STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525391	A. Building B. Wing	09/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wisconsin Dells Health Services	300 Race St Wisconsin Dells, WI 53965

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)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33166 Based on interview and record review, the facility failed to ensure staff were following the plan of care, failed to complete a root cause analysis, and failed to ensure fall interventions were functioning properly for 1 of 3 residents (R3) reviewed for falls. R3 has severe cognitive impairment. R3's care plan states R3 is assist of 1 for transfer resident was observed transferring and ambulating independently. Staff were not aware R3 required assistance with transfer and ambulation and did not know a fall intervention was not functioning. Evidenced by: The Facility Fall Prevention and Management Guidelines revised 7/18/24, includes, in part: each resident will be assessed for fall risk and will receive care and services in accordance with their individualized plan of care to minimize the likelihood of falls or reduce the possibility/severity of injury. 3. The nurse will initiate interventions to help prevent falls on the resident's baseline care plan. 6. Each residents risk factors and environmental hazards will be evaluated when developing the residents comprehensive care plan. 8. Review each fall/fall investigation during the next morning meeting/clinical meeting with the IDT (interdisciplinary team). Action of the IDT may include: a. Review of the investigation and determination of potential RCA of fall. b. Review of fall risk care plan and any updates to plan of care completed post fall. c. Additional revisions to the plan of care including any physical adaptation to room, furniture, wheelchair, and /or assistive devices. d. Education of staff as to any care plan revisions. e. Scheduling resident/family conferences. Note: If after the IDT review, it is determined that existing interventions in the care plan are most appropriate, document rationale and describe any additional actions taken. (continued on next page)

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R3 admitted to the facility 4/14/23 with diagnoses including Alzheimer's Disease, weakness, gait disorder and CKD-3 (chronic kidney disease). R3's quarterly Minimum Data Set (MDS), dated [DATE], indicated R3's cognition is severely impaired with a Brief Interview for Mental Status (BIMS) score of 3 out of 15. Section GG indicates R3 requires partial/moderate assistance with toileting, sit to stand is independent, toilet transfer independent, chair bed to chair independent. Walk 10 ft supervision or touch assistance, walk 50 ft supervision or touch assistance with verbal cues or touching/steadying assistance, walk 150 independent. R3 is incapacitated and has an activated power of attorney for healthcare. R3's Assistance for Daily Living (ADL) care plan dated 4/14/23 states in part; ADL self-care deficit r/t (related to) deconditioning/weakness. Interventions: Toileting Assist of 1 stand/pivot and ambulate to bathroom with 4 ww (wheeled walker) revised 4/17/23. Transfer with assist of 1 stand/pivot 4 ww revised 5/5/23. Of note, this is not consistent with R3's most recent MDS. It should be noted besides the mention of assisting to ambulate to the bathroom R3's care plan does not address ambulation in room or hallway. R3's Fall care plan dated revised on 5/2/23 states in part; at risk for fall d/t (due to) deconditioning/weakness, medication use. Resident will self-transfer and attempt to ambulate in halls without waiting for staff assist d/t her cognitive status. Resident likes to rummage with items. Resident frequently forgets to use her 4 WW with ambulation. Goal: Minimize risk for injury r/t falls. Minimize risk for falls. Interventions include anti-skid strips on floor on both sides of bed, initiated 9/11/23, bathroom door alarm, initiated 8/14/23, Bed in low position with resident in bed initiated 4/14/23, bilateral grab bars on bed for positioning/transfers initiated 5/2/23, during periods of restlessness, offer resident items she may rummage through such as a purse, or laundry to fold. Provide with other activity items of interest as needed, initiated 5/4/23. Encourage resident son to assist resident out of car when out of facility near a no curb area, if possible, initiated 9/16/23. Encourage to transfer and change positions slowly, initiated 4/14/23. Ensure that resident is wearing appropriate footwear-gripper socks or shoes on at all times when up OOB (out of bed), initiated 4/18/23. Have commonly used articles and call light within easy reach at all times date initiated, 4/18/23. Offer diversional activity with resident is noted to be rummaging date initiated 5/22/23. Offer to close residents curtains in room after she eats supper date initiated 6/13/23. Offer to walk with resident or provide diversional activity prior to supper date initiated 6/13/23. Reinforce need to call for assistance date initiated 4/14/23. Reinforce wheelchair safety as needed such as locking the brakes date initiated, 4/14/23. Report development of pain, bruises, change in mental status, ADL functioning, appetite, or neurological status post fall date initiate 4/14/23. Sign in room and on walker to remind her to use it at all times when ambulating date initiated 6/25/23. [NAME] at bedside date initiated 6/26/23. Wheel chair removed from room as resident no longer uses this for mobility and stationary chair replaced in room in spot where resident enjoys sitting frequently during the day date initiated 8/29/23. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R3's Certified Nursing Assistant (CNA) Kardex (plan of care) as of 8/31/24 states in part; locomotion wheelchair, 4ww 1 AS (1 assist), remind to use walker, anti-skid strips on floor on both sides of bed, bilateral grab bars, bathroom door alarm, proper footwear gripper socks/shoes when out of bed, call light w/i easy reach at all times, sign in room and on resident walker to remind her to use it at all times when ambulating, stationary chair replaced in room in spot where resident enjoys sitting frequently during the day, walker at bedside, transfer with assist of 1 with gait belt and 4 ww, toilet assist of 1 stand/pivot and ambulation to bathroom with 4 ww. Of note, R3's Kardex and plan of care are not consistent with R3's most recent MDS. R3 has a Post Fall assessment dated [DATE] with a lock time of 22:18 (10:18 PM). Category: Low Risk, Score: 5.0 Triggering: Un-witnessed fall 6/13/24. Date and Time: 6/13/24 at 21:00 (9:00 PM). Current Fall Information: Ask resident following question immediately after the fall: why do you think you fell ? Answer: getting ready for bed. What time was resident last seen: 20:55 (8:55 PM). Who was the staff member that last saw the Resident? Answer (CNA Name). What position was the resident in when last seen? Sitting in chair. What footwear was the resident wearing? Gripper Socks. What was the resident doing at the time of the current fall? Walking. Location of current fall? Bedroom. What assistive devices were in use? Walker. Mental/Behavior Status: Mental Status Prior to current fall? Confused/disoriented most of the time. Mental Status after the fall? Confused/disoriented most of the time. Environment? Call light in reach. Care Plan: List new immediate interventions. Keep walker at her side. Education provided to the following: Resident. Of note, there is an intervention to keep walker at bedside that was initiated on 6/26/23. There is no intervention stating to keep walker at her bedside on R3's care plan after this fall, R3 was last seen in her chair. R3 stated, she was getting ready for bed. According to R3's plan of care R3 needs assistance of 1 to transfer, ambulate. The fall assessment states education was provided to R3; R3 has significant cognitive impairment with a BIMS of 3 and it is unlikely R3 would retain any education. Progress notes date 6/13/24 at 21:42 (9:42 PM) state in part; resident found on floor in her room at 21:00 (9:00 PM) history of falls. Assessed by RN and no injuries. Continue to remind to use walker. A Post Fall assessment dated [DATE] with a lock time of 14:59 (2:59 PM). Category: Low Risk, Score: 7.0 Triggering: Witnessed fall 7/9/24. Date and Time: 7/9/24 at 14:59 (2:59 PM). Fall History: Last 1 month (30 days) 1-2 times. Last 3 months (90 days) 1-2 times. Last 6 months (180 days) 1-2 times. Current Fall Information: List any life safety measures in place prior to this current fall: Shoes, walker with reminders to use, call light within reach. Ask resident following question immediately after the fall: why do you think you fell ? Answer: Caught up in my feet. Resident was going to her room. What time was resident last seen: 13:05 (1:05 PM). Who was the staff member that last saw the Resident? Answer (CNA Name). What position was the resident in when last seen? Walking with her walker. What footwear was the resident wearing? Shoes. What was the resident doing at the time of the current fall? Walking. Location of current fall? Hallway. What assistive devices were in use? Walker. Mental/Behavior Status: Mental Status Prior to current fall? Confused/disoriented most of the time. Mental Status after the fall? Confused some of the time. Care Plan: List new immediate interventions. Don't shuffle feet when walking. Education provided to the following: Resident. We will remind (R3's name) to pick up her feet when walking. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Progress notes dated 7/9/24 at 15:02 (3:02 PM) SBAR (Situation, Background, Assessment, Response) Nurse heard overhead page and went to 300 hall. Resident was on floor on her stomach with her arms tucked into her chest. Resident stated she got caught up in her feet. Assessed for injuries, vital signs taken, staff rolled onto sling and used Hoyer to lift into bed. LUE (left upper extremity) no range without pain. Recommendation: Pick up feet when walking. Late entry for 7/9/24 16:26 (4:26 PM) unwitnessed fall with injury. Note from Assistant Director of Nursing. History of falls became weak tripped over feet. Resident was using her 4 ww. Sent to ER (emergency room) d/t pain in L shoulder. Had dislocated shoulder which ER fixed and requiring to wear a sling times 7 days. New Intervention: To remind resident if feeling weak to not ambulate independently and wait for staff member to help. Of note, R3's Physical Therapy notes indicate R3 was independent with transfers and walking 10 feet at the time of the fall however the facility did not update R3 physical care plan to indicate this change. Additionally, remind resident to pick up feet was not placed on the care plan and R3 is likely not able to remember to pick up feet d/t her severe cognitive impairment. R3 is currently working with therapy on strengthening and gait training. R3 has cognitive impairment and is unlikely to remember to ask for assistance. Progress notes 7/9/24 at 20:17 (8:17 PM) resident has been at hospital most of shift d/t unwitnessed fall earlier. Called @ 1900 (7:00 PM) and advised resident has been released and being sent back. Ambulance arrived at 2000 (8:00 PM) and was in good spirts. Sling to L shoulder which she tries to remove. Continue use of APAP (acetaminophen) or ibuprofen and ice area. Progress notes dated 7/26/24 at 18:51 (6:51 PM) SBAR resident sitting in chair watching T.V. at approximately 1725 (5:25 PM), at 1735 (5:35 PM) staff heard resident calling for help. Resident found on floor with walker parked next to stand under T.V. and resident lying on floor with feet (gripper socks) near walker and head towards center of room resting face first on ground. Unwitnessed fall, resident was trying to get up on own power and staff requested that nurse check her our first. Vital signs within normal limits, full ROM noted to all extremities (of note R3 has a dislocated shoulder and does not have full range of motion of the left shoulder), no bruising, deformities noted at this time. Resident laughing and denying pain. Refused help up with Hoyer just wanted to get up. Staff assisted to sitting position and resident and staff assisted for safety. Signage placed on walker within reach of resident. Monitor frequently. Of note, there is no RCA for this fall. On 9/3/24 at 8:40 AM Surveyor noted a sign on R3's bulletin board, bedside table and walker that stated take your walker. Surveyor noted fall anti slip strips on bilateral sides of bed, a door alarm on the bathroom door and call light in recliner, not within R3's reach. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor asked R3 if she could look for a CNA care card in R3's closet. Surveyor reviewed the care card/Kardex and noted the following: as of 8/31/24, locomotion wheelchair, 4ww 1 AS (1 assist), remind to use walker, anti-skid strips on floor on both sides of bed, bilateral grab bars, bathroom door alarm, proper footwear gripper socks/shoes when out of bed, call light w/i easy reach at all times, sign in room and on resident walker to remind her to use it at all times when ambulating, stationary chair replaced in room in spot where resident enjoys sitting frequently during the day, walker at bedside, transfer with assist of 1 with gait belt and 4 ww, toilet assist of 1 stand/pivot and ambulation to bathroom with 4 ww. Of note, these are the exact interventions from R3's care plan dated 4/13/23. On 9/4/24 at 9:00 AM, Surveyor saw R3 stand up independently in her room, grab her walker and walk to the bathroom. When R3 opened the bathroom door, the door did not alarm. On 9/4/24 at 9:05 AM, Surveyor interviewed CNA C regarding R3 and R3's fall interventions. Surveyor asked CNA C how she is made aware of residents fall interventions. CNA C stated the nurses will report fall interventions, she asks other staff, or uses the Kardex on the computer or in the closet. Surveyor asked CNA C regarding R3's fall interventions. CNA C stated R3 has had some falls and staff need to monitor her. Surveyor asked CNA C what monitoring means, CNA C said to observe her when she is up to be sure she is using her walker. Surveyor asked CNA C about R3's call light and if it was in reach if R3 is sitting in the corner in her wheelchair and the call light is in the recliner, CNA C stated R3 would have to get up to use her call light, but she doesn't really use it. Surveyor asked CNA C about R3's bathroom door alarm and if the alarm should ring when the door is opened. CNA C stated yes. Surveyor asked CNA C if she could test the alarm. CNA C opened the door, and the bathroom door did not alarm. CNA C tried to get the alarm to function, and it would not alarm. CNA C stated I think the battery is dead and went to find a new battery. Surveyor asked CNA C to review R3's Kardex, Surveyor asked CNA C based on what is on the Kardex is R3 to be ambulating independently or toileting independently? CNA C stated no, R3 should be 1 staff assist for transfers and ambulation. On 9/4/24 at 9:15 AM, Surveyor interviewed LPN D regarding R3 and R3's falls and interventions. LPN D stated R3 has a history of falls and has several interventions in place. Surveyor asked LPN D if the call light in the recliner would be within reach if R3 is sitting in her w/c in the corner. LPN D stated R3 would have to wheel to the call light or walk to the light so it's not really in reach; however, R3 does not use her light. Surveyor asked LPN D if R3's bathroom door alarm should ring when the door is opened LPN D stated yes. Surveyor asked LPN D what happens when a resident falls. LPN D stated they complete a post fall assessment, complete vital signs, ensure resident is not injured and will add a new intervention any time it is necessary. The IDT will meet later and discuss the fall and add interventions they feel are appropriate. Surveyor asked LPN D if she was aware of R3's interventions, LPN D stated we need to watch her close and make sure she is using her walker. On 9/4/24 at 2:50 PM, Surveyor observed R3 to be ambulating in the hall way independently with a 4ww. R3 walked through the hall and into her room and sat in her wheelchair there were multiple staff in the hall and no staff assisted R3 with ambulation. R3's call light was observed in the recliner. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/4/24 at 2:55 PM, Surveyor interviewed CNA E regarding R3's fall interventions. CNA E stated R3 is independent with ambulation using her walker. Surveyor asked CNA E if she could review R3's Kardex. After reviewing the Kardex CNA E stated I guess R3 is to be 1 assist with 4ww and gait belt for transfer and ambulation. Surveyor asked CNA E if R3's call light was in reach of where R3 was sitting CNA E stated no but R3 does not use her call light. Surveyor asked CNA E if she could test R3's bathroom alarm, CNA E opened the bathroom door and the alarm immediately sounded. Surveyor asked CNA E based on R3's Kardex should R3 be up alone? CNA E stated no. On 9/4/24 at 1:50 PM, Surveyor interviewed NHA A (Nursing Home Administrator) and asked if she would expect care planned interventions such as ambulate or transfer with 1 assist to be followed, NHA A stated yes. Surveyor asked if fall interventions such as door alarms should be functioning and call lights within reach NHA stated she would expect the door alarm to be functioning and call lights within reach. Surveyor discussed observations of R3 ambulating in the hall independently and ambulating in room and going to bathroom independently. NHA A stated she would agree based on the care plan staff should be assisting R3. Surveyor discussed the observation of the door alarm not functioning in R3's bathroom and the call light now within reach. NHA A stated she would expect the alarm to be functioning and the call light within reach.