STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525494	A. Building B. Wing	09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Serenity Spring Senior Living at Scandia Village	10560 Applewood Rd Sister Bay, WI 54234

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40342 Based on staff interview and record review, the facility did not ensure allegations of potential neglect were thoroughly investigated for 2 residents (R) (R2 and R1) of 3 sampled residents. R2 passed away on [DATE] following a fall on [DATE]. The facility did not thoroughly investigate the incident of potential neglect. R1 fell on [DATE]. R1 went to the hospital on [DATE] due to increased pain and a change in condition and was diagnosed with a clavicle fracture. The facility did not thoroughly investigate the fall or the potential for abuse or neglect. Findings include: The facility was unable to provide a policy related to abuse and neglect investigations. 1. On [DATE], Surveyor reviewed R2's medical record. R2 was admitted to the facility on [DATE] with diagnoses including cerebral infarction affecting right dominant side, familial dysautonomia (a rare inherited condition that affects the nervous system), congestive heart failure, sick sinus syndrome (a group of abnormal heart rhythms resulting from malfunction of the heart's primary pacemaker, the sinus node) and chronic kidney disease. R2's Minimum Data Set assessment, dated [DATE], stated R2's Brief Interview for Mental Status (BIMS) score was 15 out of 15 which indicated R2 had intact cognition. R2 had an activated Power of Attorney for Healthcare (POAHC). R2's code status was Do Not Resuscitate. R2 passed away at the facility on [DATE]. Surveyor reviewed a fall investigation report, dated [DATE], that indicated a Certified Nursing Assistant (CNA) called a nurse to R2's room. Upon arrival, the nurse observed R2 on the floor with a small amount of blood on R2's cheek. The report indicated R2 stated R2 was not sure what happened but did not lose consciousness. Surveyor reviewed a facility-reported incident (FRI) investigation that indicated R2 experienced an unwitnessed fall at approximately 10:27 PM on [DATE]. Emergency Medical Services (EMS) were contacted and responded immediately. EMS assessed R2 and indicated they could find no reason to transfer R2 to the hospital. R2 and R2's POAHC declined further evaluation at the emergency room (ER). Neurological (neuro) checks were initiated. On [DATE] at approximately 5:45 AM, staff reported that R2 was found deceased . The facility initiated an investigation. The report did not indicate any CNAs were interviewed and did not indicate when R2 was last seen alive. (continued on next page)

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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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R2's medical record contained a Post-Fall Steps form, dated [DATE] at 9:30 PM, that indicated neuro checks should be completed every 30 minutes x four, then every eight hours x 3 days. The form indicated neurochecks were completed on [DATE] at 9:30 PM, 10:00 PM, 10:30 PM, 11:00 PM, and 11:30 PM. R2's medical record did not contain any CNA documentation for the overnight (NOC) shift of [DATE] to [DATE]. In addition, R2's medical record contained a nursing note, [DATE] at 11:30 PM, that indicated R2 was in bed, R2's neuro check was within baseline, and R2 did not complain of pain. A nursing note, dated [DATE] at 5:30 AM, indicated the nurse went to complete a neuro check and found R2 unresponsive with no heart rate or respirations. There were no nursing notes between [DATE] at 11:30 PM and [DATE] at 5:30 AM. On [DATE] at 12:15 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A who verified the PM and NOC shift nurses were interviewed, but no CNAs were interviewed. On [DATE] at 1:43 PM, Surveyor interviewed Director of Nursing (DON)-B who indicated staff check residents on the NOC shift every two hours in general. DON-B indicated DON-B would have to check CNA documentation to see if R2 was checked by a CNA during the NOC shift. DON-B indicated R2 used a call light to have R2's urinal emptied if needed. On [DATE] at 4:08 PM, Surveyor interviewed CNA-C via phone who verified CNA-C worked the NOC shift of [DATE]-[DATE]. CNA-C indicated CNA-C also worked the [DATE] PM shift and found R2 on the floor and alerted the nurse. CNA-C indicated R2 was using a wheelchair to go to the bathroom at the time of the fall and was found with a scratch on R2's face. CNA-C indicated CNA-C and Licensed Practical Nurse (LPN)-D checked on R2 approximately every two hours during the night and CNA-C personally checked on R2 at 10:00 PM, 12:00 AM, 1:00 AM, and 3:00 AM. CNA-C indicated LPN-D found R2 passed away on last rounds. CNA-C indicated CNA-C did not notice anything unusual when R2 was checked. CNA-C indicated R2 was sleeping on R2's right side and CNA-C heard R2 snoring which was not unusual. CNA-C indicated R2 activated R2's call light at approximately 11:00 PM and asked to have R2's urinal emptied. On [DATE] at 10:12 AM, Surveyor interviewed LPN-D via phone. LPN-D verified LPN-D worked the NOC shift from [DATE]-[DATE]. LPN-D indicated when LPN-D arrived at approximately 10:00 PM, it was reported to LPN-D that R2 fell on the PM shift and refused to go to the hospital. LPN-D indicated LPN-D completed R2's neuro checks as described above. LPN-D indicated LPN-D checked R2 at approximately 3:00 AM and R2 was sleeping, breathing okay, and was not snoring. LPN-D indicated when LPN-D went into R2's room to complete a neuro check at 5:30 AM, LPN-D found R2 without a pulse, not breathing, and laying on R2's right side with the call light within reach. 43361 2. On [DATE], Surveyor reviewed R1's medical record. R1 was admitted to the facility on [DATE] and had diagnoses including clavicle fracture and muscle weakness. R1's MDS assessment, dated [DATE], had a BIMS score of 12 out of 15 which indicated R1 had moderate cognitive impairment. R1 did not have an activated POAHC. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE], the facility submitted a FRI that indicated R1 complained of new onset of pain on [DATE]. R1 was immediately assessed and sent to the ER for further evaluation. R1 was diagnosed with a clavicle fracture and returned the facility the same day. The facility initiated an investigation. A root cause analysis was completed and indicated the fracture could have been from a fall on [DATE]. At the time of the fall, R1 stated R1 was trying to pick up R1's mail and slipped out of R1's chair. R1 was immediately assessed. R1's range of motion, vital signs, and neuro checks were within normal limits. Dycem to R1's wheelchair was added as an intervention. The fall was an isolated incident and unwitnessed. Surveyor reviewed the FRI and noted the investigation contained interviews with R1 and 1 nursing staff who was working when R1 fell on [DATE]. The investigation did not contain interviews with any CNAs who were working or any other nursing staff who worked between [DATE] and [DATE] regarding the potential that another incident caused R1's fracture. In addition, R1 was not asked if another incident occurred between [DATE] and [DATE] that could have caused R1's fracture. On [DATE] at 1:10 PM, Surveyor interviewed NHA-A regarding the interviews and lack of questioning to rule out other causes of R1's fracture in the 3 days between R1's fall and change in condition. NHA-A acknowledged more interviews and questioning should have been completed as part of the investigation.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40342 Based on staff interview and record review, the facility did not ensure thorough neurological checks were completed per the facility's policy for 2 residents (R) (R2 and R1) of 3 sampled residents. Staff did not consistently complete vital signs during neuro checks following R2's fall on 8/24/24. Staff did not complete neuro checks per the facility's policy after R1 fell and hit R1's head on 8/17/24. Findings include: The facility's Neurological Assessment 2001 Med-Pass policy, revised October 2010, indicates: Neurological Assessment are indicated: Upon physician order; Following an unwitnessed fall; Following a fall or other accident/injury involving head trauma; or when indicated by the resident's condition. 2. When assessing neurological status, always include frequent vital signs. Particular attention should be paid to widening pulse pressure (difference between systolic and diastolic pressures). This may be indicative of increasing intracranial pressure (ICP). Steps in the Procedure: .6. Take temperature, pulse, respirations, blood pressure. 1. On 9/17/24, Surveyor reviewed R2's medical record. R2 was admitted to the facility on [DATE] with diagnoses including cerebral infarction affecting right dominant side, familial dysautonomia (a rare inherited condition that affects the nervous system), congestive heart failure, sick sinus syndrome (a group of abnormal heart rhythms resulting from the malfunction of hearts primary pacemaker, the sinus node) and chronic kidney disease. R2's Minimum Data Set (MDS) assessment, dated 7/3/24, stated R2's Brief Interview for Mental Status (BIMS) score was 15 out of 15 which indicated R2 had intact cognition. R2 had an activated Power of Attorney for Healthcare (POAHC). R2's code status was Do Not Resuscitate. R2 passed away at the facility on 8/25/24. R2's medical record indicated R2 had an unwitnessed fall on 8/24/24. A Post-Fall Steps form, dated 8/24/23 at 9:30 PM, indicated neuro checks should be completed every 30 minutes times x four, then every eight hours x 3 days. The form indicated neuro checks were completed on 8/24/24 at 9:30 PM, 10:00 PM, 10:30 PM, 11:00 PM, and 11:30 PM. R2's neuro check forms included instructions in the Observations and Measurements section that stated, When entering the vital signs, click on 'new'. The date and time will auto-populate, but can be changed if needed. R2's neuro check forms contained the following information: ~ 9:30 PM: Temperature and oxygen saturation (O2 sat) from 6/19/24 at 1:26 AM ~ 10:00 PM: Same temperature as above entry, pulse and respiration rate from 8/24/24 at 9:30 PM ~ 10:30 PM: Same temperature as above entry, pulse and respiration rate from 8/24/24 at 9:30 PM and O2 sat from 8/24/24 at 10:00 PM (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	~ 11:00 PM: New set of all vital signs ~ 11:30 PM: All vital signs listed were from 8/24/24 at 11:00 PM On 9/17/24 at 1:43 PM, Surveyor interviewed Director of Nursing (DON)-B who verified nurses should obtain a new set of vital signs with every neuro check completed. DON-B verified not all R2's vital signs were completed as indicated above. 43361 2. On 9/17/24, Surveyor reviewed R1's medical record. R1 was admitted to the facility on [DATE] and had a diagnosis of clavicle fracture. R1's MDS assessment, dared 9/5/24, stated R1 had a BIMS score of 12 out of 15 which indicated R1 had moderate cognitive impairment. R1 did not have an activated POAHC. A progress note, dated 8/17/24 at 6:05 PM, indicated R1's family was informed that R1 slid out of R1's wheelchair and was found on the floor. R1 hit R1's head and had a small abrasion on the right temple but did not want to go to the hospital. The writer informed R1's family that the facility's fall protocol was to check vital signs and complete neuro checks for 72 hours. R1's family would be notified of any changes. Surveyor reviewed R1's neurological assessments. The assessment forms indicated: Purpose: To record observations following a fall resulting in a known or possible head injury or any other conditions requiring a neuro check. After the completion of the initial neuro check evaluation with vital signs, continue neuro check evaluations every (Q) 30 minutes x 4, then every 8 hours for 3 days or as directed by the provider. Surveyor noted the facility should have completed a total of 12 neuro checks per their policy, however, the facility completed 6 of 12 neuro checks. Surveyor also noted vital signs for 2 of the 6 neuro checks were obtained during a previous neuro check. Documentation was as follows: R1 fell . An initial neuro check was completed and entered at 6:17 PM on 8/17/24. Q 30 x 4 (1) - Completed at 6:30 PM on 8/17/24 Q 30 x 4 (2) - Not completed Q 30 x 4 (3) - Not completed Q 30 x 4 (4) - Completed at 8:00 PM on 8/17/24 Q Shift (1) - Night (NOC) shift - Completed at 4:00 AM (8/18/24). Surveyor noted vital signs were taken from the 8/17/24 neuro check at 8:00 PM. Q Shift (2) - 8/18/24 AM shift - Completed at 12:18 PM. Surveyor noted vital signs were taken from the 8/17/24 neuro check at 6:17 PM. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Q Shift (3) - 8/18/24 PM shift - Not completed Q Shift (4) - 8/18/24 NOC shift - Not completed Q shift (5) - 8/19/24 AM shift - Completed at 8:42 AM Q shift (6) - 8/19/24 PM shift - Not completed Q shift (7) - 8/19/24 NOC shift - Not completed Q shift (8) - 8/20/24 AM shift - R1 experienced an increase in pain and was sent to the hospital Q shift (9) - 8/20/24 PM shift - R1 was at the hospital On 9/17/24 at 1:10 PM, Nursing Home Administrator (NHA)-A acknowledged neuro checks were not completed per the facility's policy and 2 of the neuro checks had previously obtained vital signs. NHA-A indicated a new set of vital signs should be taken for each neuro check.

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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** 43361 Based on observation, staff interview, and record review, the facility did not ensure adequate assistive devices and interventions were in place to prevent falls for 1 resident (R) (R1) of 3 sampled residents. R1's care plan contained an intervention for a tab alarm. The intervention was not consistently implemented. Findings include: The facility's Safety and Supervision of Residents policy (from 2001 Med-Pass, Inc.), revised July 2017, indicates: Individualized, Resident-Centered Approach to Safety: .4. Implementing interventions to reduce accident risks and hazards shall include the following: .d. Ensuring that interventions are implemented. On 9/17/24, Surveyor reviewed R1's medical record. R1 was admitted to the facility on [DATE] and had diagnoses including clavicle fracture and muscle weakness. R1's Minimum Data Set (MDS) assessment, dated 9/5/24, stated R1 had a Brief Interview for Mental Status (BIMS) score of 12 out of 15 which indicated R1 had moderate cognitive impairment. R1 did not have an activated Power of Attorney for Healthcare (POAHC). R1's falls care plan, created on 6/29/23, indicated R1 had gait/balance problems and poor safety awareness. The care plan contained an intervention, dated 7/12/23, for a tab alarm used to alert staff to R1's movement and to assist staff in monitoring R1's movement. On 9/17/24 at 11:40 AM, Surveyor observed R1 in R1's room. R1 was dressed and sitting in the middle of the room in a wheelchair. Surveyor noted R1's tab alarm was not connected to R1's clothing. Certified Nursing Assistant (CNA)-E entered the room to escort R1 to lunch, retrieved R1's flannel shift from a chair, and connected the tab alarm to R1's shirt. When Surveyor asked CNA-E if the alarm should have been in place prior to that moment, CNA-E said yes and stated R1 had a shower that morning. In a subsequent interview at 12:28 PM, CNA-E indicated R1 received a shower at approximately 10:45 AM. On 9/17/24 at 1:10 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A who acknowledged R1's tab alarm should have been in place while R1 was in R1's room in a wheelchair.