STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0012212	A. BUILDING: _____ B. WING _____	C 07/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMEPLACE (THE)	225 E 4TH AVE STANLEY, WI 54768

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	Initial Comments On 07/07/2023, Surveyor conducted a 2-complaint investigation at The Homeplace. Data collection continued through 07/28/2023. Two of 2 complaints were substantiated. Six deficiencies were identified. Two of the 6 were repeat violations (see SOD OFNP11, dated 04/02/2019, SOD NQFE11, dated 03/04/2020, and SOD S75L13, dated 05/10/2022). Census: 22	N 000		
N 158	83.12(2)(a) Caregiver: Investigating abuse & neglect Investigating and reporting abuse, neglect, or misappropriation of property. Caregiver. 1. When a CBRF receives a report of an allegation of abuse or neglect of a resident, or misappropriation of property, the CBRF shall take immediate steps to ensure the safety of all residents. 2. The CBRF shall investigate and document any allegation of abuse or neglect of a resident, or misappropriation of property by a caregiver. If the CBRF ' s investigation concludes that the alleged abuse, or neglect of a resident or misappropriation of property meets the definition of abuse or neglect of a resident, or of misappropriation of property, the CBRF shall report the incident to the department on a form provided by the department, within 7 calendar days from the date the CBRF knew or should have known about the abuse, neglect, or misappropriation of property. The CBRF shall maintain documentation of any investigation.	N 158		

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

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N 158	Continued From page 1 This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure an investigation of staff that allegedly verbally abused a resident was reported to department within 7 days. Findings include: The provider is licensed to care for 33 residents in the client groups advanced aged and irreversible dementia/Alzheimer's disease. On 07/07/2023 at 1:53 PM, Surveyor interviewed Caregiver C. Caregiver C stated Caregiver D had allegations of resident abuse about 8 months ago and was pulled off the third floor. S/he no works in the kitchen. On 07/07/2023 at 3:20 PM, Surveyor interviewed Director A. Director A stated s/he had completed an investigation and the allegations were unsubstantiated. Director A stated s/he had pulled Caregiver D off the floor until the investigation was completed. Director A stated Caregiver D was able to come back and only work on the first floor until Caregiver D chose to take a position in the kitchen instead. Surveyor reviewed the investigation, dated 07/05/2022. The investigation indicated the alleged abuse occurred on 07/04/2022. The abuse allegations were found to be unsubstantiated. On 07/28/2023 at 11:00 AM, Surveyor interviewed Director A. Surveyor inquired if the allegations of abuse by Caregiver D were reported to the department. Director A told Surveyor it was not reported to the Department as s/he did not know	N 158		

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N 158	Continued From page 2 it had to be since the allegations were unsubstantiated. Surveyor reviewed reporting requirements with Director A. The provider did not ensure a self-report was sent to the department within 7 days of the incident.	N 158		
N 163	83.12(4)(a) Reporting when resident's whereabouts unknown A CBRF shall send a written report to the department within 3 working days after any of the following occurs: Any time a resident ' s whereabouts are unknown, except those instances when a resident who is competent chooses not to disclose his or her whereabouts or location to the CBRF, the CBRF shall notify the local law enforcement authority immediately upon discovering that a resident is missing. This reporting requirement does not apply to residents under the jurisdiction of government correctional agencies or persons recovering from substance abuse. This Rule is not met as evidenced by: Based on record review and interview, the provider did not send a written report to the department within 3 working days after a resident's whereabouts were unknown. Findings include: On 06/27/2023, the department received a complaint with concerns about supervision of residents. The provider is licensed to care for 33 residents in the client groups advanced aged and	N 163		

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N 163	Continued From page 3	N 163		

irreversible dementia/Alzheimer's disease.

On 07/07/2023, Surveyor reviewed Resident 3's record. Resident 3 was admitted on 01/18/2019 and has a guardian. Resident 3 has diagnoses that include dementia with behavioral disturbance, Alzheimer's disease, and history of a left hip fracture.

Resident 3's individual service plan (ISP), last dated 05/04/2023, indicated s/he was on 15-minute checks for wandering, inability to notice unsafe situations, and inability to alert staff of needs. Resident 3's ISP indicated Resident 3 was independently ambulatory with no assistance device.

The staff observation notes, dated 07/03/2023, indicated Resident 3 was found downstairs in the kitchen by another resident's family. The staff observation note indicated Resident 3 had gotten off the elevator by him/herself but did not indicate for how long Resident 3 had eloped.

Surveyor observed the kitchen was located on the main floor and was not part of the facility.

On 07/28/2023 at 11:00 AM, Surveyor interviewed Director A. Surveyor inquired if Resident 3's elopement was reported to the department. Director A told Surveyor it was not reported to the Department as s/he did not know it had to be since Resident 3 was still in the building. Surveyor reviewed reporting requirements with Director A and explained how the main floor was not on the facility's floor plan and not part of the facility.

The provider did not send a written report to the Department within 3 working days after Resident

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N 163	Continued From page 4 3's whereabouts were unknown by staff.	N 163		
N 165	83.12(4)(c) Reporting incidents with serious injury A CBRF shall send a written report to the department within 3 working days after any of the following occurs: Any incident or accident resulting in serious injury requiring hospital admission or emergency room treatment of a resident. This Rule is not met as evidenced by: Based on record review and interview, the provider did not send a written report to the department within 3 working days after Resident 4 fell, resulting in emergency room (ER) treatment for arm fracture. Findings include: On 06/27/2023, the department received a complaint with concerns about supervision of residents. The provider is licensed to care for 33 residents in the client groups advanced aged and irreversible dementia/Alzheimer's disease. On 07/07/2023, Surveyor reviewed Resident 4's record. Resident 4 was admitted on 09/01/2020 and has a guardian. Resident 4 has diagnoses that include delusional disorder, epilepsy, chronic obstructive pulmonary disease, and repeated falls. Resident 4's individual service plan (ISP), last dated 06/04/2023, indicated s/he was on	N 165		

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N 165	Continued From page 5	N 165		

15-minute checks for inability to notice unsafe situations and inability to alert care team of needs. Resident 4's ISP indicated Resident 4 needed 2 staff to transfer with a gait belt. The ISP indicated Resident 4 had frequent falls.

Staff observation notes, dated 06/01/2023, indicated Resident 4 was sent to the ER to be evaluated after a fall due to hitting his/her head.

The department did not receive a fall report for 06/01/2023 as of 07/07/2023.

Medical notes, dated 06/01/2023, indicated this was the initial encounter for a closed fracture of supracondylar humerus and facial contusion due to a fall.

On 07/28/2023 at 11:00 AM, Surveyor interviewed Director A. Surveyor inquired if Resident 4's injury on 06/01/2023 was reported to the department. Director A stated s/he thought it had been reported to the department since it occurred around the same time another resident had been injured and that the self-report had been received by the department. Surveyor gave Director A until the end of the day to send the self-report.

On 07/28/2023 at 1:19 PM, Director A called Surveyor and stated s/he had not actually sent in Resident 4's self-report to the department for the fall with injury on 06/01/2023. Director A stated s/he thought s/he had sent it in but must have forgotten.

The provider did not report Resident 4's fall that resulted in ER treatment due to an arm fracture.

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N 355	Continued From page 6	N 355		
N 355	83.32(3)(k) Rights of Residents: Self-determination In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Self-determination. Make decisions relating to care, activities, daily routines and other aspects of life which enhance the resident ' s self reliance and support the resident ' s autonomy and decision making. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not ensure Resident 5's right to self-determination: to make decisions relating to care, activities, daily routines and other aspects of life which enhance the resident's self-reliance and support the resident's autonomy and decision-making. Findings include: On 06/27/2023, the department received a complaint with concerns about supervision of residents. On 07/07/2023 at approximately 12:00 PM, Surveyor observed Resident 5 in the anteroom outside his/her bedroom fiddling with the sink located there. Surveyor observed Resident 5 try to turn on the sink but no water came out. On 07/07/2023 at 12:30 PM, Surveyor interviewed Caregiver B. Caregiver B stated Resident 5 had dementia with an exacerbation and increase in behaviors recently. Caregiver B stated they had to take all his/her personal items including clothes, towels, and incontinent briefs out of Resident 5's bedroom due to Resident 5	N 355		

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N 355	Continued From page 7	N 355		

plugging his/her bathroom sink and toilet. Caregiver B stated Resident 5 was on frequent checks due to this behavior. Caregiver B stated Resident 5 had flooded his/her bedroom a week ago. Caregiver B stated they had fans going to dry everything out and get rid of the musty smell. Caregiver B stated Resident 5 flooded the room so bad the water ran down to the first floor (Resident 5 resides on the third floor).

Surveyor reviewed Resident 5's record. Resident 5 was admitted on 03/15/2023 and had an activated power of attorney (POA). Resident 5 had diagnoses that included vascular dementia with behavioral disturbance, anxiety disorder, Alzheimer's disease with late onset, mild cognitive impairment, cognitive communication deficit, and history of falling.

Resident 5's individual service plan (ISP) indicated s/he was on 15-minute checks due to a recent fall and injury. The ISP indicated Resident 5 was unable to notice unsafe conditions and required a safe environment. The ISP indicated all paper towels and gloves would be kept outside of Resident 5's room. The ISP indicated Resident 5 had a history of trying to flush his/her personal belongings down the toilet or plug his/her bathroom sink. The ISP stated, "Because of this, we will keep all of [Resident 5's] personal belongings in the storage closet next to the elevator. [Resident 5's] laundry basket and dirty clothes will be kept in the same storage closet for the same reason. The ISP stated, "Staff may turn bathroom sink water off when not using to reduce the risk of [Resident 5] plugging the sink and flooding the area. POA is in agreement with this plan. May turn water back on for resident cares and when [Resident 5] wishes to use the sink to wash up."

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N 355	Continued From page 8 The staff observation notes indicated the following: 06/11/2023 at 4:30 PM - Staff found Resident 5 in his/her bathroom eating a bar of soap. Staff removed all soaps and chemicals and stored in a locked cabinet outside his/her bedroom. Staff had also locked up Resident 5's incontinent briefs and pads due to Resident 5 trying to flush them down the toilet. 07/02/2023 at 12:30 AM - Staff checked on Resident 5 at 12:00 AM and found wet toilet paper wads on the bathroom floor, wet clothes in his/her sink. Resident 5 was also carrying around wet clothes in a basket. Staff removed all items they thought Resident 5 could put down the sink from his/her room. Staff requested to have Resident 5's sink water turned off when not in use to prevent Resident 5 overflowing his/her sink and to keep his/her belongings dry and clean. Staff washed Resident 5's clothes and put them in a closet. 07/03/2023 at 2:15 AM - "[Resident 5] has a history of removing [his/her] personal belongings from the closets, dressers, etc. [Resident 5] has a history of attempting to flush items down the toilet or plugs [his/her] sink with them. Items have been moved to the storage closet next to the elevator because of this. Please be sure to continue to keep [his/her] items in that closet. Personal Care items such as gloves, soaps, wash cloths, etc. may continue to be kept in the kitchenette drawers right outside [his/her] room." On 07/07/2023 at 3:20 PM, Surveyor interviewed Director A. Director A stated s/he wasn't sure what changed with Resident 5 to start this	N 355		

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N 355	Continued From page 9 behavior. Director A stated they asked Resident 5's POA if they could just lock the bathroom unless staff were with Resident 5, but the POA declined that intervention. Surveyor explained how that would be a self-determination right issue. Director A stated they removed all Resident 5's items from his/her room and Resident 5's POA agreed to turn the bathroom sink water off this week unless staff were helping Resident 5 in the bathroom. Director A stated Resident 5 still had full access to his/her toilet. Director A stated there has never been water to the sink in the anteroom outside Resident 5's room. On 07/28/2023 at 11:00 AM, Surveyor interviewed Director A. Surveyor asked Director A if a waiver was sent to the department to request removing Resident 5's personal items from his/her room and securing them elsewhere. Director A stated s/he had not sent in a waiver and did not know s/he had to for this situation. Director A stated s/he had permission from Resident 5's POA though. The provider did not protect the residents right of self-determination. Resident 5's personal belongings were kept locked in a cabinet outside his/her room and water to his/her bathroom sink was shut off when staff were not there to monitor due to Resident 5 plugging his/her sink and toilet with them.	N 355		
N 423	83.37(3)(g) Medication storage: controlled substances. Controlled substances. The CBRF shall provide separately locked and securely fastened boxes or drawers or permanently fixed compartments within the locked medications area for storage of	N 423		

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N 423	Continued From page 10 schedule II drugs subject to 21 USC 812 (c), and Wisconsin ' s uniform controlled substances act, ch. 961, Stats. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure controlled substances were double locked in the medication refrigerator for storage. This is a repeat deficiency. See Statement of Deficiency (SOD) NQFE11, dated 03/04/2020. Findings include: The provider is licensed to care for 33 residents in the client groups advanced aged and irreversible dementia/Alzheimer's disease. On 07/07/2023 at approximately 2:00 PM, Surveyor observed a medication pass with Caregiver B. Surveyor observed Caregiver B enter the secured medication room. Within the secured medication room was the medication mini refrigerator. Surveyor did not observe any kind of lock on the medication refrigerator or a lock box to double lock the controlled substances inside within the refrigerator. Surveyor observed sublingual lorazepam for Resident 1 and Resident 2 stored within the medication refrigerator. Caregiver B stated sometimes they stored morphine in the medication refrigerator too. Surveyor asked Caregiver B if this was the only place where refrigerated controlled substances were stored and Caregiver B confirmed it was. On 07/28/2023 at 11:00 AM, Surveyor interviewed Director A. Director A stated the medication refrigerator probably used to be locked but s/he	N 423		

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N 423	Continued From page 11 had never thought about double locking refrigerated controlled substances before. Director A stated they would double lock the refrigerated medications immediately.	N 423		
N 426	83.38(1)(b) Supervision. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident's highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Supervision. The CBRF shall provide supervision appropriate to the resident's needs. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure adequate supervision for Resident 3, Resident 4, and Resident 5. Resident 3, who had a history of elopement and exit seeking behavior, eloped from the facility on 07/03/2023 and had multiple incidents of aggressive behavior toward staff and other residents. Resident 4 had multiple falls over the last few months with one resulting in significant injury on 06/01/2023. Resident 5 had two episodes of flooding his/her bathroom sink over the past few weeks.	N 426		

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N 426	Continued From page 12 This is a repeat deficiency. See Statement of Defieciency (SOD) OFNP11, dated 04/02/2019, and SOD S75413, dated 05/10/2022. Findings include: On 06/27/2023 and 07/07/2023, the department received complaints with concerns about supervision of residents. The provider is licensed to care for 33 residents in the client groups advanced aged and irreversible dementia/Alzheimer's disease. Surveyor observed the facility's layout consisted of 3 secured floors separated by egress alarm doors with a keypad code. The only way to get to each floor was by two stairways with the egress alarm doors or by two elevators secured by a key that only staff had access to. Residents were not able to move freely between the three floors. The kitchen and residential care apartment complex (RCAC) tenant dining area was located on the main floor, separate from the facility within the building. Resident 3, Resident 4, and Resident 5 all resided on the third floor. On 07/07/2023 at 9:45 AM, Surveyor interviewed Director A. Director A stated this was the first day to try 3 staff in the facility per shift, which would be 1 staff per each floor (second floor was closed due to remodeling) and 1 float staff between the two open facility floors. The medication passer would float between the first floor and the RCAC. On 07/07/2023 at 10:30 AM, Surveyor interviewed Caregiver E. Caregiver E stated residents had call buttons and staff use walkie talkies to communicate throughout the facility. Caregiver E stated that on the third floor, there	N 426		

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N 426	Continued From page 13	N 426		

were 4 to 5 residents on 15-minute checks, 2 residents that needed a Hoyer lift for transfers, 3 residents that would exit seek (1 of the residents had a successful elopement in the last week), 2 residents that used a sit-to-stand for transfers, 1 resident that needed 2-staff assistance for transfers with a gait belt, and 2 residents with challenging, aggressive behaviors. Caregiver E stated the recent staffing change to 3 staff for the whole facility was not right and resident quality of care would suffer. Caregiver E stated there had also been an increase in falls lately, with some injuries. Caregiver E stated that at times, staff hours staggered with starting times and staff could be alone for an hour at a time on each floor.

RECORD REVIEW

Resident 3

On 07/07/2023, Surveyor reviewed Resident 3's record. Resident 3 was admitted on 01/18/2019 and had a guardian. Resident 3 had diagnoses that included dementia with behavioral disturbance, Alzheimer's disease, and history of a left hip fracture.

Resident 3's individual service plan (ISP), last dated 05/04/2023, indicated s/he was on 15-minute checks for wandering, inability to notice unsafe situations, and inability to alert staff of needs. Resident 3's ISP indicated Resident 3 was independently ambulatory with no assistive device. Resident 3's ISP indicated s/he needed light supervision and verbal cuing to enforce positive interaction with other residents. The ISP indicated Resident 3 had a history of the following behaviors: striking out at staff and other residents; arguing; and severe anger that was difficult to redirect.

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N 426	Continued From page 14 Surveyor reviewed the staff observation notes and found the following: 06/02/2023 6:45 PM - Resident 3 had been in and out of other residents' rooms. Resident 3 pulled and pinched staff's arms when they tried to redirect. 06/04/2023 10:45 AM - Resident 3 was getting more restless and had been hitting staff and other residents. 06/10/2023 4:30 PM - Resident 3 hit staff multiple times and bent staff's thumb backward. 06/11/2023 9:45 AM - Resident 3 was chasing staff to get a garbage bag back s/he was trying to put a couch cover in. 06/11/202310:00 AM - Resident 3 was found hitting another resident in the face. 06/11/2023 7:30 PM - Resident 3 slapped another resident in the face multiple times. 06/17/2023 7:30 AM - Resident 3 had been hitting that morning. 06/17/2023 1:45 PM - Resident 3 was hitting another resident sitting in a wheelchair in the back 4 times. 06/21/2023 8:30 PM - Resident 3 was found by staff in another resident's room hitting him/her with a closed fist in the head and pulling their hair. 06/23/2023 1:00 AM - Resident 3 was hitting another resident in the stomach with a closed fist.	N 426		

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N 426	Continued From page 15 06/25/2023 2:45 PM - Resident 3 was seeking unlocked resident rooms, so staff locked the rest of the resident rooms to redirect behavior. 06/28/2023 3:45 PM - Resident 3 was pulling on another resident to get them to follow him/her around the floor and tried hitting staff several times during change of shift. 06/29/2023 12:30 PM - Resident 3 kicked staff and tied to punch staff in the face while getting washed up. 07/03/2023 6:30 PM - Resident 3 was found downstairs in the kitchen by another resident's family. The staff observation note indicated Resident 3 had gotten off the elevator by him/herself but did not indicate for how long Resident 3 had eloped. The staff observation note indicated staff should wait for the elevator to shut before they walk away and if staff push the third-floor button by accident they should call up and let the staff know. 07/03/2023 7:45 PM - Resident 3 pulled on staff's hands and arms and pinched staff several times throughout the shift. Resident 3 kicked staff in the stomach when assisting into bed. 07/04/2023 7:45 AM - Resident 3 slapped staff in the forehead, bent fingers back and punched staff in the chin for no apparent reason. Resident 3 hit the other staff in the ribs during the shift. 07/07/2023 12:30 PM - Resident 3 was seen by a physician on 07/05/2023. The progress note indicated Resident 3 had a history of end stage dementia with aggressive behavior toward other residents and staff. Resident 3 also displayed exit seeking and inappropriate behaviors. The	N 426		

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progress note indicated psychiatry was not available. The physician made medication adjustments and would follow-up weekly to monitor behaviors.

The staff observation notes, dated 06/01/2023 to 07/13/2023, indicated Resident 3 had multiple attempts to exit seek from the third floor and multiple times Resident 3 was found in other residents' rooms.

An elopement report, dated 07/01/2023, indicated Resident 3 eloped for 5 minutes and was found by staff on the other side of the facility egress alarm door. The elopement report comments stated Resident 3 was not noticed missing initially by staff, but staff heard the door alarm and that was what alerted them Resident 3 had eloped. The comments also stated the main floor staff was in another resident's room during the time of the elopement.

The department did not receive an elopement report for the 07/03/2023 elopement incident from the provider as of 07/07/2023.

Resident 4

On 07/07/2023, Surveyor reviewed Resident 4's record. Resident 4 was admitted on 09/01/2020 and had a guardian. Resident 4 had diagnoses that included delusional disorder, epilepsy, chronic obstructive pulmonary disease, and repeated falls.

Resident 4's ISP, last dated 06/04/2023, indicated s/he was on 15-minute checks for inability to notice unsafe situations and inability to alert care team of needs. Resident 4's ISP indicated Resident 4 needed 2 staff to transfer with a gait

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belt. The ISP indicated Resident 4 had frequent falls and had history of being impulsive. The ISP indicated Resident 4 had the following fall interventions in place: fall mat; bed and chair alarm; frequent monitoring; involvement in activities; lowering of bed to the floor when resident was in it; having staff nearby with off the floor interactions such as bingo occur; toileting every 2 to 4 hours; encouraging meals and snacks; reassuring; ensuring resident was not too hot or cold; and remaining at resident's side when toileting. The ISP indicated Resident 4 had a history of seizures.

Surveyor reviewed the staff observation notes, dated 06/01/2023 to 07/07/2023 and found the following:

06/01/2023 9:30 PM - Resident 4 was sent to be evaluated for hitting his/her head during an unwitnessed fall in front of the recliner. Staff just checked on Resident 4 and had him/her sit back in his/her recliner prior to leaving the room. Resident 4's chair alarm went off shortly after staff left the room.

06/01/2023 9:45 PM - Resident 4 returned from medical evaluation with a splint and has a sling to wear when s/he is out of bed. Staff were to give as need pain medication and ice Resident 4's arm every 3 hours during awake hours for 30 minutes.

06/02/2023 6:45 PM - Resident 4 received his/her helmet and was to wear it when up and in the dining room.

06/14/2023 11:15 AM - Resident 4 returned from his/her appointment with diagnosis of right distal humerus fracture.

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N 426	Continued From page 18 06/15/2023 11:45 PM - Resident 4 was found by staff on the floor and put back into bed with a Hoyer lift. Resident 4 was sent out to be evaluated due to pain. 06/16/2023 11:00 AM - Resident 4 returned from medical evaluation after a fall and was diagnosed with a urinary tract infection (UTI), but no new injuries. 06/18/2023 9:30 PM - Resident 4 was found on the floor and Resident 4 told staff s/he was trying to get up by him/herself. 06/21/2023 3:45 AM - Resident 4's bed alarm was going off and staff found Resident 4 in bed with his/her head at the foot of the bed. Staff had just changed Resident 4 at 3:00 AM. 06/27/2023 12:00 AM - Staff helped Resident 4 to bathroom on the toilet. Resident 4 did not use the call button and attempted to transfer by him/herself to the wheelchair. Resident 4 had a fall hitting his/her head and was transferred by staff into wheelchair and back into bed. 07/06/2023 4:45 PM - Resident 4 was found on the floor and Resident 4 told staff s/he was trying to turn his/her fan off. Surveyor reviewed the last 3 months of fall reports for Resident 4 and found the following: 05/04/2023 8:50 AM - Resident 4 was found sitting on his/her bottom in front of the recliner by staff. 05/07/2023 4:50 AM - Staff found Resident 4 laying on the floor next to his/her recliner.	N 426		

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N 426	Continued From page 19 05/12/2023 2:22 PM - Resident 4 was found sitting on the floor in front of his/her recliner. 05/14/2023 6:58 PM - Staff heard a thud from Resident 4's room and found Resident 4 on the floor in front of his/her recliner. 05/16/20238 11:52 AM - Resident 4 pushed his/her call button and before staff could get to his/her room the bed alarm went off. Staff found Resident 4 laying on the floor and Resident 4 stated s/he had to go to the bathroom. 06/01/2023 - No fall report was provided for the fall that occurred on this date. 06/15/2023 11:05 PM - Resident 4's bed alarm went off and staff found Resident 4 on the floor. Resident 4 was sent to be medically evaluated. The fall report follow-up comments stated, "[Resident 4] to discharge to sister facility on 06/26/2023 for more 1:1 care." 06/18/2023 8:20 PM - Staff heard Resident 4's alarm and found Resident 4 on the floor. 06/27/2023 - No fall report provided for the fall that occurred on this date. 07/06/2023 - No fall report provided for the fall that occurred on this date. Medical notes, dated 06/01/2023, indicated this was the initial encounter for a closed fracture of supracondylar humerus and facial contusion due to a fall for Resident 4. The medical note stated, "[Resident 4] had a recent fall with positive swelling about the right elbow and [s/he] has had multiple falls in the past related to careless this	N 426		

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[sic], as well as from seizures." The physician orders indicated staff were to watch for falls and give Resident 4 as much safety as possible to avoid recurrent falls.

The medical notes, dated 06/08/2023, stated, "[Resident 4] is noted have [sic] had a right distal humeral fracture that was nondisplaced and based on orthopedic recommendations, was to be [sic] sling when able and hopefully would heal on its own. However [Resident 4] has had recurrent falls and I am unsure how this is happening. [Resident 4] has [sic] numerous falls the weather [sic] is related to clumsiness, impulsiveness, weakness, or if it is self-induced, [s/he] now is injured [his/her] right arm again and x-ray of the last check revealed angulated and comminuted fracture of the distal humerus ...Psychiatry really should be involved with this patient at this time we do not have that available here. [Resident 4] really needs care somewhere were [sic] psychiatry is available on a daily basis if needed."

The medical notes, dated 06/16/2023, indicated Resident 4 was evaluated for a fall and diagnosed with contusion of the right shoulder region and UTI.

The medical notes, dated 06/21/2023, indicated Resident 4 had a behavioral disorder component related to his/her multiple falls and the physician was unsure if Resident 4's falls were unintentional. The note indicated the physician recommended Resident 4 would benefit from behavioral health working with him/her, but the facility had nothing available. The medical note indicated Resident 4 would require frequent supervision due to history of recurrent falls. The medical note stated, "[Resident 4] be [sic]

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transferred to the [another facility] on June 26, 2023 as a plan to try to help improve [his/her] overall health. [His/Her] risk of fall as great here we have had difficult time avoiding injury and I am concerned about [him/her]. We have tried everything possible within the means available but staffing is an issue for the type of behaviors [Resident 4] has."

A 30-day notice, dated 03/30/2023, indicated Resident 4 required a level of care beyond what was offered at the facility. Resident 4's discharge was 07/07/2023.

Resident 5

On 07/07/2023, Surveyor reviewed Resident 5's record. Resident 5 was admitted on 03/15/2023 and had an activated power of attorney (POA). Resident 5 had diagnoses that included vascular dementia with behavioral disturbance, anxiety disorder, Alzheimer's disease with late onset, mild cognitive impairment, cognitive communication deficit, and history of falling.

Resident 5's ISP indicated s/he was on 15-minute checks due to a recent fall and injury. The ISP indicated Resident 5 was unable to notice unsafe conditions and required a safe environment. The ISP indicated Resident 5 had a history of trying to flush his/her personal belongings down the toilet or plug his/her bathroom sink.

The staff observation notes indicated the following:

06/06/2023 9:15 PM - Resident 5 was going into other resident's rooms and taking their belongings around 6:00 PM.

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06/11/2023 4:30 PM - Staff found Resident 5 in his/her bathroom eating a bar of soap and ended up with a swollen lip s/he was sent in to be evaluated for. Staff found other resident's belongings on his/her person, and s/he continued to wander into other residents' rooms stealing their belongings.

06/13/2023 3:30 AM - Resident 5 had been entering common areas and causing noise disturbances, wandering, and entering other residents' rooms for about a week.

06/17/2023 9:15 PM - At 6:00 PM staff found Resident 5's room flooded. Resident 5 had 2 of his/her rugs in the toilet and turned on the sink faucet pushing it away, so the water was running off the sink onto the floor.

06/23/2023 11:45 PM - Resident 5 had been taking personal belongings out of other resident rooms and was being loud waking other residents since 10:30 PM. Staff shut and locked the other residents' doors so Resident 5 wouldn't enter.

06/25/2023 2:15 PM - Resident 5 had left his/her room to visit other residents and staff checked on his/her room. Staff found towels and a sock over his/her bathroom sink drain and the water was running.

06/26/2023 11:15 AM - Resident 5 was going in and out other resident rooms all day and taking their personal belongings. Staff kept all resident rooms locked.

06/27/2023 6:15 AM - Resident 5 had clothes in the toilet that staff removed. When staff went to check back on Resident 5's room, s/he had more clothes in the toilet. Staff found a pant leg down

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the toilet bowl hole and the toilet was starting to overflow.

06/27/2023 4:15 PM - Resident 5 had been going in and out of other residents' rooms all day trying to take their personal belongings. Resident 5 had been swearing and calling other residents names. Resident 5 took everything off the medication cart and all the gloves out of the glove box.

06/29/2023 12:30 PM - Staff locked all resident doors for the whole shift due to Resident 5 trying to go into their rooms and taking their belongings.

06/29/2023 9:30 PM - Staff checked on Resident 5's bedroom and found clothes in the bottom of the shower with the water running.

06/30/2023 12:45 AM - Resident 5 got into another resident's room and was going through their personal belongings on the dresser. Resident 5 had stripped the other resident's bed sheet off half the bed. Resident 5 entered another resident's room while staff were doing cares.

07/02/2023 12:30 AM - Staff checked on Resident 5 at 12:00 AM and found wet toilet paper wads on the bathroom floor and wet clothes in his/her sink. Resident 5 was also carrying around wet clothes in a basket. Staff removed all items they thought Resident 5 could put down the sink from his/her room. Staff requested to have Resident 5's sink water turned off when not in use to prevent Resident 5 overflowing his/her sink and to keep his/her belongings dry and clean. Staff washed Resident 5's clothes and put them in a closet.

07/03/2023 2:15 AM - "[Resident 5] has a history of removing [his/her] personal belongings from

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the closets, dressers, etc. [Resident 5] has a history of attempting to flush items down the toilet or plugs [his/her] sink with them. Items have been moved to the storage closet next to the elevator because of this. Please be sure to continue to keep [his/her] items in that closet. Personal Care items such as gloves, soaps, wash cloths, etc. may continue to be kept in the kitchenette drawers right outside [his/her] room."

INTERVIEW

On 07/07/2023 at 10:30 AM, Surveyor interviewed Caregiver E. Caregiver E stated Resident 5 still had the behavior of trying to flush items down his/her toilet and plugging the sink. S/he had even attempted to do this in other residents' rooms recently.

On 07/07/2023 at 12:30 PM, Surveyor interviewed Caregiver B. Caregiver B stated Resident 4 had frequent falls and was discharging today to a smaller facility where s/he would get more 1:1 supervision. Caregiver B confirmed Resident 5 had all his/her personal belongings taken out of his/her room due to behavior with water and making a mess constantly of his/her room. Caregiver B stated other interventions included doing frequent checks and trying to get Resident 5 out in common areas. Caregiver B stated Resident 5 had flooded his/her room a week prior to the point the water ran down to the first floor. Caregiver B stated s/he wished they had enough staff today and felt 3 staff were not sufficient in an emergency. Caregiver B stated multiple staff quit without notice recently and they had been working short the last couple weeks. Caregiver B stated staff shift start times were staggered and staff would be alone on a floor between 6:00 AM and

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7:00 AM and for 2 hours between 2:00 PM to 4:00 PM. Caregiver B stated this was typically "doable" unless a resident was having exacerbated behaviors.

On 07/07/2023 at 1:53 PM, Surveyor interviewed Caregiver C. Caregiver C stated staff were informed late the night before about the staffing change today to 3 staff per shift due to being short staff. Caregiver C stated they had no kitchen staff on the weekends and staff had to go downstairs to the kitchen and get food for the residents. Caregiver C expressed concern how this would be appropriate with 3 staff working per shift.

On 07/07/2023 at 3:20 PM, Surveyor interviewed Director A. Director A stated s/he wasn't sure what changed with Resident 5 to start the water behavior. Director A stated Resident 5 had been successful at least 2 times in flooding his/her room. Director A stated they asked Resident 5's POA if they could just lock the bathroom unless staff were with Resident 5 in there, but the POA declined that intervention. Director A stated they removed all Resident 5's items from his/her room and Resident 5's POA agreed to turn the bathroom sink water off unless staff were helping Resident 5 in the bathroom. Director A stated Resident 5 still had full access to his/her toilet. Director A stated they were still working on Resident 5's behaviors. Director A stated they had to decrease staff from 2 to 1 staff for each floor due to recent staff changes.

On 07/14/2023 at 1:33 PM, Surveyor interviewed Family Member H. Family Member H stated s/he came to visit Resident 4 on 06/29/2023 at around 3:00 PM in the afternoon and found Resident 4's door locked. Family Member H stated s/he found

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staff and they did not have a key to unlock the door. Family Member H stated they had to wait for staff to come up from the first floor in order to unlock the door. Family Member H had concerns Resident 4 had not been checked throughout the day and offered fluids. Family Member H stated Resident 4 was recently discharged from the facility to a smaller facility so s/he could receive more 1:1 supervision.

On 07/21/2023 at 4:07 PM, Surveyor interviewed Caregiver F. Caregiver F stated Resident 4 was challenging because s/he was unstable on his/her feet and would try to get up without assistance. Caregiver F stated Resident 4 had many unwitnessed falls. Caregiver F confirmed Resident 4 had a family member visit and Resident 4's door was locked. Caregiver F confirmed staff did not have the keys on them and had to have a different staff come up with keys to unlock Resident 4's door. Caregiver F stated Resident 4 was to be discharged to another facility due to needing more 1:1 supervision. Caregiver F stated that to prevent Resident 3 and Resident 5 from going into other residents' rooms, staff would shut and lock all the other residents' doors.

On 07/21/2023 at 3:58 PM, Surveyor interviewed Caregiver G. Caregiver G stated they were understaffed and had gone back to staffing 2 staff per floor. Caregiver G stated Resident 4 had challenging behaviors and needed 1:1 supervision.

On 07/28/2023 at 11:00 AM, Surveyor interviewed Director A. Director A stated Resident 3 was admitted to the facility with an aggressive nature and they were still working with Resident 3's physician to make medication changes. Director A

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0012212	A. BUILDING: _____ B. WING _____	C 07/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMEPLACE (THE)	225 E 4TH AVE STANLEY, WI 54768

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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stated that the first time Resident 3 eloped s/he was found on the other side of the egress door, still on the third floor. Director A stated for Resident 3's second elopement on 07/03/2023 staff had sent the elevator up and a visitor let Resident 3 on the elevator. Surveyor asked about Resident 4. Director A stated they had been waiting 2 years for a new placement for Resident 4 due to his/her impulsiveness and frequent falls. Director A stated s/he believed Resident 4 may self-sabotage and would wait for staff to leave the room before falling. Director A stated they had been trying to get behavioral health involved. Director A stated they had done everything they could with Resident 4 but were not sure what to do anymore. Director A stated Resident 4 requested his/her door be locked so wandering residents could not enter. Director A stated Family Member H would not have had to wait long for the door to be unlocked by another staff. Director A stated there were 2 residents that could not physically open their room doors but verbally stated they wanted them locked. Director A stated these 2 residents could use their call buttons if help was needed. Director A stated there was one resident that could not verbally consent to his/her door being locked and it was kept unlocked all the time. Surveyor asked about current staffing. Director A stated the 3 staff per shift lasted only 8 hours and they had gone back to their previous staffing pattern of 4 staff per shift.

SUMMARY

The provider did not ensure the safety of Resident 3, Resident 4, and Resident 5. Staff were unaware of how long Resident 3 was gone when s/he eloped on 07/03/2023. Resident 3 had daily occurrences of wandering into other resident rooms and taking their personal belongings, with

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N 426	Continued From page 28 staff locking the other residents' doors and 13 documented incidents of Resident 3 being aggressive to staff and other residents. Resident 4 had 10 falls from 05/04/2023 to 07/06/2023. Resident 4 had a fall on 06/01/2023 and was diagnosed with a fracture of the right humerus. Resident 4 continued to have 4 more falls after the injury on 06/01/2023. Resident 5 had two successful attempts of flooding his/her room to the point the water had seeped down to the first floor of the facility. Resident 5 had daily occurrences of wandering into other resident rooms and taking personal belongings, with staff locking the other residents' doors. Cross References N0163 83.12(4)(a) Reporting When Resident's Whereabouts Unknown N0165 83.12(4)(c) Reporting Incidents With Serious Injury N0355 83.32(3)(k) Rights Of Residents: Self-Determination	N 426		