

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525279	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/05/2024
NAME OF PROVIDER OR SUPPLIER Tudor Oaks Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE S77 W12929 McShane Dr Muskego, WI 53150	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49044</p> <p>Based on observation, interview, and record review, the facility failed to ensure a licensed practical nurse (LPN) classified an incident in which a resident was found on the floor beside their bed as a fall for 1 (R1) of 4 sampled residents reviewed for accidents. As a result, the LPN did not implement all post-fall protocols in accordance with facility policies and practices, including the completion of a post-fall evaluation, a post-fall fall risk evaluation, immediate initiation of a fall investigation, communication of a fall to the oncoming shift, and listing the fall on the facility's fall tracking log. In addition, the facility failed to ensure certified nursing assistants (CNAs) transferred a resident using a Hoyer lift (a type of full-body mechanical lift) per the resident's assessment and plan of care for 1 (R2) of 4 sampled residents reviewed for accidents.</p> <p>Findings included:</p> <p>An undated facility policy titled, Falls Management and Prevention, revealed, Purpose: Fall risk assessment, identification and implementation of appropriate interventions as necessary, to maintain resident safety, prevent falls and reduce further injury from falls. The section of the policy titled, Post Fall Procedure indicated, 12. The interdisciplinary team reviews the fall and care plan changes and may, if needed, implement additional interventions. 13. Additional professionals may be contacted to provide assessment and/or interventions regarding fall risk and prevention, including but not limited to, attending physician/provider, pharmacist, physical therapist, occupational therapist, and speech therapist. 14. Documentation of the above items is completed. The policy defined a fall as an unintentional change in position coming to rest on the ground or onto the next lower surface (e.g. [exempli gratia, for example] onto a bed, chair or bedside mat). The fall may be witnessed, reported by the resident or an observer or identified when a resident is found on the floor or ground.</p> <p>An undated facility document titled, HELP I'VE [I have] FALLEN .NOW WHAT?? revealed, as you walk by a room, you glance and see a resident on the floor next to their bed, in the bathroom, dining room, etc. [et cetera, other similar items] What do you do now?? DON'T PANIC! Just follow these simple steps. This document indicated nurses should, -Complete a progress note, risk management assessment, fall risk assessment, and place the resident on the 24 hour report [a report used to communicate information from shift to shift]. The document indicated nurses should also, Obtain statements from all staff on duty and attach them to the fall report and place them under the DON [Director of Nursing] door.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A facility policy titled, Accident / Incident Occurrence- Fall Response, dated 09/26/2018, revealed, The purpose of this procedure is to provide guidelines for assessing a resident after an accident/incident occurrence and to provide guidance in investigating the root cause(s) of the accident/incident. The policy indicated, 2. Investigate Fall Circumstances a. After evaluating and treating the resident, the licensed nurse will initiate an investigation at the time of the fall, evaluating chains of events or circumstances preceding a fall to identify possible or likely causes of the incident. 1) The licensed nurse should talk with the nursing assistant who was assigned to the resident at the time of the fall 2) The staff person that discovered or witnessed the fall should draw the fall scene using stick figures. 3)They should brainstorm together to determine likely causes 4) Re-enacting the incident may be necessary to evaluate the situation more thoroughly. It is critical that the investigation occurs immediately so that valuable clues are not missed. The policy further indicated, 3. Record Circumstances, Resident Outcomes and Staff Response a. The licensed nurse will initiate the Risk Management (SNF [skilled nursing facility]), Incidents (AL) process. b. A progress note should be written by the licensed nurse/s describing the accident/incident in its entirety. The policy specified, d. The incident/accident is added to the monthly incident log for further review by the Falls Management Program team and for QAPI (Quality Assurance and Performance Improvement) analysis/statistics.</p> <p>1.) R1's Admission Record revealed the facility admitted the resident on 12/04/2023. According to the Admission Record, the resident had a medical history that included diagnoses of unspecified dementia, personal history of pathological fracture, orthostatic hypertension, repeated falls, dizziness and giddiness, vertigo, age-related osteoporosis, and other specified disorders of bone density and structure.</p> <p>A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/08/2024, revealed R1 had a Brief Interview for Mental Status (BIMS) score of 13, which indicated the resident had intact cognition. According to the MDS, the resident had no functional impairment in range of motion, used a walker and a wheelchair for mobility, and transferred from one surface to another with supervision or touch assistance. Per the MDS, the resident had sustained one fall without injury since their prior assessment.</p> <p>R1's Care Plan included a focus area, initiated on 12/13/2023, that indicated the resident was at risk of for falls related to dementia, orthostatic hypotension (low blood pressure upon standing), and a history of falls. An intervention dated 12/13/2023 directed staff to follow the facility's fall protocol.</p> <p>An undated facility document titled, Investigation Summary for [R1], signed by the Director of Social Services (DSS), revealed on 05/08/2024, R1 had complaints of pulled muscle pain in their groin area. Per the document, on 05/09/2024, the DSS began collecting statements from staff who worked with the resident, and CNA E reported they found R1 on the floor on 05/07/2024 around 7:20/7:30 PM. The document also indicated that the resident's assigned CNA on the evening of 05/07/2024 was CNA K. According to the summary, CNA K reported she had assisted the resident to bed sometime around 7:00 PM and had not witnessed a fall or assisted in getting the resident off the floor. CNA K reported she was informed of the fall by LPN D, who indicated she was completing the fall incident report. However, the document further indicated that LPN D denied knowledge of a fall in her initial statement and during subsequent follow-ups. The document indicated, It was determined that [LPN D] did not follow the standard of care management protocol when a resident has a fall.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A May 2024 [NAME] Oaks Falls Tracking log did not reflect a fall involving R1 on 05/07/2024, when the resident was found on the floor by staff.</p> <p>R1's Progress Notes revealed a Health Status Note, documented by LPN D on 05/07/2024 at 10:16 PM, that indicated LPN D observed the resident climbing into [his/her] bed, and the resident reported they went to the bathroom and were getting back into bed but thought they may have pulled a muscle in their left inguinal region. While the note reflected the resident was assessed and the resident's bed was low to the floor, a fall mat was in place beside the bed, and the resident's call light was within reach, LPN D's documentation did not specify the resident was found on the floor or sustained an unwitnessed fall.</p> <p>Continued review of R1's Progress Notes revealed no evidence LPN D immediately initiated a fall investigation or began gathering statements from staff, as directed by the facility policy. There was also no indication a post-fall evaluation tool, post-fall fall risk assessment, and risk management assessment were completed related to R1 being found on the floor by staff on 05/07/2024.</p> <p>An email from CNA E to the DSS, sent on 05/13/2024, revealed CNA E provided a typed accounting of her knowledge regarding the incident involving R1 on 05/07/2024. Per the email, CNA E reported R1 was not technically on her assignment list for the day but she did help the resident to the bathroom a few times during the shift. CNA E indicated that later in the evening, after the resident had already been put to bed, she heard the resident screaming for help, and the resident told her they had fallen. CNA E said she saw the resident on the floor near their bed, and the resident told her they fell approaching their bed after toileting themselves independently. CNA E indicated LPN D, and other staff arrived to the room shortly after, and R1 denied pain multiple times. The email further indicated CNA E reported it seemed as though the other staff involved did not feel the need to consider the incident a fall, because the resident had been experiencing multiple falls. CNA E indicated she did not feel she was responsible for saying anything about that because LPN D was also present and as a nurse, knew more about the procedures for falls.</p> <p>During a telephone interview on 06/04/2024 at 10:45 AM, CNA E confirmed she found R1 on the floor sitting by their bed on 05/07/2024. CNA E indicated staff notified LPN D the resident was on the floor again.</p> <p>An Investigation Statement of Staff from LPN D, dated 05/08/2024, revealed LPN D reported she observed R1 climbing around in bed on 05/07/2024, and the resident said they thought they may have pulled a muscle in their left groin. Per the statement, LPN D assessed the resident with no injuries noted and notified the physician and the resident's family.</p> <p>During a telephone interview on 06/03/2024 at 7:12 PM, LPN D stated she remembered R1. LPN D indicated R1 had just moved to the long-term care unit from the rehabilitation unit. LPN D said R1 climbed in and out of bed and got up and down all night long, and the aides had to assist the resident numerous times because the resident was out of bed. LPN D said R1 did not have a fall on 05/07/2024, to her knowledge, but then stated the resident was on the floor on a fall mat. LPN D again stated she did not think the resident fell , but confirmed she knew the resident was on the fall mat. LPN D said no one told her the resident fell , only that the resident was on the floor.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a telephone interview on 06/03/2024 at 6:36 PM, LPN P stated she was not working on 05/07/2024 but worked on the morning of 05/08/2024. LPN P said when she came onto her shift, LPN D did not report that R1 had sustained a fall.</p> <p>During an interview on 06/05/2024 at 11:10 AM, the Administrator (NHA) stated if a resident had a fall, she expected staff to report the fall to her or the Director of Nursing (DON). The Administrator said when a resident was found on the ground, she expected whoever found them to notify the nurse, and the nurse then obtained statements from any staff with knowledge of the incident. The Administrator said the nurse was responsible for starting the investigation, so they could attempt to determine what caused the fall and implement interventions to prevent further incidents. The Administrator said they should also complete a post-fall evaluation, a risk management assessment, and a new fall risk evaluation.</p> <p>During an interview on 06/05/2024 at 11:37 AM, the DON stated she expected the nurse to immediately begin an investigation if a resident fell . The DON said the nurse should also complete the required assessments, including a post-fall evaluation, a skin check, and a fall risk assessment. The DON said if a resident was found on the floor, it was considered a fall and indicated LPN D knew the definition of a fall.</p> <p>2. A facility policy titled, Lifting Machine, Using a Mechanical, revised in 07/2017, revealed, The purpose of this procedure is to establish the general principles of safe lifting using a mechanical lifting device. It is not a substitute for manufacture's training or instruction. General Guidelines 1. At least two (2) nursing assistants are needed to safely move a resident with a mechanical lift. 2. Mechanical lifts may be used for tasks that require: a. Lifting a resident from the floor; b. Transferring a resident from bed to chair; c. Lateral transfers; d. Lifting limbs; e. Toileting or bathing; or f. Repositioning. The policy indicated, Steps in the Procedure 1. Before using a lifting device, assess the resident's current condition including: a. Physical:(1) Can the resident assist with transfer? (2) Is the resident's weight and medical condition appropriate for the use of a lift? b. Cognitive/Emotional: (1) Can the resident understand and follow instructions? The policy directed staff to, Document the following in the medical record: 1. The reason for the transfer. 2. The type of lift used. 3. Equipment size and condition.</p> <p>4. The names and titles of staff assisting. 5. The resident's physical and mental condition before and after the procedure. 6. How the resident tolerated the procedure.</p> <p>R2's Admission Record revealed the facility admitted on the resident on 04/19/2024. According to the Admission Record, the resident had a medical history that included diagnoses of a displaced fracture of the lateral malleolus of right fibula, unspecified fall, muscle weakness, difficulty in walking, unsteadiness on feet, reduced mobility, need for assistance with personal care, hemiplegia and hemiparesis, morbid obesity, and vascular dementia.</p> <p>An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/23/2024, revealed R2 had a Brief Interview for Mental Status (BIMS) score of 10, which indicated the resident had moderately impaired cognition. According to the MDS, the resident had a functional limitation in range of motion on both sides of their upper and lower extremities and was dependent on staff for transfers.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R2's Assistive Device Evaluation, effective 04/19/2024, revealed the resident could not transfer independently. The evaluation specified the resident was to use a walker with therapy's assistance but was to be transferred using a Hoyer lift by staff on the unit and indicated if the device was not used, the resident would be at risk for falls.</p> <p>R2's care plan included a focus area, initiated on 04/30/2024, that indicated the resident was at risk for falls related to deconditioning and a recent fall while at home. Another focus area, initiated on 04/30/2024, indicated the resident had an activities of daily living (DL) self-care performance deficit related to hemiplegia. The goal included demonstrating appropriate use of adaptive devices to increase the resident's abilities. An intervention dated 04/30/2024 indicated the resident would be evaluated and treated by physical therapy (PT) and occupational therapy (OT) per physician's orders; however, the care plan did not specify how staff should assist the resident with transfers.</p> <p>A Physical Therapy Plan of Care, signed by a physical therapist on 04/21/2024, revealed R2 was unsafe with a walker and various models of sit-to stand mechanical lifts, including an EZ stand lift, and the resident required a Hoyer lift at this time.</p> <p>R2's PT/OT/ST [speech therapy] Recommendations to Caregivers, dated 04/21/2024, revealed PT directed staff to utilize two staff members with a Hoyer lift when transferring R2.</p> <p>An undated facility document titled, CNA ASSIGNMENT [sic] #5, also reflected R2 required two staff and the use of a Hoyer lift for transfers.</p> <p>An Alleged Nursing Home Resident Mistreatment, Neglect and Abuse Report, dated 04/26/2024, revealed R2's assigned CNA prepared the resident for a transfer from their wheelchair back to bed using an EZ stand (a type of sit-to-stand mechanical lift). Per the report, during the transfer, the resident had difficulty holding onto the handles of the lift, slid down in the mechanical lift, and ended up sitting on the edge of their mattress. Per the report, the resident did not sustain any injuries, but a post-incident review discovered the resident was supposed to be transferred using a Hoyer lift.</p> <p>During a telephone interview on 06/03/2024 at 10:07 AM, CNA J stated that on 04/26/2024 she and CNA I transferred R2 with a sit-to-stand mechanical lift. CNA J said that during the transfer, the resident started sliding and let go. According to CNA J, the sit-to-stand mechanical lift was approved by therapy, but when asked what R2's care plan reflected for transfer requirements, CNA J said she thought it said Hoyer lift. CNA J said on the day of the incident, she was shown a binder that reflected each resident's transfer requirements.</p> <p>During an interview on 06/03/2024 at 2:14 PM, CNA I stated she remembered the incident involving R2. CNA I said CNA J asked her to assist with transferring R2, and when CNA I asked CNA J what the resident's transfer status was, CNA J said the resident used a sit-to-stand mechanical lift. CNA I indicated she did not know much about the resident, because she had not been assigned to care for them before. CNA I said they used the sit-to stand mechanical lift to transfer R2 from their wheelchair to the bed, but during the transfer, the resident started slipping, and a family member who was also present, held the resident up by their pants to keep them from falling to the floor, while the CNAs maneuvered the resident up onto the bed with the lift.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 06/03/2024 at 12:10 PM, the Director of Nursing (DON) stated R2 required a Hoyer lift for transfers and had not been assessed to use a sit-to-stand mechanical lift at the time of the incident.</p> <p>During a telephone interview on 06/03/2024 at 6:36 PM, LPN P stated on the day of the incident, the CNAs reported they used a sit-to-stand lift; however, LPN P said she did not think the resident was supposed to be transferred with that type of lift. LPN P said R2 required the use of a Hoyer lift instead.</p> <p>During a telephone interview on 06/04/2024 at 1:03 PM, LPN O stated he remembered the incident involving R2. LPN O said he believed it was a misunderstanding between the CNAs on how the resident was supposed to be transferred. LPN O said the resident was supposed to be transferred using a Hoyer lift, but the CNAs used an EZ Stand lift instead.</p> <p>During an interview on 06/05/2024 at 9:50 AM, the Certified Occupational Therapy Assistant/Rehab Manager (COTA/RM) stated she remembered R2. The COTA/RM said that when R2 first came to the facility, they were very weak and required a Hoyer lift for transfers. She said she was the only PT staff involved when staff transferred R2 using the wrong lift. The COTA/RM said on the day of the incident, staff got her, and when she entered the resident's room, the resident was connected to the EZ Stand lift, and appeared to be sliding down, with their buttocks half-way on the bed. The COTA/RM said that after they got the resident situated in the bed, she notified the Administrator the CNAs used the wrong lift, so that the Administrator could address it with the staff.</p> <p>During an interview on 06/05/2024 at 11:10 AM, the Administrator stated she expected staff to follow the care plan and expected a resident's assigned CNA to know how to care for the resident.</p> <p>During an interview on 06/05/2024 at 11:37 AM, the DON stated CNAs should know their residents before they transferred them. The DON further stated CNAs could always check and verify the appropriate mode of transfer if there was a question.</p>		