <p>The documentation of what Resident 3 said had caused the event includes, "Was bending over to</p>	N 353			

For long term care providers, a plan of correction is required for class A, B, & C violations.

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N 353	<p>Continued From page 14</p> <p>pick up pendant which had fallen off, and fell"; The documentation of "How was staff educated" includes, "N/A (not applicable)."</p> <p>The "Preventative measures taken" documentation includes, "Education done on letting families and MD's (physician's) know right away when fall happens."</p> <p>The "Investigation Summary" documentation includes no investigation was indicated.</p> <p>These sections of the form were reviewed by Administrator A on June 14, 2012 and RCC/RN C on June 11, 2012, as signed.</p> <p>* Resident 3's "Event First Responder Worksheet", completed by Caregiver/Medication Assistant E, includes the following documentation of Resident 3's fall on June 10, 2012 at 10:15 A.M.;</p> <p>Resident 3 experienced an "alleged fall/witnessed fall." Resident 3 was sent to the hospital. Resident 3's POA-HC was notified at 10:05 A.M. and Physician I was notified at 10:20 A.M. At the top of the page, the documentation includes, "(Former Facility RN M) notified at 10:33 A.M."</p> <p>* Resident 3's "Event (after hours) Physician Communication Form", completed by Caregiver/Medication Assistant E on June 10, 2012 at 3:30 P.M. and to be sent to Physician I, includes the following documentation;</p> <p>The form instructions include, "This form is only to be used for after hours and non-emergency situations. Once completed, a copy of this form must be provided to the Executive Director for review."</p> <p>Caregiver/Medication Assistant E's written description of Resident 3's event includes, " MA (Medication Assistant) went up to resident room to bandage skin tear from previous fall when</p>	N 353			

For long term care providers, a plan of correction is required for class A, B, & C violations.

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N 353	Continued From page 15 found resident on floor by table MA done R.O.M. (range of motion) All bruises/skin tear comes from first fall. MA then call for assistance. Got resident off floor onto chair. MA then ask resident would (Resident 3) like to go to hospital Res (Resident 3) stated yes. RA (Resident Assistant) also notice when waiting on (ambulance service) that (Resident 3) has been drooling from the mouth, hard for resident to stand on own. Resident was admitted @ (at) (local hospital). Vitals same from first fall. " Resident 3's Service Notes include the following documentation by RCC/RN C. RCC/RN C's documentation includes, "June 10, 2012 0620 (6:20 A.M.). On 6/10/12 resident had a fall. MA (Medication Assistant) went into room to give (Resident 3) A.M. meds (medications) - MA found resident on the floor next to (Resident 3's) recliner (and) heater. MA did ROM (range of motion) and called for assist. ROM (-) (negative) for deficit. MA asked resident what happened (and) resident stated (Resident 3) was going to the bathroom (and) fell. Resident did not have call pendant around (Resident 3's) neck. Resident remained in community - refused to go to hospital. Hands discolored . V.S. (vital signs) done (and) resident up in recliner. Small s/t (skin tear) on arm (and) abrasion on forehead. Resident assisted (with) 2 staff to BR (bathroom) (and) then in recliner. Call pendant placed around residents neck (and) encouraged to call if (Resident 3) needs any help. @ (At) 10:15 (A.M.) MA went up to bandage L (left) knee skin tear (and) found resident on the floor by (Resident 3's) table. (Resident 3) stated that (Resident 3) was picking up (Resident 3's) call pendant (and) lost balance (and) fell again. Staff states that resident was drooling (and) L (left) side of body "didn't seem the same " - Resident was 2 person assist.	N 353			

For long term care providers, a plan of correction is required for class A, B, & C violations.

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N 353	<p>Continued From page 16</p> <p>VS = 96.6 (temperature)-84 (pulse) -18 (respirations) -122/58 (blood pressure). Resident was sent out to (local hospital) per (ambulance service) @ (at) 10:40 A.M. Was admitted to hospital " and "Received a phone call this a.m. from SW (social worker) @ (at) hospital asking if resident had a signed POA-HC. No formal papers received here."</p> <p>On September 4, 2012 at 4:10 P.M., RCC/RN C told Surveyor 14940 she believed POA-HC H was Resident 3's POA-HC, but didn't have documentation of POA-HC in Resident 3's record.</p> <p>Surveyor 14940 asked RCC/RN C to discuss the facility's policy/procedure related to events/falls resulting in known and/or possible head injury, including what is expected of the caregivers on duty.</p> <p>RCC/RN C told Surveyor 14940 that if a resident has a known or possible head injury and does not have an activated power of attorney or legal guardian, that resident should be sent to the hospital, but they may refuse. If the resident refuses to be sent to the hospital, the resident would stay within the community and the caregivers would check on them regularly. If a resident has a known or possible head injury, refuses to go to the hospital, and does have an activated power of attorney or legal guardian, the caregiver would call that resident's activated power of attorney or legal guardian and ask if the resident should be sent to the hospital.</p> <p>RCC/RN C told Surveyor 14940 that Caregiver/Medication Assistant E was 'written up' because Caregiver/Medication Assistant E did not contact a physician, Resident 3's POA-HC H, and RCC/RN C or on-call management after Resident 3's initial fall at 6:20 A.M. on June 10, 2012.</p>	N 353			

For long term care providers, a plan of correction is required for class A, B, & C violations.

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N 353	<p>Continued From page 17</p> <p>Caregiver/Medication Assistant E did not make the necessary contacts until after Resident 3 fell at 10:15 A.M. on the same morning. RCC/RN C said Caregiver/Medication Assistant E was not specific when asked why she did not contact them after Resident 3's first fall that morning.</p> <p>RCC/RN C told Surveyor 14940 that Caregiver/Medication Assistant E continues to work as a caregiver at the facility. RCC/RN C and Surveyor 14940 reviewed Caregiver/Medication Assistant E's "Action Plan For Success Form" signed by Caregiver E and RCC/RN C on June 12, 2012.</p> <p>The "Areas in which the employee's performance is falling below expectations" documentation includes, "Failing to carry out assigned responsibilities or performing substandard work (in quality or quantity), (Resident 3)--family was not called after first fall. Was very upset that she wasn't. Discrepancies in fall report. Looks like family was called before the fall even occurred. No report of hematoma to residents forehead on either report...was it there? Denies that it was present when (Resident 3) left the facility. New set of vital signs must be taken with every fall, yes, even if 4 hrs (hours) apart. You (Caregiver/Medication Assistant E) are lead MA (medication assistant). Please check over work before handing it in to make sure it is totally accurate. Remember, when your name is on it, you are responsible for the information on that report."</p> <p>The "Action Plan for Success" documentation includes, "Call family promptly after a fall. Take vital signs right after every fall, even if is only a short period of time before (sic) falls. Notify R.N. on call immediately after a fall so she can do some assessing over the phone and ask pertinent questions. "</p>	N 353			

For long term care providers, a plan of correction is required for class A, B, & C violations.

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N 353	Continued From page 18 On September 5, 2012, Surveyor 14940 received an email from RCC/RN C that includes the facility's "Resident Emergency Response " procedure, as requested. The document includes the 'Purpose' is "To provide guidance to staff members for responding to resident medical emergencies, accidents or injuries." The document includes, "If an emergency occurs: 1. Evaluate resident's condition. 2. Begin First Aid: Basic first aid care can be administered by an appropriately trained and certified care staff member. 3. If it becomes apparent that a resident is in need of medical help, call 9-1-1 for emergency assistance. Refer to list of Major Emergencies below. If the condition worsens, treat as a major emergency. 4. Keep the resident safe and comfortable and stay with them until help arrives. 5. Provide resident information to the emergency personnel. This should include..... 6. Notify the family/responsible party and physician. 7. Report the event to the Quality Services department and to the state regulatory agency, as required." The documentation of "Major Emergencies" includes, "If a resident experiences any of the following, begin first aid and call 911." The list of "Major Emergencies" includes, "Any trauma to the head." Surveyor 14940 received copies of Resident 3's hospital medical records, as a result of a hospital medical records request. Resident 3's hospital history and physical, dated June 10, 2012, includes, "(Resident 3) presenting with a Fall" and "(Resident 3) complains of a slight headache in (Resident 3's) left temporal area.." Resident 3 has "bruising over left temporal	N 353			

For long term care providers, a plan of correction is required for class A, B, & C violations.

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N 353	<p>Continued From page 19</p> <p>region." Resident 3 received a CT Scan of the head and X-rays of the elbow and knee. Resident 3 was admitted with diagnoses including "Subarachnoid bleed" and a contusion to elbow and knee. Resident 3's hospital discharge summary includes Resident 3 was admitted to the hospital from the facility on June 10, 2012 and discharged to a skilled nursing facility on June 12, 2012.</p> <p>Resident 3's hospital discharge summary, dated July 18, 2012, includes Resident 3 was admitted to the hospital from the skilled nursing facility on June 17, 2012 and discharged back to the skilled nursing facility on June 18, 2012. The summary includes, "(Resident 3) was admitted for observation for subdural hematoma with probable seizure."</p> <p>On September 20, 2012, Surveyor 14940 conducted a telephone interview with POA-HC H. POA-HC H told Surveyor 14940 that she was Resident 3's Durable Power of Attorney for Healthcare during Resident 3's stay at the facility. Surveyor 14940 received a copy of this document from POA-HC H on September 20, 2012. POA-HC H said the facility was given a copy of this document following Resident 3's admission to the facility. POA-HC H said Resident 3's Durable Power of Attorney for Healthcare was activated after Resident 3 was admitted to the hospital on June 10, 2012. POA-HC H told Surveyor 14940 that the facility did not contact her to report Resident 3's initial fall on June 10, 2012. POA-HC H told Surveyor 14940 that she called the facility around 10:00 A.M., or so, on June 10, 2012 and a caregiver told her Resident 3 was being sent to the hospital as a result of falls at the facility.</p>	N 353			

For long term care providers, a plan of correction is required for class A, B, & C violations.

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N 353	<p>Continued From page 20</p> <p>On September 20, 2012, the Department received a certified copy of Resident 3's death certificate. The death certificate includes Resident 3's immediate cause of death as "Complications Following Blunt Trauma of Head with Acute and Chronic Subdural Hematoma" and "Fell While Ambulating." The date and the location Resident 3's injury occurred is documented as "June 10, 2012" at "1601 Wheeler Rd, City of Madison, WI (Legacy Gardens Assisted Living Community)". Resident 3 died on July 23, 2012.</p> <p>On September 27, 2012, Surveyor 14940 conducted a telephone interview with Caregiver/Medication Assistant E.</p> <p>Caregiver/Medication Assistant E told Surveyor 14940 that she was on duty at the facility on Saturday, June 9, 2012 and Sunday, June 10, 2012. Caregiver/Medication Assistant E said she has worked at the facility as a caregiver for approximately five years.</p> <p>Caregiver/Medication Assistant E described Resident 3's condition on Saturday, June 9, 2012 to be Resident 3's baseline. Caregiver/Medication Assistant E said Resident 3 was performing Resident 3's normal activities, such as walking independently and toileting self. Resident 3 was not confused, did not fall during the day shift, and did not have any visible bruises, abrasions, or skin tears. Caregiver/Medication Assistant E said Resident 3 was fine and didn't have any complaints.</p> <p>Caregiver/Medication Assistant E said she came back on duty the morning of Sunday, June 10,</p>	N 353			

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N 353	<p>Continued From page 21</p> <p>2012. Caregiver/Medication Assistant E said she received report from the previous shift prior to starting her duties. Caregiver/Medication Assistant E said the caregivers from the previous shift did not report any changes in Resident 3's condition.</p> <p>Caregiver/Medication Assistant E said she entered Resident 3's room between 6:00 A.M. and 6:30 A.M. to give Resident 3's medication. Resident 3 was on the floor and said Resident 3 had fallen. Caregiver/Medication Assistant E said she noticed Resident 3 had a bruise on the left side of Resident 3's forehead and a skin tear. Caregiver/Medication Assistant E said she and another caregiver assisted Resident 3 up from the floor because Resident 3 was weak. Resident 3 was incontinent of urine, which was unusual for Resident 3. The other caregiver stayed to assist Resident 3 with cares and gave Resident 3 breakfast to eat in Resident 3's room. Caregiver/Medication Assistant E said she believes the other caregiver put a call pendant around Resident 3's neck and told Resident 3 to use it if Resident 3 needed help.</p> <p>Caregiver/Medication Assistant E said she did not call the facility's on call management, a physician, nor Resident 3's POA-HC H after Resident 3's first fall because Resident 3 refused to go the hospital when asked and Resident 3 didn't seem weak. However, Caregiver/Medication Assistant E did tell Surveyor 14940 that Resident 3 did not normally require caregiver assistance with mobility, was not normally incontinent, and did not normally need assistance with cares, all of which occurred after Resident 3's first fall. Caregiver/Medication Assistant E said she also needed to get the rest of her morning medications passed to the other residents. Caregiver/Medication Assistant E said she</p>	N 353			

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N 353	<p>Continued From page 22</p> <p>planned on checking on Resident 3 after she was done with the morning medication pass.</p> <p>Caregiver/Medication Assistant E said she returned to Resident 3's room at approximately 10:00 A.M. that morning to provide first aid to Resident 3's skin tear and to check the bruise on Resident 3's forehead. Caregiver/Medication Assistant E said this was the first time she saw Resident 3 after Resident 3's earlier fall that morning. Caregiver/Medication Assistant E told Surveyor 14940 that she found Resident 3 lying on the floor when she entered the room. Caregiver/Medication Assistant E said she checked Resident 3's range of motion and called for a second caregiver to help get Resident 3 up and into the recliner. Caregiver/Medication Assistant E said she called 911 because Resident 3 was confused and wasn't acting right. Resident 3 was not able to walk without assistance and wasn't able to sit up in the chair without assistance.</p> <p>Caregiver/Medication Assistant E said she called the nurse that was on-call that weekend, Former Facility Nurse M, and reported Resident 3's two falls that morning. Former Facility Nurse M told her she should have called Former Facility Nurse M right away after Resident 3's first fall.</p> <p>Caregiver/Medication Assistant E said Resident 3's POA-HC H called the facility and Caregiver/Medication Assistant E informed POA-HC H that Resident 3 had fallen twice and was being sent to the hospital.</p> <p>On September 27, 2012, Surveyor 14940 conducted a telephone interview with Administrator A. Administrator A told Surveyor 14940 that she did not report Resident 3's fall with injury and hospitalization to the Department because she</p>	N 353			

For long term care providers, a plan of correction is required for class A, B, & C violations.

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N 353	Continued From page 23 didn't realize it was such a concern until after the fact. She didn't realize Resident 3's hospitalization had to do with a fall and/or head injury. Administrator A said Resident 3 received Hospice care related to general deterioration after Resident 3 was discharged from the facility. Administrator A said she would have become aware of Resident 3's falls on Monday, June 11, 2012, at the facility's morning clinical meeting. She would have signed the event report documentation for Resident 3's falls after they went through the facility's system and she was able to review them. Administrator A told Surveyor 14940 that RCC/RN C is responsible for all employee follow up action. Administrator A said she would have told RCC/RN C she needed to coach Caregiver/Medication Assistant E about the events that occurred on June 10, 2012 and then RCC/RN C would provide the coaching and document it. Administrator A said she would review RCC/RN C's follow up documentation to make sure it was accurate and didn't contain anything that could get the facility sued by the employee. Administrator A said Caregiver/Medication Assistant E received coaching, but that it was not a disciplinary issue. It was just a bad judgement call by Caregiver/Medication Assistant E early in the morning of June 10, 2012.	N 353			
{N 383}	83.35(1)(c) Listed areas for assessments. Assessment. Areas of assessment. The assessment, at a minimum, shall include all of the following areas applicable to the resident: 1.	{N 383}			

For long term care providers, a plan of correction is required for class A, B, & C violations.

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0013336	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 10/09/2012
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{N 383}	Continued From page 24 Physical health, including identification of chronic, short-term and recurring illnesses, oral health, physical disabilities, mobility status and the need for any restorative or rehabilitative care. 2. Medications the resident takes and the resident ' s ability to control and self-administer medications. 3. Presence and intensity of pain. 4. Nursing procedures the resident needs and the number of hours per week of nursing care the resident needs. 5. Mental and emotional health, including the resident ' s self-concept, motivation and attitudes, symptoms of mental illness and participation in treatment and programming. 6. Behavior patterns that are or may be harmful to the resident or other persons, including destruction of property. 7. Risks, including, choking, falling, and elopement. 8. Capacity for self-care, including the need for any personal care services, adaptive equipment or training. 9. Capacity for self-direction, including the ability to make decisions, to act independently and to make wants or needs known. 10. Social participation, including interpersonal relationships, communication skills, leisure time activities, family and community contacts and vocational needs. This Rule is not met as evidenced by: Surveyor: 14940 Based on observation, interview, and record review, the facility did not assess the use of a slide and chain type lock installed to the external, top section of Resident 4's bathroom door. The lock prevents Resident 4 from entering the bathroom unassisted. This citation of noncompliance is a repeat violation, initially issued with Statement of	{N 383}			

For long term care providers, a plan of correction is required for class A, B, & C violations.

Wisconsin Department of Health Services

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{N 383}	Continued From page 25 Deficiency (SOD) QJWI11. The findings are as follows; On September 4, 2012, Surveyor 14940 conducted an interview with Wellness Coordinator G about Resident 4's needs and services. Wellness Coordinator G told Surveyor 14940 that Resident 4 is alert and oriented. Resident 4 requires assistance with transfers from Resident 4's wheelchair, but does not like to use a call pendant or the call light system to summon caregiver assistance with mobility. Resident 4 has experienced a recent Urinary Tract Infection and recent falls. Wellness Coordinator G said a lock was recently placed on the outside of Resident 4's bathroom door to force Resident 4 to call for caregiver assistance prior to using the bathroom. This lock was requested by Resident 4's Durable Power of Attorney for Health Care (DPOA-HC) N following a fall Resident 4 experienced in the bathroom. On September 4, 2012 at 9:30 A.M., Surveyor 14940 observed Resident 4 sitting in a wheelchair in Resident 4's bedroom. Surveyor 14940 observed a chain and slide type lock located near the external, top section of Resident 4's bathroom door and wall. This lock was observed to be engaged (locked). Resident 4 told Surveyor 14940 that Resident 4's DPOA-HC N requested the lock. Resident 4 said the lock decreases Resident 4's freedom, as Resident 4 is unable to reach the lock, but Resident 4 agrees with Resident 4's DPOA-HC N's decision. On September 4, 2012 at 1:00 P.M., Surveyor 14940 interviewed Resident Care	{N 383}			

For long term care providers, a plan of correction is required for class A, B, & C violations.

Wisconsin Department of Health Services

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{N 383}	Continued From page 26 Coordinator/Registered Nurse (RCC/RN) C about Resident 4 needs and services. RCC/RN C told Surveyor 14940 that Resident 4 moved to the facility in July 2012 and has experienced several falls since admission. Resident 4 has either Dementia or mild cognitive impairment. Resident 4 has been reminded to use Resident 4's call pendant for caregiver assistance, but Resident 4 still tries to transfer from Resident 4's bed and wheelchair without assistance. Resident 4 has been found on the floor by Resident 4's bedside or on the bathroom floor following unwitnessed falls. RCC/RN C said Resident 4 has not experienced serious injury as a result of these falls. RCC/RN C told Surveyor 14940 that Resident 4 has received some physical therapy at the facility. Resident 4 uses a wheelchair, but has been ambulating to and from meals in the dining room with one assist per physical therapy's recommendation. RCC/RN C said she was aware Resident 4's DPOA-HC N had requested a lock be placed on the outside of Resident 4's bathroom door, but was not aware the lock had been installed. RCC/RN C told Surveyor 14940 that other interventions would and should have been tried first before installing the lock. RCC/RN C said no other interventions have been assessed and attempted related to prevention of Resident 4's falls, other than reminding Resident 4 to use the call pendant and assisting Resident 4 to and from meals. RCC/RN C said she did not know when or who installed the lock on Resident 4's bathroom door. On September 4, 2012, Surveyor 14940 asked RCC/RN C to provide Resident 4's record, including documentation of Resident 4's events specific to falls since Resident 4's admission to	{N 383}			

For long term care providers, a plan of correction is required for class A, B, & C violations.

Wisconsin Department of Health Services

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{N 383}	<p>Continued From page 27</p> <p>the facility.</p> <p>RCC/RN C and Surveyor 14940 reviewed Resident 4's record, including one event management document for a fall and RCC/RN C's service notes, as provided by RCC/RN C.</p> <p>In combination of RCC/RN C's services notes and event management documentation, Resident 4 experienced events pertaining to falls on July 28, August 11, August 13, August 21, and August 28, 2012.</p> <p>RCC/RN C's services notes include, "Late entry 8/17/12 Started ATB (antibiotic) for UTI (Urinary Tract Infection) today."</p> <p>RCC/RN C's services notes include, "8/28/12 FALL - Resident called for assist (and) when MA (medication assistant) answered (Resident 4) was on the floor in bathroom." The documentation includes, "CW NP (Case Worker Nurse Practitioner) contacted and) (Resident 4's DPOA-HC N) was as well. (DPOA-HC N) stated that she wanted a lock on bathroom door so (Resident 4) couldn't get in alone. Informed daughter that it may not be allowed. Will check with (Administrator A) to be sure."</p> <p>RCC/RN C told Surveyor 14940 she did not complete an assessment prior to the installation of the lock on Resident 4's bathroom door. Therefore, there is no documentation of an assessment included in Resident 4's record.</p> <p>On September 4, 2012 at 4:00 P.M., Surveyor 14940 followed up with RCC/RN C on whether or not she was able to ascertain who and when the lock on Resident 4's door was installed. RCC/RN C told Surveyor 14940 that</p>	{N 383}			

For long term care providers, a plan of correction is required for class A, B, & C violations.

Wisconsin Department of Health Services

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{N 383}	Continued From page 28 Administrator A may have installed the lock. On September 4, 2012 at 4:45 P.M., Surveyor 14940 asked Administrator A if she knew who and when the lock was installed on Resident 4's bathroom door. Administrator A told Surveyor 14940 that maintenance put the lock on Resident 4's bathroom door but was not sure who authorized the lock's installation or when it was installed.	{N 383}			
N 386	Surveyor: 21806 83.35(3)(a) Comprehensive Individualized Service Plan Comprehensive individual service plan. Scope. Within 30 days after admission and based on the assessment under sub. (1), the CBRF shall develop a comprehensive individual service plan for each resident. The individual service plan shall include all of the following: 1. Identify the resident ' s needs and desired outcomes. 2. Identify the program services, frequency and approaches under s. HFS 83.38(1) the CBRF will provide. 3. Establish measurable goals with specific time limits for attainment. 4. Specify methods for delivering needed care and who is responsible for delivering the care.	N 386			

For long term care providers, a plan of correction is required for class A, B, & C violations.

Wisconsin Department of Health Services

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N 386	<p>Continued From page 29</p> <p>This Rule is not met as evidenced by: Surveyor: 18702</p> <p>Based on observation, interview, and record review, ISP ' s (Individual Service Plans) for 2 of 2 sample residents (Resident 5 and Resident 6) with side rails attached to their beds did not address the resident's need for and use of side rails.</p> <p>This is evidenced by:</p> <p>The facility is a 73 bed, Class C NA (Non Ambulatory) CBRF (Community Based Residential Facility) licensed to serve persons with advanced age and irreversible dementia/Alzheimer's disease. The census on 9/4/12 was 60.</p> <p>On 9/4/12, the Department conducted an unannounced onsite survey at the facility, including a complaint investigation and verification visit.</p> <p>Observation:</p> <p>During a tour of the facility's second floor at 9 AM on 9/4/12, Surveyor 18702 noted Resident 5 and Resident 6's beds to be fitted with half side rails.</p> <p>Record review:</p> <p>Resident 5</p> <p>Resident 5 has resided at the facility for more than a year; was admitted with diagnoses including Type II Diabetes, Mitral Stenosis, Hyperlipidemia, COPD and CHF; and makes independent health care decisions.</p>	N 386			

For long term care providers, a plan of correction is required for class A, B, & C violations.

Wisconsin Department of Health Services

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N 386	<p>Continued From page 30</p> <p>Resident 5's last documented ISP review is dated and signed during December 2012. The resident's ISP does not indicate that the resident's bed has side rails attached; does not identify the resident's needs and desired outcomes for use of side rails; does not identify program services, frequency and approaches to be provided for use of side rails; and does not specify methods and person responsible for delivering care related to the resident's side rails.</p> <p>Resident 6</p> <p>Resident 6 has resided at the facility for approximately 6 weeks; was admitted with diagnoses including C-Diff, Gait instability, HTN, Depression, Septicemia, and Paraplegia; and has an activated Health Care Power of Attorney.</p> <p>Resident 6's comprehensive ISP is 7/21/12. The ISP documents the resident has gait/balance issues; uses a walker or wheelchair for mobility; and requires a one-person physical assist with transfers. The ISP does not indicate that the resident's bed has side rails attached; does not identify the resident's needs and desired outcomes for use of side rails; does not identify program services, frequency and approaches to be provided for use of side rails; and does not specify methods and person responsible for delivering care related to the resident's side rails.</p> <p>Interviews:</p> <p>During interview at 9:15 AM on 9/4/12, Surveyor 18702 asked Resident 5 about use of the side rails on her bed. The resident reported using the side rails for repositioning; verified understanding safety concerns related to use of side rails; and</p>	N 386		

For long term care providers, a plan of correction is required for class A, B, & C violations.

Wisconsin Department of Health Services

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N 386	Continued From page 31 verified wanting side rails on her bed. During the exit interview on 9/4/12, Surveyor 18702, Administrator A and Resident Care Coordinator/RN C discussed the side rails on Resident 5 and 6's beds and DHS 83 requirements related to the use of side rails. Administrator A and Resident Care Coordinator/RN C reported being aware of side rail requirements. Resident Care Coordinator/RN C said that she didn't think that the side rails on Resident 6's bed are used but would ensure that both ISPs were updated to include side rail information immediately.	N 386			
Z 020	HFS 12.04(2) CONTRACT BACKGROUND CHECKS REQUIREMENT An entity that enters into an agreement or contract under sub. (1) shall obtain, at a minimum from the other entity, university, college or technical school, temporary employment agency, or other person contracted with, and shall retain so that it may be promptly retrieved for inspection by the agency, a letter indicating the name or names, and social security numbers if available, of the caregivers, temporary employees, contractors, or students, listing any convictions learned of during the course of the required background checks, along with any substantiated findings of misconduct, licensure denial or restriction or any other credential limitation found by either the department or the department of regulation and licensing.	Z 020			

For long term care providers, a plan of correction is required for class A, B, & C violations.

Wisconsin Department of Health Services

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Z 020	<p>Continued From page 32</p> <p>This Rule is not met as evidenced by: Surveyor: 18702</p> <p>Based on interview and record review, the facility did not ensure CBC (caregiver background check) requirements were met for 1 of 3 sample employees out of 35 total employees that have worked at the facility for more than 60 days.</p> <p>Caregiver K lived out-of-state (WA) within 3 years prior to employment and has been employed by the facility for more than 60 days. The report from the agency the facility contracts with to process CBC's (Certiphi) included a county background check but did not include a state wide out-of-state background check for Caregiver K as required.</p> <p>This is evidenced by the following:</p> <p>On 9/4/12, Surveyor 18702 randomly selected a sample of 3 employees including Caregiver K and asked Administrator A to provide the employee's records, including CBC's, for review.</p> <p>During review of the facility's employee list and CBC reports provided for Caregiver K, Surveyor 18702 noted the following:</p> <p>Caregiver K had been employed by the facility for more than 60 days.</p> <p>The BID (background information disclosure) form, dated 7/15/11, for Caregiver K identified that Caregiver K lived out-of-state (WA) within 3 years prior to employment.</p> <p>Following review of the records provided, Surveyor 18702 was unable to verify the Certiphi</p>	Z 020			

For long term care providers, a plan of correction is required for class A, B, & C violations.

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Z 020	<p>Continued From page 33</p> <p>reports included evidence of full compliance with CBC requirements, including requirements for employees that resided outside of WI within 3 years prior to employment.</p> <p>During discussion on 9/4/12, Surveyor 18702 and Administrator A reviewed CBC requirements and the Surveyor's concerns regarding the CBC's provided for review. Administrator A stated that similar reports generated by Certiphi were reviewed by the department in the past and had not been an issue. Administrator A was reminded that a NOF (notice of findings) was issued on SOD #175M13 on 6/14/11 that included a tag for noncompliance with this requirement.</p> <p>During the exit interview, Surveyor 18702 and Administrator A agreed that the sample CBC's would be further reviewed in consultation with the Department's Office of Caregiver Quality.</p> <p>Following review of the CBC's by the Office of Caregiver Quality, on 10/3/12 Surveyor 18702 e-mailed Administrator A and facility BOD (Business Office Director)-J to inform them of the result of the review. The e-mail included the following: "Per the WI Caregiver Manual, when an entity contracts out to have CBC's completed, the entity must retain on file a written agreement allowing the contractor to retain the required background information. Then the contractor has to do one of two things:</p> <p>1. The contractor must complete a WI caregiver background check and provide the entity with the actual DOJ criminal history response and the DHS/DRL response (IBIS letter);</p> <p>Or</p>	Z 020			

For long term care providers, a plan of correction is required for class A, B, & C violations.

Wisconsin Department of Health Services

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Z 020	Continued From page 34 2. The contractor must complete a caregiver background check and certify in writing to the entity that the caregiver has no offenses on the Offenses List and advise the entity of any convictions the person has so that the entity may consider whether any convictions are substantially related to the duties of the job. At a minimum, the contracted agency must provide the entity with a letter that includes: ? Each caregiver ' s name; ? Their social security number, if available; ? Any convictions; *from the DOJ report ? Any findings of misconduct; *from the IBIS letter ? Any licensure denials or restrictions; *from the IBIS letter ? Other credential limitations. *from the IBIS letter Based on review of documents provided during the onsite review, the contractor has provided information on the first 3 bullets. What is missing from this report is the information from the IBIS letter (bullets 4,5 &6). Also, as part of the BID, the employee indicates he lived out of state within the past 3 years of hire. The report from the contracted agency did not include any information regarding this status. Per 50.065(2)(bm), the Caregiver Law requires that an entity make a good faith effort to obtain out-of-state conviction records from any state or other US jurisdiction (e.g. tribal courts, Puerto Rico, US Virgin Islands and Northern Mariana Islands, including Guam) for caregivers who are not residents of WI or who have resided outside of WI at any time during the three years preceding the date of the search. It further indicates that the information be equivalent to the	Z 020			

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Z 020	<p>Continued From page 35</p> <p>information specified in par.(am)1. or (b)1 which is the WI Dept of Justice information. That is statewide information therefore; the other state info must also be statewide information. There is no requirement to obtain criminal history information from other countries.</p> <p>The Department has determined that a good faith effort requires the entity to follow the process established in the other state to obtain complete background check information. Unfortunately, each state is different and sometimes they change so the employer needs to check the DOJ website and follow whatever the other state's current process is for requesting the information and document their attempts to obtain the information. The other option is to have the person fingerprinted and request a FBI background check through DOJ."</p> <p>On 10/9/12, Surveyor 18702 received an e-mail from Administrator A that included the following: "It does seem that we are doing everything possible and all good faith is exhibited as mentioned in the email regarding out of state inspections... Below is listed by our national HR dept all that is searched in each request... We use this process in all four communities in Wisconsin and we are the only community that this appears to be an issue. It has never been questioned anywhere else." The 10/9/12 e-mail includes details on information obtained and provided in reports from Certiphi with the following details highlighted:</p> <p>WI Criminal Notes: We will always run the WI statewide no matter where the applicant lists there primary address, if the applicant has an address outside of WI we will process the WI</p>	Z 020			

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Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0013336	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 10/09/2012
NAME OF PROVIDER OR SUPPLIER EMERITUS AT LEGACY GARDENS			STREET ADDRESS, CITY, STATE, ZIP CODE 1601 WHEELER RD MADISON, WI 53704		
(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	
Z 020	Continued From page 36 statewide plus the county of the primary address. National Criminal File Search \$6.00 (National database search covering more than 194 million criminal, sex offender and violation records, includes verification of hits) The e-mail further states "we include the Sanctions and OIG searches in our package that are above and beyond what is required." Surveyor 18702 forwarded a copy of Administrator A's e-mail to the Office of Caregiver Quality. Following review of information provided by Administrator A, the Office of Caregiver Quality e-mailed Surveyor 18702 on 10/11/12 with the results of their review. The e-mail included the following: "Based on the CBC examples you sent, I see the information that is required from the IBIS check - so this report meets that piece of the requirement. However, for out of state background checks, Certiphi does not meet the requirement as follows: WI Criminal Notes: We will always run the WI statewide no matter where the applicant lists there primary address, if the applicant has an address outside of WI we will process the WI statewide plus the county of the primary address. Per 50.065(2)(bm), the Caregiver Law requires that an entity make a good faith effort to obtain out-of-state conviction records from any state or other US jurisdiction (e.g, tribal courts, Puerto Rico, US Virgin Islands and Northern Mariana	Z 020			

For long term care providers, a plan of correction is required for class A, B, & C violations.

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Z 020	Continued From page 37 Islands, including Guam) for caregivers who are not residents of WI or who have resided outside of WI at any time during the three years preceding the date of the search. It further indicates that the information be equivalent to the information specified in par.(am)1. or (b)1 which is the WI Dept of Justice information. That is statewide information therefore; the other state info. must also be statewide information. If Certiphi conducted a statewide check for persons who lived outside of WI in the past 3 years, they would meet the requirement. Since they only do a county check of the other state the person resided in, the out of state background check requirements are not met. In summary, the facility's CBCs do not meet the WI Caregiver Law requirements for conducting out-of-state background checks.	Z 020			

For long term care providers, a plan of correction is required for class A, B, & C violations.