STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018808	A. BUILDING: _____ B. WING _____	C 12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBORETUM (THE)	W 180 N7890 TOWN HALL RD MENOMONEE FALLS, WI 53051

(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 12/10/2024, with information obtained through 12/12/2024, the Bureau of Assisted Living, Southern Regional Office, conducted a complaint investigation and standard licensing survey at Arboretum (The), a community-based residential facility located in Menomonee Falls, WI. As a result of the survey, 3 deficiencies were identified. One deficiency was a repeat deficiency. See Statement of Deficiency (SOD) GUIE11, dated 09/15/2023. The complaint was unsubstantiated. Census: 37	N 000		
N 353	83.32(3)(i) Rights of Residents: Adequate treatment In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Prompt and adequate treatment. Receive prompt and adequate treatment that is appropriate to the resident ' s needs. This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not ensure that Resident 1 received prompt and adequate treatment related to his/her left thumb proximal phalanx fracture. Resident 1, who had an activated power of attorney (POA) for healthcare, approached Surveyor with concerns s/he had of possibly breaking his/her left thumb status post fall at	N 353		

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

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approximately 10:02 a.m. on the day of the survey due to pain s/he was experiencing with it. At that time, his/her thumb was observed to be swollen and bruised with increased redness around the area. Despite caregiving staff having been alerted to the situation within an approximate 10-15-minute window after this, his/her hand wasn't assessed by a clinician, Charge Nurse F, until approximately 2:45 (approximately 5 hours after the concern was initially known by staff). Around this same time is when Resident 1's POA was first notified of the concern with the decision being made to have Resident 1's thumb evaluated by a medical provider in the urgent care clinic. Resident 1 was later diagnosed with a nondisplaced proximal phalanx fracture of his/her left thumb (middle joint of the thumb) which was addressed with follow up immobilization of a splint and then a cast.

Findings include:

On 12/10/2024, at approximately 10:02 a.m., Surveyor walked onto the memory care unit of the facility. Resident 1 approached Surveyor, using a 4-wheeled walker to ambulate, and informed him/her that s/he had concerns of having recently broken a bone in his/her thumb. Resident 1 reported that s/he had fallen earlier that morning on his/her outstretched left hand, which caused the injury. Resident 1 then held out his/her left hand towards Surveyor. Surveyor observed his/her left thumb was swollen, with redness surrounding the thumb and thenar eminence (area around the palmar side of the thumb), as well as bruising around his/her thumb's distal portion, all of which was significantly different from the appearance of his/her uninvolved right thumb/hand. Resident 1 reported that his/her thumb hurt. Resident 1 reported that s/he had

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brought up this concern to staff but that no one had done anything about it. Resident 1 asked Surveyor what s/he should do about his/her thumb. While this interaction was taking place, no staff were observed in the vicinity.

At approximately 10:09 a.m., Surveyor observed Resident 1 approach Activity Assistant G and report that s/he had broken his/her "arm." Activity Assistant G replied, "Oh no!" and attempted to redirect Resident 1 towards the activity that was about to take place. Approximately 1 minute later, Surveyor observed Caregiver C approach Resident 1 and inspect his/her left hand. Caregiver C reported that s/he would have Health Services Director B look at it. Caregiver E, who was passing resident medications in the same area, appeared to at times observe Resident 1's interactions.

At approximately 10:14 a.m., Surveyor observed Resident Care Coordinator D approach Resident 1 and inspect his/her left thumb. After this, Resident 1 was redirected to the common area where s/he was seated and watched the exercise activity taking place.

At approximately 10:15 a.m., Surveyor interviewed Caregiver E regarding the above incident. Caregiver E reported that s/he was unaware of Resident 1 having experienced any falls and that s/he only heard about the concern with his/her left thumb for the first time at approximately the same time Surveyor did. Caregiver E reported that when s/he heard Resident 1 talking about his/her thumb, s/he texted Resident Care Coordinator D about the concern. Caregiver E confirmed this was when Resident Care Coordinator D had then come onto the unit and inspected Resident 1's thumb (as

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observed by Surveyor just prior to the interview).

On 12/10/2024, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider on 11/15/2024. An assessment for Resident 1 dated 11/13/2024 documented that Resident 1 had a POA for healthcare, was not independent in daily decision making, and was experiencing dementia/Alzheimer's or memory loss. At the time Surveyor reviewed Resident 1's record, at approximately 2:00 p.m., there were no observation notes regarding his/her left thumb incident.

At approximately 2:45 p.m., Surveyor interviewed Health Services Director B, who is a registered nurse (RN). Health Services Director B reported s/he was aware that a concern was raised regarding Resident 1's thumb but since s/he was busy working through the survey process with Surveyors s/he was having Charge Nurse F, who is a licensed practical nurse (LPN), look at it.

At approximately 3:00 p.m., Surveyor returned to the memory care unit and observed Charge Nurse F talking with Resident 1. Surveyor then interviewed Charge Nurse F regarding Resident 1's thumb. Charge Nurse F reported that Resident 1 told him/her that s/he thought s/he fell that morning. Charge Nurse F reported that s/he was informed for the first time about Resident 1's thumb concern at approximately 2:15 p.m. (approximately 45 minutes prior to the interview and approximately 4 hours after the concern was known by staff). Charge Nurse F reported s/he was not able to assess Resident 1's thumb upon being initially informed about it because s/he kept getting stopped by others. Charge Nurse F reported that Resident 1's family member was coming to the facility to pick up Resident 1 and

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take him/her to urgent care for further evaluation of his/her left thumb. When asked when Resident 1's family member was informed about the concern, Charge Nurse F replied that it had been about 10 minutes prior to the interview (approximately 2:51 p.m.). Charge Nurse F reported that his/her own assessment of Resident 1's left thumb revealed that Resident 1 complained of pain, experienced difficulties moving it, and that there was bruising observed around the area. Charge Nurse F reported s/he was unsure if anything was done for Resident 1 regarding his/her left thumb concern prior to his/her assessment of it.

Near the end of Surveyor's interview with Charge Nurse F, Surveyor observed Resident 1 ambulating around the common area. Surveyor observed Resident 1's left thumb, the appearance of which was largely unchanged from Surveyor's earlier observation of it at approximately 10:02 a.m. (5 hours prior). Resident 1's left thumb continued to appear swollen with areas of redness and bruising. Resident 1 was observed walking with his/her walker, using his/her left hand to grip the walker handle.

At approximately 3:05 p.m., Surveyor interviewed Resident Care Coordinator D. Resident Care Coordinator D confirmed that Caregiver E had informed him/her at approximately 10:11 a.m. that morning of Resident 1's left thumb concern and asking him/her to assess it. Surveyor noted that this corroborated with his/her earlier observation of Resident Care Coordinator D inspecting Resident 1's left thumb at approximately the same time. Resident Care Coordinator D reported that s/he noticed Resident 1's left thumb was discolored, with areas of black and blue, and that Resident 1 complained of having pain when

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trying to move it. Resident Care Coordinator D reported s/he had informed Health Services Director B about Resident 1's left thumb concern at 10:16 a.m.

At approximately 3:45 p.m., Surveyor interviewed Executive Director A and Health Services Director B. Health Services Director B confirmed that Resident 1's family member was coming to the facility to take Resident 1 to urgent care for further evaluation of his/her thumb. Health Services Director B reported understanding Surveyor's concern that there was a gap of approximately 5 hours from the time Resident 1's left thumb concern was known by staff and action was taken to get his/her thumb evaluated by a medical provider. Nothing further was said.

On 12/11/2024, Surveyor reviewed a medical report for Resident 1 which detailed x-ray results of his/her left hand. The x-ray results confirmed from imaging completed on 12/10/2024 at 5:18 p.m. that Resident 1 had a nondisplaced fracture at the base of his/her first (thumb) proximal phalanx (middle joint of the thumb).

On 12/12/2024, at approximately 3:55 p.m., Surveyor interviewed Health Services Director B via e-mail. Health Services Director B reported that Resident 1 was provided a left hand splint from the urgent care provider to wear from 12/10/2024 until s/he had his/her appointment with an orthopedic medical provider that day (12/12/2024). Health Services Director B reported that Resident 1 had just recently returned from the orthopedic appointment where a cast was placed on his/her left hand/wrist.

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N 415	Continued From page 6	N 415		
N 415	83.37(2)(d) Documentation of medication administration. Documentation of medication administration. As required under s. DHS 83.42(1)(o), at the time of medication administration, the person administering the medication or treatment shall document in the resident record the name, dosage, date and time of medication taken or treatments performed and initial the medication administration record. Any side effects observed by the employee or symptoms reported by the resident shall be documented. The need for any PRN medication and the resident ' s response shall be documented. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that the person administering Resident 4's medications or treatments initialed the medication administration record (MAR) after administration. Repeat violation from statement of deficiency (SOD) GUIE11, dated 09/15/2023. Findings include: On 12/10/2024, Surveyor reviewed the record of Resident 4. Resident 4 was admitted to the provider on 06/08/2020 with diagnoses including dementia, hypertension, and seizure disorder. Surveyor reviewed Resident 4's November 2024 MAR. Surveyor reviewed that the following physician orders for medications were missing documenting for being administered on the following dates: Acetaminophen 500mg caplet to take 2 tablets	N 415		

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N 415	Continued From page 7 every 8 hours; 11/08/2024; 11/09/2024; 11/13/2024; 11/26/2024. Biofreeze 4% gel to apply to affected area of lower back 4 times daily; 11/08/2024; 11/09/2024; 11/13/2024; 11/26/2024; 11/28/2024. Ferrous sulfate 325mg tablet to take 2 tablet once daily at noon; 11/08/2024; 11/09/2024; 11/13/2024; 11/26/2024. Lamotringine ER 100mg tablet to take 2 tablets every 12 hours for seizures; 11/26/2024. Levetiracetam 500mg tablet to take 2 tablets twice daily for seizures; 11/26/2024. Nystatin 100,000U POW 30GM to apply topically to affected area of redness twice daily; 11/26/2024 Omeprazole 20mg capsule to take 1 capsule by mouth twice daily; 11/26/2024. Vitamin B12 1000MCG tablet to take 1 tablet daily for supplement; 11/26/2024. At approximately 3:45 p.m., Surveyors reviewed the above concerns with Executive Director A and Health Services Director B. Health Services Director B acknowledged that documentation has been a concern in the past and s/he will continue to remind his/her staff to document.	N 415		
N 481	83.43(1) Environment safe, clean, and comfortable Environment. The CBRF shall provide a living environment that is safe, clean, comfortable, and homelike. All common dining and living areas shall contain furnishings appropriate to the intended use of the room. This Rule is not met as evidenced by:	N 481		

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Based on observation and interview, the provider did not ensure that the living environment was clean and homelike.

Findings include:

Throughout the survey on 12/10/2024, Surveyors toured the facility and observed the following:

- At approximately 10:48 a.m., the air vent in the hallway outside the memory care area laundry room was observed covered in dust (Photo 1).

- At approximately 10:48 a.m., the exit sign located near the laundry room, leading out of the memory care unit, was unlit (Photo 2).

- At approximately 11:19 a.m., the heat register located along the wall near Resident 2's room appeared to be unsecured to the wall, observed both to be leaning off the wall along its top border as well as appearing to be moved approximately 4" to the right from its original location (Photo 3).

- At approximately 11:20 a.m., the carpet within Resident 3's room was observed in various spots to be scuffed with areas of carpet fuzz bunched up (Photo 4)

- At approximately 11:21 a.m., the heat register located along the wall near Resident 1's room appeared to be missing its cover, exposing the inner components within (Photo 5).

At approximately 3:45 p.m., Surveyor reviewed the above concerns with Executive Director A and Health Services Director B. Executive Director A noted Surveyor's concern regarding the dusty vent and reported it would be addressed. Both reported they were unaware of the exit sign or

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N 481	Continued From page 9 heat register concerns but made note to have them addressed. Regarding Resident 3's carpet, Executive Director A reported that the provider was in the process of changing out the facility's carpeting for laminate flooring.	N 481		