

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525630	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/01/2024
NAME OF PROVIDER OR SUPPLIER New Glarus Home		STREET ADDRESS, CITY, STATE, ZIP CODE 600 2nd Ave New Glarus, WI 53574	

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 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49436</p> <p>Based on interview and record review, the facility did not ensure facility staff treated 1 (R5) of 16 residents reviewed with dignity and respect. Facility staff held R5's arms down and gave R5 medication in a syringe when R5 displayed agitation.</p> <p>R5 has dementia with severe agitation. Facility staff held R5's arms down and gave R5 medication in a syringe when R5 displayed agitation.</p> <p>This is evidenced by:</p> <p>The facility policy Medication Administration Policy date created 9/1/23, states in part: .Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice .18. Report and document any adverse side effects or refusals .</p> <p>The facility policy Dementia Care date created 8/1/24, states in part: It is the policy of this facility to provide the appropriate treatment and services to every resident who displays signs of, or is diagnoses with dementia, to meet his or her highest practicable physical, mental, and psychosocial well-being .4. Care and services will be person-centered and reflect each resident's individual goals while maximizing the resident's dignity, autonomy, privacy, socialization, independence, choice, and safety .</p> <p>R5 was admitted on [DATE] with diagnoses that include Alzheimer's disease, dementia severe with psychotic disturbance, dementia severe with agitation, and palliative care.</p> <p>R5's Minimum Data Set (MDS) dated [DATE] indicates a Brief Interview of Mental Status (BIMS) score of 0, indicating R5 has severe cognitive impairment. Section E0100 Psychosis: A. Hallucinations is check marked, Section E0200 Behavioral Symptoms: A. Physical behaviors is marked for 1-3 days B. Verbal behaviors is marked for 1-3 days E0800 Rejection of care is marked for 4-6 days, but less than daily Section K0100 Swallowing Disorder is marked for none of the above.</p> <p>R5's Physician Orders printed 8/1/24 includes orders for the following:</p> <p>Oxycodone (pain medication) 5mg give 0.5 tablet by mouth in the afternoon for pain. Scheduled at 1200PM.</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 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Monitor for the following behaviors (specify): Inability to sleeps, sadness, tearfulness, hallucinations, delusions, paranoia, calling out every shift .</p> <p>Of note, R5's Physician Orders does not indicate medications can be crushed and given via oral syringe.</p> <p>R5's comprehensive care plan ADL self-care performance deficit dated 3/8/24 states in part: .Eating: independent after setup .</p> <p>R5's comprehensive care plan has a [sic] behaviors of agitation, being verbally and physically aggressive toward staff, and being sad and tearful r/t (related to) mood disorder and dementia dated 2/15/24 states in part: .caregivers to provided [sic] opportunity for positive interaction, attention .explain all procedures to the resident before starting and allow the resident to adjust to changes .intervene as necessary to protect the rights and safety of others. Approach/speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed .</p> <p>R5's comprehensive care plan has impaired cognitive function dated 2/15/24 states in part: .face the resident when speaking and make eye contact. Reduce any distractions .The resident understands consistent, simple, directive sentences .stop and return if agitated .</p> <p>R5's comprehensive care plan has a communication problem dated 2/15/24 states in part: .do not rush . provide a safe environment .monitor/document for physical/ nonverbal indicators of discomfort or distress, and follow-up as needed .</p> <p>Surveyor reviewed written statement provided by the facility written by CNA H (Certified Nursing Assistant). CNA H's statement dated 7/8/24, states in part: I had just gotten R5 up for the day at 11:45 AM. She was irritable from not wanting necessary cares done. Immediately after bringing her out to the dining room in her Broda chair (special wheelchair), MT E (Med Tech; a CNA that has been trained to administer medications) tried giving R5 her meds. She was refusing to take them and swinging her arms out of confusion and frustration. MT E continually tried to force her to take her pills, spilling chocolate milk all over R5's clothes. After grabbing her arms and holding them down, she told R5 she is not a five-year-old and to stop acting like one. She doesn't have any teeth or dentures but did try to bite. MT E stated, You can bite me, you don't have any teeth, but I do. I feel this was an extremely inappropriate interaction and feel obligated to report it .</p> <p>Surveyor left a voicemail for CNA H. CNA H has not called Surveyor back for an interview.</p> <p>Surveyor reviewed a written statement provided by the facility written by MT E. MT E's statement dated 7/9/24, states: R5 got up at noon she was in an upset. I laid my arm acrossed [sic] her arms so she could not continue to hit me. She attempted to bit [sic] me I made a comment about don't bit [sic] me you would not want me to bit [sic] you. I then but [sic] her oxy in a suringe [sic] and water. I put liquid in her mouth and rubbed her throat to help her swallow.</p> <p>(continued on next page)</p>		

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<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 8/1/24 at 1:07 PM, Surveyor interviewed MT E. MT E indicated she recalled the incident. MT E indicated the following: She was trying to give R5 her medication but R5 was combative and trying to hit and bite her. MT E was standing in front of and to the left of R5. MT E placed her arms above R5's arms to block R5 from hitting MT E. MT E was trying to reason with R5 saying, You wouldn't want someone to bite you so don't try to bite me. MT E gave R5 her medication via oral syringe because she wanted to make sure R5 received her pain medication. Surveyor asked MT E why she gave the medication via oral syringe. MT E indicated R5 was agitated and would not take her medication. Surveyor asked MT E if R5's behaviors of striking out and trying to bite might be indicative of R5 refusing. MT E agreed that R5's behaviors indicated R5 was refusing her medications. Surveyor asked MT E if R5 has the right to refuse medications. MT E agreed R5 has the right to refuse medications. Surveyor asked MT E if MT E bypassed R5's right to refuse medications by giving medications through an oral syringe in the manner she gave R5 her medication. MT E agreed she did bypass R5's refusal by giving the medication in that manner. MT E indicated she should not give medications if a resident refuses and residents have the right to refuse.</p> <p>On 8/1/24 at 1:52 PM, Surveyor interviewed MT F. MT F indicated if a resident refuses medication, staff will usually try again later or have someone else reapproach. MT F indicated she has used an oral syringe to give R5 medications in the past; usually in the morning if R5 was hollering out or in pain. Surveyor asked MT F if R5 has the right to refuse medications and if staff are bypassing her right to refuse by using the syringe. MT F indicated R5 can refuse medications and staff could be bypassing R5's refusals when they use a syringe.</p> <p>On 8/1/24 at 2:18 PM, Surveyor interviewed RN K. RN K indicated R5 does not always understand why she needs her medications and at times will push them away. RN K indicated when R5 would push the medications away, RN K would try again later. RN K indicated she has never used an oral syringe to give R5 her medications.</p> <p>On 8/1/24 at 2:50 PM, Surveyor interviewed HCM G (Hospice Case Manager). HCM G indicated the following: R5 can take her medications whole but will sometimes spit the medication out. Staff can crush the medication and put the medication in pudding or applesauce. HCM G also indicated R5 has the right to refuse and some of the behaviors could be indicative of R5 refusing. HCM G indicated hospice has not given an order to give medications through an oral syringe and by using the syringe, staff are bypassing R5's refusal.</p> <p>On 8/1/24 at 4:30 PM, Surveyor interviewed DON B (Director of Nursing). DON B indicated residents have the right to refuse medications and by using an oral syringe staff are bypassing R5's refusals.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>49436</p> <p>Based on interview and record review, the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment are thoroughly investigated for 1 of 3 residents (R5) reviewed for self-reports.</p> <p>On 7/9/24, the facility reported an allegation of abuse to the state agency. The facility did not complete a thorough investigation for this allegation.</p> <p>This is evidenced by:</p> <p>The facility policy Abuse, Neglect, and Exploitation Policy & Procedure last updated 2/25/23, states in part: . V. Investigation of Alleged Abuse, Neglect and Exploitation A. An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur .4. Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations .6. Providing complete and thorough documentation of the investigation .</p> <p>On 8/1/24, Surveyor reviewed a self-report the facility submitted regarding an allegation of abuse. Surveyor reviewed statements and interviews the facility had completed regarding the allegation of abuse. Surveyor noted a statement by CNA H (Certified Nursing Assistant) dated 7/8/24. CNA H indicated in her statement a resident's wife may have witnessed part of the incident. Surveyor reviewed interviews completed by the facility. The interviews completed were from 9 residents.</p> <p>Of note, there is no documented interview from the potential witness that CNA H named in her statement. There is no documented interview of the nurse who was supervising the accused med tech (a CNA who is trained and certified to administer medications). In addition, there are no documented interviews from other staff that may have worked with the accused. There are no documented interviews from staff that worked the previous or following shift the day the alleged incident took place.</p> <p>On 8/1/24 at 4:30 PM, Surveyor interviewed DON B (Director of Nursing). DON B indicated there is no other documented interviews and there is no audit or education associated with this allegation of abuse. DON B stated this is not a thorough investigation.</p>		

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<p>F 0689</p> <p>Level of Harm - 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** 41788</p> <p>Based on observation, interview, and record review, the facility did not ensure residents have an environment free of hazards and did not provide adequate supervision and assistive devices for 2 of 5 total sampled residents (R2 & R1).</p> <p>R2's care plan was not followed, resulting in a fall with left distal femur fracture on 7/10/24.</p> <p>R1 was an elopement risk and wears a WanderGuard. R1 was known to make attempts to follow others out of the building. On 7/18/24, R1 eloped from the facility and was found by Witness T approximately 0.3 miles down the road across the street from the church. R1's WanderGuard did not alarm when she exited the Memory Care Unit (MCU) and staff were not aware R1 exited the building.</p> <p>Evidenced by:</p> <p>The facility policy entitled Safe Resident Handling/Transfers, dated 7/15/23, states, in part: .</p> <p>Policy: It is the policy of this facility to ensure that residents are handled and transferred safely to prevent or minimize risks for injury and provide and promote a safe, secure and comfortable experience for the resident while keeping the employees safe in accordance with current standards and guidelines.</p> <p>Policy Explanation:</p> <p>All residents require safe handling when transferred to prevent or minimize the risk for injury to themselves and the employees that assist them. While manual lifting techniques may be utilized dependent upon the resident's condition and mobility, the use of mechanical lifts are a safer alternative and should be used.</p> <p>Compliance Guidelines:1. The Interdisciplinary team or designee will evaluate and assess each resident's individual mobility needs, taking into account other factors as well, such as weight and cognitive status. 2. The resident's mobility needs will be addressed on admission and reviewed quarterly, after a significant change in condition or based on direct care staff observations or recommendations. 3. Mechanical lifting equipment or other approved transferring aids will be used based on the resident's needs to prevent manual lifting except in medical emergencies .13. Staff members are expected to maintain compliance with safe handling/transfer practices .14. Resident lifting and transferring will be performed according to the resident's individual plan of care. This plan of care is to be reviewed and transfer status verified prior to performance of the mechanical lift/transfer .</p> <p>The facility policy entitled Fall Prevention Program, dated 4/4/23, states, in part: .Policy Statement: Each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls .</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Policy: .3. The nurse will indicate on the care plan, the resident's fall risk and initiate interventions on the resident's baseline care plan, in accordance with the resident's level of risk .8. Each resident's risk factors, and environmental hazards will be evaluated when developing the resident's comprehensive plan of care. a. Interventions will be monitored for effectiveness. b. The plan of care will be revised as needed .</p> <p>Example 1:</p> <p>R2 was admitted to the facility on [DATE], and has diagnoses that include unspecified dementia (a group of conditions characterized by impairment of at least two brain functions, such as memory loss and judgement), repeated falls, osteoporosis (a condition in which bones become weak and brittle), and primary generalized osteoarthritis (type of arthritis that occurs when flexible tissue at the ends of bones wears down).</p> <p>R2's Quarterly Minimum Data Set (MDS) assessment dated [DATE] shows R2 has a Brief Interview of Mental Status (BIMS) score of 7 out of 15, indicating R2 has severe cognitive impairment.</p> <p>R2's Care Plan, dated 2/1/24, states, in part: .Focus: (R2) has an ADL (Activities of Daily Living) self-care performance deficit r/t (related to) admission from hospital (11/18/23-11/22/23) for AMS/slurred speech following an unresponsive episode at [Aster ALF], Hx (history) of dementia, CAD (coronary artery disease), arthritis, osteoporosis, depression, HTN (hypertension), HLD (hyperlipidemia), DM2 (Type 2 Diabetes Mellitus), cervicla spondylosis. Date Initiated: 2/1/24 Revision on: 5/9/24.</p> <p>Goal: (R2) will maintain her abilities to participate in her ADLs through the review date. Date Initiated: 2/27/24. Revision on: 7/10/24. Target Date: 8/27/24.</p> <p>Interventions: .</p> <p>*Transfer: EZ Lift 1 assist Date Initiated: 5/9/24</p> <p>*Transfer: EZ Lift 2 Assist Date Initiated: 2/1/24 Revision on: 7/16/24 .</p> <p>Focus: (R2) is at Low Risk for falls r/t Fall Risk Assessment. Falls: 7/10. Date Initiated: 2/1/24. Revision on: 7/11/24.Goal: (R2) will be free of falls through the review date. Date Initiated: 2/1/24. Revision on: 7/10/24. Target Date: 8/27/24 .</p> <p>*Anticipate and meet the resident's needs. Date Initiated: 2/1/24 .</p> <p>*Follow facility fall protocol. Date Initiated: 2/1/24 .</p> <p>*Staff education provided on proper assistive devices for transfers for resident safety. Date Initiated: 7/11/24 .</p> <p>R2's Fall Report, dated 7/10/24, states, in part: .</p> <p>Incident Location: Resident's room .</p> <p>Incident Description-</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Nursing Description: Resident was being assisted to pivot transfer into recliner when her knees gave out and CNA (certified nursing assistant) assisted her to the floor .</p> <p>Immediate Action Taken:</p> <p>Description: Vitals obtained and WNL (within normal limits), AROM (active range of motion) in all extremities, assisted into recliner with 2 staff.</p> <p>Resident Taken to Hospital: N (no) .</p> <p>Injury Type: No Injuries observed at the time of incident .</p> <p>Predisposing Environmental Factors: None</p> <p>Predisposing Physiological Factors: None</p> <p>Predisposing Situation Factors: None</p> <p>Other Info: Failure to follow care plan .</p> <p>Notes:</p> <p>7/18/24 - IDT (Interdisciplinary Team) met and discussed fall- x-rays obtained- fracture noted- transferred to hospital had surgery. Staff educated on transfer status.</p> <p>7/18/24 - Incident reported to state as SRI (self-reported incident). Allegation substantiated. Employee terminated via progressive disciplinary process . for failure to follow plan of care/Kardex resulting in negative patient outcome.</p> <p>(CNA transfered R2 via stand pivot transfer and did not use the EZstand to transfer R2 per the care plan.)</p> <p>R2's Progress Notes:</p> <p>Dated 7/10/23 at 19:26 (7:26 PM) Type: Communication- with Physician</p> <p>Situation: Resident was lowered to the floor during a pivot transfer after supper. Resident's knees buckled during transfer .</p> <p>Assessment (RN (Registered Nurse))/Appearance (LPN (Licensed Practical Nurse)): Resident sitting on floor in front of recliner. Resident was grimacing d/t (due to) pain in bilateral knees and wanted off of the floor. Vitals WNL, AROM in all extremities.</p> <p>Recommendations: (Physician Name) on call, gave verbal order for Diclofenac Sodium Topical Gel 1% every 6 hours as needed to affected areas for pain.</p> <p>On 7/11/24 at 11:11 AM, Type: Communication- with Physician: .Recommendations: Update NP (Nurse Practitioner) of left leg pain with transfers- x-ray to left leg ordered.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 7/11/24 at 1:42 PM Type: Transfer to Hospital Summary. Note Text: Resident was noted to have fallen on the PM shift on 7/10; resident complaining of left leg pain when transferring with the EZ stand but not when sitting; x-ray order for whole left leg noted fracture; POA (Power of Attorney)(name) called and agreed with transfer to (hospital name) ER (emergency room) .</p> <p>R2's Facility Reported Incident, dated 7/18/24, states, in part: .Summary of Incident: Allegation Type: Neglect: Intentionally withholding care, disregard of policy or care plan.</p> <p>Name Affected Person- (R2) .Date occurred: 7/10/24. Time Occurred: 6:00 PM .</p> <p>Brief Summary of Incident: On 7/11/24, it was discovered during review of clinical records that at approximately 18:00 (6:00 PM) on 7/10/24, resident (R2) became weak during a transfer and was lowered to the floor with staff assistance. Resident (R2) was immediately assessed and began to complain of leg pain; a stat x-ray was ordered, revealing the resident had sustained a fracture. The involved staff member was immediately suspended pending the outcome of the investigation. POA and MD (Medical Doctor) were notified, and orders were received to send the resident to the ER for further evaluation and treatment. Investigation initiated, final report to follow .</p> <p>Summary of Incident: .Briefly Describe the incident .On 7/11/24, it was discovered during review of clinical records that at approximately 18:00 on 7/10/24, resident (R2) became weak during a transfer and was lowered to the floor with staff assistance. Resident (R2) was immediately assessed and began to complain of leg pain; a stat x-ray was ordered, revealing the resident had sustained a fracture.</p> <p>Describe the effect that the incident had on the affected person, the person's reaction to the incident, and the reaction of others who witnessed the incident . :</p> <p>Post incident (R2) was complaining of leg pain. POA and MD notified; MD gave orders to apply topical pain-relieving gel every 6 hours as needed for pain, which was effective for the remainder of the day. On 7/11/24, resident (R2) continued to complain of pain in the left leg. The MD was notified, and stat x-rays of the left leg were ordered. Results indicated a mildly displaced, oblique fracture to the left leg, corresponding clinically with osteopenia. The MD was again notified, and this time gave orders for resident (R2) to be sent to the hospital for further evaluation and treatment, as needed. (R2) was admitted and underwent surgical repair to the fracture, returning to the facility on [DATE]. Based on a review of the hospital records, (R2) has a left distal femur fracture due to a combination of osteoporosis and trauma, as trauma alone would not have caused the fracture.</p> <p>Explain what steps the entity took upon learning of the incident to protect the affected person(s) and others from further potential misconduct . :A further review of the incident revealed that the CNA performed a pivot-style transfer on resident (R2); it was further noted that the transfer status orders for resident (R2) was for an assist of one person using an EZ Stand mechanical lift. This was discovered prior to the CNA reporting to work that day; the CNA was disciplined using the facility's progressive disciplinary process, resulting in termination of employment from the facility on 7/12/24. The CNA did not provide any care to the residents on that day as the termination happened prior to the commencement of the shift .</p> <p>R2's Radiology Report, dated 7/11/24, states, in part: .</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Femur Min 2 Views, Left: Results: Mildly displaced, oblique fracture through the distal femur metadiaphysis . Conclusion: Mildly displaced, oblique fracture through the distal femur metadiaphysis .</p> <p>R2's Orthopedic Surgery History & Physical, dated 7/11/24, states, in part: .</p> <p>admitted : 7/11/24 7:01 PM .Chief Complaint: Left leg pain. History: . history including dementia, HTN, hyperlipidemia presents today with a complaint of left leg pain. She apparently had fallen yesterday and was complaining of pain. She doesn't remember how she had fallen. She had some x-rays of the left femur done at an outside facility showing she had a distal femur fracture .</p> <p>Date of Injury: 7/10/24</p> <p>Location (pain): left leg</p> <p>Quality/description (pain): nothing at rest to sharp with movement</p> <p>Severity: (1-10): 0-6/10</p> <p>Modifying factors: None</p> <p>Associated signs and symptoms: unable to bear weight .</p> <p>Patient Active Problem List: .</p> <p>Closed fracture of left femur, unspecified fracture morphology, unspecified portion of femur, initial encounter .</p> <p>Imaging: I personally reviewed the x-rays of the left femur which demonstrate non-displaced distal femur fracture .</p> <p>Assessment: Left distal femur fracture due to a combination of osteoporosis and trauma .</p> <p>Plan:</p> <p>-Indicated operation: Retrograde nailing of left femur by (Physician name)</p> <p>-Date of operation: 7/12/24 .</p> <p>R2's Discharge Summary, dated 7/15/24, states, in part: .Date of Admission: 7/11/24 Date of Discharge: 7/15/24</p> <p>Clinical Resume: (R2) . female who suffered the following injury prior to admission: left distal femur fracture . She was evaluated by the orthopedic service and left femur retrograde nailing was recommended . She was taken to the operating room on 7/12/24 where the above procedure was performed .By post-op day number 3, she was found to be both medically and orthopedically stable but not appropriate to return home independently. Therefore, she is being sent to a nursing home for proposed short term nursing home care and therapy .</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER New Glarus Home		STREET ADDRESS, CITY, STATE, ZIP CODE 600 2nd Ave New Glarus, WI 53574	
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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 8/1/24 at 10:08 AM, Surveyor interviewed CNA I who indicated staff follow resident care plans and Kardex's to care for residents. CNA I indicated staff should never use less assistance than what a resident is care planned for, and no staff should use a pivot transfer if a care plan says to use an EZ stand.</p> <p>On 8/1/24 at 10:13 AM, Surveyor interviewed CNA J who indicated staff follow the Kardex/care plans to care for the residents. CNA J indicated staff should never use less assistance than what the care plan indicates.</p> <p>On 8/1/24 at 12:55 PM, Surveyor interviewed LPN C (Licensed Practical Nurse) and asked LPN C to tell Surveyor about the events on 7/11/24 that led to sending R2 to the ER. LPN C indicated when she came onto shift, she saw the fall report on R2 on 7/10/24 that indicated R2 had fallen from a pivot transfer. LPN C indicated R2 was an EZ stand transfer. LPN C indicated the CNAs reported to her that morning that R2 was complaining of left knee pain with morning care. LPN C indicated she had asked other staff if R2 had been sent out to ER from fall and was told no, the MD had been notified and an order was received to use Voltaren Gel. Surveyor asked if R2 had pain in her knees prior to fall and LPN C indicated no. LPN C indicated she asked RN D (Registered Nurse), who is one of the charge nurses, if facility could get an order for an x-ray. LPN C indicated the facility uses Mobile X that comes to facility to x-ray. An order was obtained from nurse practitioner and Mobile X arrived at facility around 11:00 AM to x-ray R2's left leg. LPN C indicated R2 had stayed in bed after breakfast up until transfer to ER due to pain with any movement to left leg. At 1:30 PM, after receiving the x-ray results the MD was phoned, and orders were received to send R2 to ER.</p> <p>On 8/1/24 at 1:15 PM, Surveyor interviewed RN D and asked what R2's transfer status was at the time of the fall on 7/10/24, and RN D indicated R2 was assist of 1 with an EZ stand. Surveyor asked RN D at the time of the fall how was R2 transferred, and RN D indicated she was not here at the time of the fall but in the clinical meeting it was discussed, and R2 was transferred with assist of 1 pivot transfer. RN D indicated LPN C had come to her the morning of 7/11/24 and indicated R2 was having pain when standing and no pain with resting. RN D sent an urgent email to NP and received orders to x-ray at facility. Surveyor asked RN D if she had assessed R2 and RN D indicated no, it was discussed at the clinical meeting with three nurse managers, DON B (Director of Nursing), and NHA A (Nursing Home Administrator) to get x-ray order.</p> <p>On 8/1/24 at 4:30 PM, Surveyor interviewed DON B and asked if she would expect staff to follow care plans and DON B indicated yes. Surveyor asked DON B if a resident is care planned to transfer with an EZ stand and 1 assist would you expect that to be followed and DON B indicated yes. Surveyor asked DON B if she would have expected an RN to assess R2 for pain the morning R2 was complaining of left leg pain and DON B indicated yes. Surveyor asked DON B what the facility has done at this point to ensure staff are following the care plans and DON B indicated the care plans and Kardexs have been reviewed and updated. Surveyor asked DON B since R2's fall on 7/10/24 has DON B observed any transfers with staff and DON B indicated yes but they are not documented. DON B indicated the facility will be doing audits on transfers.</p> <p>On 8/1/24 at 2:15 PM, Surveyor interviewed NHA A. NHA A indicated he has been working on a PIP (Performance Improvement Plan) regarding R2's fall on 7/10/24 FRI (Facility Reported Incident). NHA A indicated education on Safe Resident Handling and Policy was put out on the work web for staff on 7/19/24. NHA A indicated this will be going to QAPI (Quality Assurance and Performance Improvement) on 8/14/24. NHA A indicated the audits have not been started yet.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Of note: Six staff were working on 8/1/24 that had not yet been educated on following the care plan related to R2's fall with fracture.</p> <p>On 8/5/24 at 3:15 PM, Surveyor interviewed RN R. RN R indicated the CNA did not follow R2's care plan and should have. RN R indicated the CNA had come and asked RN R to assist R2 off the floor as she had to lower her to the floor. RN R indicated the CNA had transferred R2 by pivot transfer and R2 should have been a one assist with an EZ stand transfer. RN R indicated she checked ROM to lower extremities and all checked out. RN R indicated R2 was able to lift left leg just not as high as right leg. RN R indicated R2 had no complaints of pain anywhere but in her knees. RN R had phoned the MD and son, received orders for Voltaren gel. Voltaren gel and tylenol was administered to R2 by RN R and was effective.</p> <p>The facility did not follow R2's care plan while transferring R2 resulting in R2 obtaining a left distal femur fracture.</p> <p>The following example is isolated, no actual harm potential for minimum:</p> <p>30992</p> <p>Example 2:</p> <p>The facility policy, Elopement and Wandering, last revised 6/5/24, indicates the following: The facility ensures that residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk.</p> <p>Definitions</p> <p>Wandering is random or repetitive locomotion that may be goal-directed (e.g., the person appears to be searching for something such as an exit or non-goal directed or aimless.</p> <p>Elopement occurs when a resident leaves the premises or a safe area without authorization (i.e., an order for discharge or leave of absence) and/or any necessary supervision to do so.</p> <p>Procedure:</p> <ol style="list-style-type: none"> 1. The facility is equipped with door locks/alarms to help avoid elopements. 2. Alarms are not a replacement for necessary supervision. Staff are to be vigilant in responding to alarms in a timely manner. 3. The facility shall establish and utilize a systematic approach to monitoring and managing residents at risk for elopement or unsafe wandering, including identification and assessment of risk, evaluation and analysis of hazards and risk, implementing interventions to reduce hazards and risks, and monitoring for effectiveness and modifying interventions when necessary. <p>Monitoring and Managing Resident at Risk for Elopement or Unsafe Wandering</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>.e. Interventions to staff awareness of the resident's risk, modify the resident's behavior, or minimize risks associated with hazards will be added to the resident's care plan and communicated to appropriate staff. F. Adequate supervision will be provided to help prevent accidents or elopements.</p> <p>Procedure for Post-Elopement</p> <p>.e. Staff may be educated on the reasons for elopement and possible strategies for avoiding such behavior.</p> <p>The facility's Memory Care Unit (MCU) is unlocked and equipped with Wanderguard sensors at each exit.</p> <p>R1 was admitted to the facility on [DATE] with diagnoses that include severe dementia without behavioral disturbance, encephalopathy, muscle weakness, chronic kidney disease stage 3, disorders of bone density and structure.</p> <p>R1's Admission Minimum Data Set (MDS) dated [DATE] indicates R1 has a Brief Interview of Mental Status (BIMS) of a 3 out of 15, which indicates she is severely cognitively impaired. R1 has an Activated Power of Attorney for Health Care (APOAHC).</p> <p>R1's Comprehensive Care Plan indicates the following: Focus: I am at risk for elopement as evidenced by a history of wandering r/t Dementia. Goal: I will not leave the facility unescorted through next review. Interventions:</p> <p>(Date Initiated: 7/15/24) Move resident to memory care unit</p> <p>(Date Initiated: 7/22/24) Monitor Wanderguard placement and function every 4 hours. If Wanderguard is not functioning properly, replace it.</p> <p>(Date Initiated: 7/22/24) If Wanderguard system is not functioning/alerting properly, provide frequent checks on residents at elopement risk, Initiate batch order in TAR (Treatment Administration Record) and monitor until system is functioning properly.</p> <p>(Date Initiated: 7/22/4) I wear a Wander Guard on ankle</p> <p>(Date Initiated: 7/1/24) Anticipate my needs to the extent possible to help alleviate my wandering and exit seeking.</p> <p>(Date Initiated: 7/1/24) Ensure I do not accidentally follow visitors out of the building</p> <p>(Date Initiated: 7/1/24) [NAME] my room door with a familiar object, photo, etc. to aid in remembering its location.</p> <p>(Date Initiated: 7/1/24) Provide me reassurance and comfort when I am anxious.</p> <p>(Date Initiated: 7/1/24) Reassess my elopement at least quarterly.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>(Date Initiated: 7/1/24) Use diversional activities that I enjoy when exit-seeking behavior is occurring (i.e.: offer snacks, provide tactile stimulation, listen to music with me, etc.)</p> <p>(Date initiated: 7/1/24) Use verbal cues and gentle touch to redirect my exit-seeking behaviors.</p> <p>R1's Elopement Risk Evaluation dated 7/1/24 documents a score of 2, indicating R1 is At Risk of elopement. A score of greater than or equal to 1 = At Risk.</p> <p>R1's Elopement Risk Evaluation dated 7/18/24 documents a score of 4, indicating R1 is At Risk of elopement.</p> <p>On 7/18/24 the facility completed a Self-Report</p> <p>Is the date and time when occurred known: Yes</p> <p>Date occurred: 7/18/24</p> <p>Time occurred 6:00 PM</p> <p>Is occurred date and time estimated: Yes</p> <p>Date discovered: 7/18/24</p> <p>Briefly describe the incident: It was reported by facility staff that at approximately 6:00 PM on 7/18/24 staff were alerted to a resident outside the facility.</p> <p>Explain what steps the entity took upon learning of the incident to protect the affected person(s) and others from further potential misconduct: At approximately 5:45 PM, as staff were rounding the unit, it was noted that resident (R1) was no longer in her room. A more thorough search of the unit and immediate area did not reveal the location of R1. A facility-wide search was initiated and the family and Administrator were notified. At approximately 6:00 PM, the facility was notified that R1 was found to be at the Baptist church immediately adjacent to the facility property. The resident was returned to the facility and immediately assessed. There were no obvious signs or symptoms of physical, mental, or psychosocial distress nor new complaint of pain. The POA (Power of Attorney) and MD (Medical Doctor) were notified, and no new orders were received. Resident (R1) was placed on increased staff observation for the remainder of the evening.</p> <p>The facility's Self Report documents the following staff have Information about incident: CNA L (Certified Nursing Assistant), CNA M (Certified Nursing Assistant), RN Q (Registered Nurse) Maintenance Director N, FM O (Family Member) and FM P (Family Member).</p> <p>CNA L's (Certified Nursing Assistant) wrote the following statement: R1 had been in her room with her family member (FM P - Family Member) eating. FM P left to go help her other family member. R1 came to dining room and sat with another resident. R1 went to her room around 5-5:15 PM and had not been seen by myself as I had been feeding other residents, CNA M (Certified Nursing Assistant) was helping a sick resident in his room, RN Q (Registered Nurse) was passing meds (medications). No alarms sounded to alert us to anything wrong.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>CNA M (Certified Nursing Assistant) wrote the following statement: R1 was here. FM P brought her supper. She left after FM P went home. We did not hear any alarms going off.</p> <p>RN Q (Registered Nurse) wrote the following statement: R1 was reported to last be seen in dining room at about 5:15 PM. Was alerted to resident not being at NGH (New Glarus Home - the facility) by LPN C (Licensed Practical Nurse). LPN C stated that the resident was at the church. R1 was known to be with FM P for dinner at 4:30 PM, seen by me. 6:10 PM, FM P was called for whereabouts of resident (R1) was not with FM P. 6:25 PM DON B (Director of Nursing) was contacted. No alarms were activated on unit from 3:00 PM until R1 was returned to the 400 unit.</p> <p>On 7/18/24 at 7:53 PM, Maintenance Director N sent the following email to NHA A (Nursing Home Administrator). Hello (NHA A's name), After receiving your call at 6:37 PM, I came in to check the Wanderguard system for the 400 wing. I spoke with RN Q (Registered Nurse) who was stationed there and he said it never went off during his shift which started at 3pm. I was in my office until 6pm and I did not hear the Wanderguard go off during that timeline.</p> <p>I asked if I could take her tag (Wanderguard) to test it, however they said they didn't know if they had another band for her. I used our testing tag on the North side of the 400 wing (the side they said she must have left from), and I was unable to get out of the door approximately 7 times that I tested it. I then placed the tag inside my boot. At this point I was able to get through the door without setting the alarm off. I proceeded to test this approximately 3 more times with two more escape successes. I then proceeded to look at the control box and confirm the sensor settings were correct. The sensor sensitivity was set at almost the maximum frequency. I went back into the hallway and adjusted the motion sensor to be more fixated on the door. I proceeded to test the door with the tag in my boot and noticed going back into the 400 the alarm did not go off. I tested the door a few more times with at least one more success. I proceeded back into the control box and this is when I noticed the antenna was hanging from a wire and the sheath was on the floor. I was able to put the antenna back without further damage to it and proceeded to test the door approximately 10 more times. Each time the alarm went off. I tested going fast as well as multiple times going very slowly. Additionally, for a frame of reference, while going slow, I had the door about 1/3rd of the way open before the alarm would go off.</p> <p>At approximately 7:17 (pm), I called Accutech to have a technician to come out and inspect the system to confirm it is working properly. It is after hours, so I left a message for them to come out. Additionally, I purchased a plastic crate to put over the control box to deter damage from happening to the antenna (scheduled to arrive Monday July 22nd). Until a technician comes out with a new antenna and checks over the system to confirm it is working properly, I will do daily checks of the Wanderguard system. (Of note, the technician came out on 7/19/24 and the issue was resolved at that time.)</p> <p>Note there is no statement from FM P (Family Member) in the investigation.</p> <p>On 8/1/24 at 12:20 PM Surveyor spoke with RN Q (Registered Nurse). Surveyor asked RN Q if he put a new Wanderguard on R1. RN Q stated, no, because when we tested it after she returned to the facility it was working. RN Q reiterated that no alarms sounded at the time R1 eloped from the facility. RN Q stated, when she was brought back through the Wellness Center that door alarmed. When we tested her alarm through both doors on the 400 unit, R1's Wanderguard alarmed both times. RN Q stated, he did not change out the Wanderguard because it was working after she returned to the facility.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 8/1/24 at 12:38 PM, Surveyor spoke with FM P (Family Member). Surveyor asked FM P to tell surveyor about R1 and what occurred on 7/18/24. FM P stated she took care of R1 prior to her admission to the facility. FM P stated, R1 is more of a handful with her memory. FM P stated, R1 never wandered away from her home prior to moving to the facility. FM P stated, when R1 was still living at home she found her trying to open a bottle of toilet bowl cleaner that R1 verbalized she was going to to put in her mouth. Surveyor asked FM P, does R1 have decreased safety awareness. FM P stated, Oh god, yes! FM P stated R1 is in excellent physical shape and she used to walk 2 1/2 miles every day. FM P stated, R1 fell at home many times, cracked her head on a TV stand but never broke any bones. FM P stated, on 7/18/24 she brought R1 Culvers and they had dinner together in R1's room. FM P stated, I told them (staff) I was leaving. FM P stated, she suspects that R1 saw her leave the facility and attempted to follow her. FM P stated, she was home for 45 minutes before she received a call from the facility asking if R1 was with her. FM P stated, It was very messed up. FM P stated, RN Q (Registered Nurse) told her, We don't know where R1 is. FM P stated, hearing that the facility does not know where R1 is made her feel, Really, really, really upset. FM P stated, she can easily see R1 going for a walk in the woods next to the facility. FM P stated, R1 does not like to be alone, she likes to talk with others. FM P stated, she later found out a couple found R1 near the Baptist church down the road from the facility and they returned her safely to the facility. FM P stated, her understanding from the facility is if the bracelet (Wanderguard) is exposed it works if covered by a pant leg it would not work. FM P stated, R1 will make statements that She wants to go home and that she's Going home.</p> <p>FM O (Family Member) is R1's APOAHC (Activated Power of Attorney for Health Care). Surveyor attempted to speak with FM O without success.</p> <p>On 8/1/24 at 1:50 PM, Surveyor spoke with LPN C (Licensed Practical Nurse). Surveyor asked LPN C to tell surveyor about what occurred on 7/18/24. LPN C stated, she was working on the 100 and 200 units and took the phone call. LPN C stated, she received a phone call from Activ Asst S (Activity Assistant) who was not working at the time. Activ Asst S's family member, Witness T, saw R1 walking down the road near the church and contacted Activ Assist S to see if she knew R1. Activ Asst S told Witness T, R1 lives at the facility to bring her back to the facility to the Wellness Center (Rehab entrance) and wait until a staff member meets them at the door. Activ Asst S reiterated, she told Witness T to not leave R1 until somebody comes to get her. Activ Asst S stated, That's a long walk, thank god she didn't get hurt. Surveyor requested Witness T's name and phone number. Activ Asst S provided Witness T's name and phone number.</p> <p>On 8/1/24 at 2:06 PM, Surveyor spoke with MR U (Medical Records). Surveyor asked MR U to describe her system for Wanderguards. MR U stated, the only things she does is to purchase the bands and tags and when she receives a tag she uses a tester box. MR U stated she does not have a spreadsheet or any system to know which resident has what Wanderguard or to know when they expire. MR U stated, when staff report a Wanderguard is not working they give it to her or leave it in her mailbox and she returns it to the manufacturer.</p> <p>(continued on next page)</p>		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 8/1/24 at 2:47 PM, Surveyor spoke with Witness T. Surveyor asked Witness T to tell Surveyor what happened on 7/18/24. Witness T stated, she and her family were going to church for supper. Witness T stated, she saw R1 walking slowly by the church and She couldn't walk well. Witness T stated, R1 looked out of place. Witness T stated, I was worried she was really hunched over. Witness T asked R1 if she needed help crossing the street. R1 told Witness T she was trying to get home and lives by the Landhaus (Chalet Landhaus Inn). Witness T stated, R1 said, I walked down the hill but my legs are so tired. Witness T offered to give R1 a ride home. R1 [TRUNCATED]		