STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525069	A. BUILDING _____ B. WING _____	03/11/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MAPLEWOOD CENTER	8615 W BELOIT RD WEST ALLIS, WI 53227

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0689 **Level of harm -** Actual harm **Residents Affected -** Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility did not ensure that 2 (R1, R4) of 2 residents reviewed had an environment that was free from accident hazards and received adequate supervision and assistive devices to prevent accidents. *R1 had 2 falls that were not thoroughly investigated and the interventions put into place post falls did not address the reason for the falls to prevent future falls. One fall resulted in major injury of an intraparenchymal hemorrhage (brain bleed) and right patellar fracture. *R4 had a fall that was not thoroughly investigated and interventions were not put into place to prevent future falls. Findings include: The facility policy, entitled Falls-Prevention/Falling Star, dated 11/01 and revised 11/19, states: (Facility) maintains the responsibility to assess each residents as to the risk of injury from falling, implement an individualized interdisciplinary care plan addressing those risks in a proactive manner and evaluates the effectiveness on a routine basis. In addition to addressing the issue of individual fall incidents, (the facility) takes seriously its responsibility to be at the forefront in fall prevention efforts by tracking and trending of fall incidents to identify extrinsic as well as [MEDICATION NAME] causes and implementing fall prevention interventions. . Proactive: To prevent the first fall: 1. All residents are assumed to have some risk of falls and staff is aware of the potential for a fall of any resident at any time and takes precautions when transferring/ambulating all residents. . 3. Care Plan will be updated to reflect changed in interventions that are necessary to maintain Resident's safety. Residents that have a score of 18 or higher on Fall Risk Assessment, or residents that experience a fall incident, will have one or more interventions implemented immediately following each fall incident. . Assessing Risk Potential: . 2. Assessment and care planning and monitoring of residents related to fall issues will be initiated by the primary nursing staff along with input from Team Meetings, observation and/or staff report. . V. Documentation: 1. All fall interventions will be care planned and recorded on Care Plan and on CNA (certified Nursing Assistant) care card as appropriate. . 3. Interdisciplinary review of fall incident will be completed in EHR (Electronic Health Record). . VI. Post Fall Incident: 4. Determine and implement an immediate intervention to prevent another fall with guidance from fall program coordinator or designee. . VII. Nurse Manager to review fall incident within 24 hours of fall (next business day). . 2. The fall intervention recommendations from the meeting will be added to the Resident Care Plan . 3. The Care Plan will be reviewed and modified as needed. . 1. R1 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. R1's Change in status Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 11/24/19, documents: A Brief Interview of Mental Status (BIMS) score of 14, indicating R1 is cognitively intact for decision making; requires extensive assistance of 2 staff for toilet use and transfers, extensive assist of 1 staff for bed mobility, dressing and personal hygiene and walking in the corridors did not occur; unsteady and only able to stabilize with staff assistance for moving from a seated to standing position, walking, turning around, moving on and off the toilet and transferring between surfaces, frequently incontinent of urine and always continent of bowel. Care Area Assessment (CAA)'s documented for Falls indicates: Proceed to care plan to decrease fall risk; (R1) triggered for falls because she has impaired balance, a history of falls and is on an antidepressant, (R1) was readmitted to the facility after hospitalization for a right gluteal abscess. . (R1) attends therapy per MD (Medical Doctor) order to promote resident to return to top of her baseline level of function. R1's Care Plan, dated 7/5/19, documents: (R1) has the potential for falls related to generalized weakness, [MEDICAL CONDITION], orthostatic [MEDICAL CONDITION]. Interventions include: Encourage to use assistive devices, if applicable Describe: w/c (wheelchair), (start: 7/5/19); PT (physical therapy)/OT (occupational therapy) scree/evaluation and treat as ordered, (start: 7/5/19); Floors free from spills or clutter, (start: 7/5/19); Provide adequate, glare free lighting, (start: 7/5/19); Keep call light, personal, and frequently used items within reach, (start: 7/5/19); Assist to wear non-skid footwear, (start: 7/5/19); Mat to floor when in bed, (start: 7/5/19); Bed at safe transfer height and soft touch call light, (start: 7/5/19). (R1) has had multiple falls related to [MEDICAL CONDITION], orthostatic [MEDICAL CONDITION] and weakness. Interventions include: Have resident stand up slowly from a sitting position for a few minutes before attempting to ambulate or stand. Monitor Orthostatic BPs (blood pressures) prn (as needed), (started: 7/5/19); Instruct to stand and gain balance before beginning ambulation, (started: 7/5/19); Will wear proper fitting shoes that are supportive with non-skid soles for ambulation, (started: 7/5/19); Falling Star, (started 10/7/19). (R1) has impaired mobility related to orthostatic [MEDICAL CONDITION], generalized weakness, [MEDICAL CONDITION], history of C7 (Cervical spine) fracture as evidenced by required assistance with ADL's (Activities of Daily Living). Interventions include: . Transfers with sit to stand lift prior to 11 AM, After 11 AM assist with 1 and 2 ww (wheeled walker), bed mobility extensive A (assist) of 1, (start: 8/13/19). (R1) will not display alerted self-esteem, UTIs (urinary tract infections), will remain clean, dry and free from breakdown related to incontinence, (start: 10/3/19), interventions include: . Offer toileting Q (every) 1 H (hour) and prn (as needed), (start: 10/7/19). On 10/4/19, at 10:15 AM, R1's Medical Record documents a Fall/Incident Report: Resident found on the floor in shower room in her bedroom laying on her right side with head against the wall. Resident states she was going to the shower to get something and the walker tipped on the raised tile and she fell and hit her head. Resident was assessed by RN (Registered Nurse) on floor, assisted up by two CNAs (Certified Nursing Assistances) with Hoyer lift and laid into bed. Writer assessed resident and noted hematoma to top of head and forehead, ice pack applied, NP (Nurse Practitioner) and POA (Power of Attorney) updated. New orders received to send resident to ER (emergency room) for CT (Computed Tomography) scan. . Pre-incident ambulation status: Limited Assistance; Continent at the time of the fall; . Investigation/Follow Up: Dated 10/7/19: Investigation/IDT (Interdisciplinary Team) met to discuss fall. Toileting schedule, medication review, labs to be requested. R1's Fall Evaluation, dated 10/4/19 at 10:15 AM, documents: . Resident was ambulating with the proper device; call light was in reach, call light was not sounding; performing the specific activity: getting something out of the shower; the resident was agitated; prior to the fall the resident was incontinent; New interventions put into place following the fall: fall review with IDT, toileting program was implemented/revised, UA (Urinary Analysis) OT/ PT/ ST (speech therapy) referral; care plan updated to include new interventions added: offer toilet Q 1 H (every 1 hour) and PRN (as needed). The resident's Fall Risk Assessment: prior to the fall was: 20 and after the fall was 23; a score of 18 or higher is considered high risk for falls. The new interventions added to the care plan does not address the reason for R1's fall. R1 did not fall ambulating to the bathroom for use of the bathroom. R1 fell on the way to the bathroom to get something from the shower room that was located in the bathroom. Facility documentation states the shower caddy was moved to a more assessable position and the tile on the bathroom floor was checked for any concern that would have caused R1 to fall. On 2/23/20, at 2:20 PM, R1's Medical Record documents a Fall/Incident Report: (R1) found lying on right side on bathroom entrance floor; R1 stated: I'm clumsy when asked for a description of what occurred; Several staff respond to lg (large) thud across from nurse's station to Pt's

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

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525069	A. BUILDING _____ B. WING _____	03/11/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MAPLEWOOD CENTER	8615 W BELOIT RD WEST ALLIS, WI 53227

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0689 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) (patient's) room. Found lying on right side @ (at) bathroom entrance floor. Lg bleeding observed from O/A (open area) on crown of head. Lg hematoma right forehead: Pt. A/O (alert/oriented) x3 (person, place, time), forgetful per baseline. Pt ind (independently) moved all extremities when instr. (instructed). Pt rpt (reported) pain to O/A rated @ 3/10 on pain scale. LOC (Loss of Conscience) intact throughout incident; VSS (vital signs stable), pressure applied to bleeding f/b (followed by) kerlix. Cold compress applied to hematoma sit until EMT (Emergency Medical Team) arrived. 14:42 (2:42 PM) Pt transported via Bell ambulance to SLMC (St. Luke's Medical Center). Staff in nursing station and heard someone fall and went across to resident's room and located resident on the floor in front of bathroom. Resident stated she didn't know why she didn't use call light for help. Staff CNA went in room at beginning of shift and resident declined the need to be toileted. Resident bleeding from head, supervisor administered first aid and writer called 911, and daughter. Supervisor updated MD (Medical Doctor) and DON (Director of Nursing). Contributing environmental factors: lost balance; footwear: non-skid footwear; pre-incident ambulation status: Extensive Assistance; continent at the time and toileting schedule in place. On 2/24/20, Investigation/Follow-Up: IDT met to discuss fall. Resident at high risk for falls. Upon readmission, res will be added to falling star program, a new B&B (Bowel and Bladder) will in initiated and placed on 15 minute checks x (times) 3 days to assess activity patterns. Surveyor noted adding R1 to the falling star program was an intervention that was supposed to be in place following the October 2019 fall. On 2/23/20, at 2:20 PM, R1's Medical Record documents, Fall Evaluation: . Prior to the fall R1 was sitting in recliner chair; . attempting to transfer from recliner chair to the bathroom; . R1 was offered and declined toileting when staff CNA went in resident's room at the beginning of the shift; . new interventions put into place following the fall: pt education/staff education/family educations, falling star, add to list. . New Interventions added to the care plan: date and time, this area was left blank and not completed; Fall Risk Assessment worksheet updated after the fall. Fall Risk score prior to the fall was: 18, and Fall Risk score after the fall was 30. A score of 18 or higher is considered High Risk for falls. R1 was hospitalized from [DATE]-3/2/20, following the fall, and was diagnosed with [REDACTED]. R1's Fall Evaluation does not document when R1 was actually last assisted to use the toilet prior to the staff offering and R1 declining at the beginning of the shift. R1's Care Plan documents: R1 should be offered toileting Q 1 Hour and PRN. R1's Care Plan, dated 3/2/20, documents new interventions of: Offer toileting 1-2 hours and prn; mat to floor when resident is in bed; close supervision when resident in bathroom, 15 minute checks x 72 hours upon readmission; Falling Star program; new B&B assessment to be initiated upon readmission and encourage to be in common areas (i.e. dining room during meals, activities per schedule) as appropriate for closer supervision. R1's Care Plan from 10/7/19 already documented the interventions of: offer toileting assistance Q 1 hour; Falling Star program. The new interventions documented do not address the reason for the fall as R1 self-transferred and self-ambulated to the bathroom. On 3/11/20, at 11:36 AM, Surveyor interviewed Registered Nurse (RN) Unit Manager-C, who stated: R1 has [MEDICAL CONDITION] and has very specific times medications are dispensed. This causes R1 to have different level of care needs. In the morning, before 11:00 AM, before the [MEDICAL CONDITION] medications kicks in, R1 requires as sit to stand for transfers, after 11:00 AM, R1 requires assist of 1 for transfers and ambulation. RN Unit Manager-C stated: R1 is very stubborn and tries to do things for herself. R1 was not cleared to ambulate independently at the time of the fall on 2/23/20. RN Unit Manager-C stated, the shift changes occurs at 2:00PM, and at that time staff offered R1 assist with toileting. R1 declined staff assistance and did not use the call light and self-transferred and self-ambulated to the bathroom. RN Unit Manager-C, stated she does not know when R1 was actually last assisted to the toilet as the CNA's will document toileting at the end of the each shift so accurate times of toileting are not documented. RN unit Manager-C, stated R1 does not always use her call light to alert staff for assistance. R1 typically will stand up, walk then fall vs standing and falling right away. RN Unit Manager-C stated: the IDT will review all falls that occurred that week on Friday. The IDT will come up with new interventions to prevent falls and the Director of Nursing or Unit Manager will add the new interventions to the care plan. RN Unit Manager-C stated: the new fall interventions that were initiated after R1's fall on 2/23/20, were to complete 15 minute checks for 72 hours and add R1 to the Falling Star program. RN Unit Manager-C was not aware R1's care plan, prior to the fall, documented a toileting schedule of offering toileting assistance Q1 hour and prn and the Falling Star program. RN Unit Manager-C stated she wasn't aware of any other new fall interventions for R1. On 3/11/20, at 1:14 PM, Surveyor interviewed Licensed Practical Nurse (LPN)-D, who stated: R1 would get up and walk and was very spontaneous in her behavior. R1's use of the call light was hit and miss and was day by day. Some days R1 would call for staff assistance and other days R1 would not. R1's fall that occurred on 10/4/19, occurred on the unit that LPN Unit Manager-D was assigned to. LPN Unit Manager-D, stated: on the day of the fall, R1 got up to get something that was in the bathroom/shower room that was located in her room. The family brought in a cabinet/basket [MEDICATION NAME] for R1's belongings. R1 was reaching for the item in the [MEDICATION NAME], located in the shower, when she fell . LPN Unit Manager-D, stated: R1's walker got stuck on the raised tile of the shower stall. Per LPN Unit Manager-D, the tile is raised in that area to keep the water in the shower and off the bathroom floor. LPN Unit Manager-D stated she moved the [MEDICATION NAME] so it allowed for easier access for R1 and maintenance staff checked the tile to make sure there was nothing defective, and no defects were found. LPN Unit Manager-D stated: the new interventions put into place to prevent future falls was to relocate the [MEDICATION NAME] for easy access for R1 and for maintenance to check the floor tile. LPN Unit Manager-D, stated the IDT did not put any intervention into place for R1 self-ambulating and self-transferring as they facility only uses motion sensors when someone attempts to get out of bed unassisted but not from a chair. The interventions of moving the [MEDICATION NAME] for easier access and maintenance to check the shower tile were not documented in R1's Care Plan. On 3/11/20, at 3:25 PM, Surveyor informed: Director of Nursing-B, Assistant Administrator-E, and Administrator-A, via speaker phone of the above concerns. 2. R4 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. R4's Admission Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 2/26/20, documents: A Brief Interview of Mental Status (BIMS) score of 14, indicating R4 is cognitively intact for daily decision making; requires extensive assistance of 2 staff for bed mobility and transfers, requires extensive assist of 1 staff for locomotion on and off the unit, dressing, toilet use and personal hygiene; is unsteady and only able to stabilize with staff assistance when moving from seated to standing position, walking, turning around, moving off the toilet and surface to surface transfers; has an indwelling catheter and is frequently incontinent of bowel. R4's Care Plan, dated 2/19/20, documents: (R4) has potential for falls related to weakness, AMS (Altered Mental Status), DM2 (Diabetes Mellitus 2), [MEDICAL CONDITION] with A Fib ([MEDICAL CONDITION] Fibrillation). Interventions include: Encourage use of assistive devices, if applicable Describe: per therapy, (start: 2/19/20); PT (Physical Therapy)/OT (Occupational Therapy) screen/evaluation and treat as ordered, (start: 2/19/20; Floors free from spills or clutter, (start: 2/19/20); Provide adequate, glare free lighting, (start: 2/19/20); Keep light, personal, and frequently used items within reach, (start2/19/20); Assist to wear non-skid footwear, (start 2/19/20); Bed at safe transfer height, (start 22/19/20). On 2/25/20, at 7:20 PM, R4's Medical Record documents: Res (resident) found lying flat on the floor, on his stomach, Res appeared angry, yet calm. Asked if anyone hurt him, res stated no. Supervisor notified and came to assess. Vitals signs taken and neuro-checks started. . Pre-Incident ambulation status: Extensive Assistance. R1 was documented to be barefoot and incontinent. On 2/26/20, the IDT (Interdisciplinary Team) met to discuss the fall. Placed immediately on 15 minute checks. Transferred to the hospital with increasing lethargy and AMS (Altered Mental Status). No injuries were documented related to the fall. On 2/25/20, at 7:20 PM, R4's Medical Record, documents a Fall Evaluation stating: (R4) is alert and oriented x (times) 3 (person, place, and time), alert with some confusion and forgetfulness, cognitive impairment but no change from baseline; R4 is angry, stating I want to go home; . Prior to the fall the resident was: sitting in w/c (wheelchair) in bedroom; Environmental Conditions contributing to the fall: resident was attempting to self-transfer from w/c to toilet; the call light was within reach but not sounding; the resident was anxious and agitated; the last time the resident was toileted: before dinner; and the resident was incontinent at the time of the fall; new interventions put into place following the fall: this area is left blank. R4's Care Plan, dated 3/2/20, upon return to the facility after the fall, documents new fall intervention of: low bed with fall mat in place when resident is in bed. The intervention added to the care plan does not addressed the reason for R4's fall from the wheelchair. R4's Fall Evaluation does not document the last time R4 was actually assisted with toileting needs. On 3/11/20, at 11:47 AM, Surveyor interviewed Registered Nurse (RN) Unit Manager-C, who stated: R4 was not cleared by therapy to be transferring or ambulating without staff assistance. RN Unit Manager-C stated: R4 fell from the wheelchair trying to toilet himself when he has a Foley catheter. RN Unit Manager-C stated she is unable to determine when R4 was last assisted with toileting needs as the CNA's will enter in toileting documentation at the end of each shift. RN Unit Manager-C stated: the IDT will review all falls that occurred that week on Friday. The IDT will come up with new interventions to prevent falls and the Director of Nursing or Unit Manager will add the new interventions to the care plan. RN Unit Manager-C stated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525069	A. BUILDING _____ B. WING _____	**03/11/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MAPLEWOOD CENTER	**8615 W BELOIT RD WEST ALLIS, WI 53227**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0689 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 2) she was unable to identify new interventions that were put into place to prevent future falls. On 3/11/20, at 3:25 PM, Surveyor informed: Director of Nursing-B, Assistant Administrator-E, and Administrator-A, via speaker phone of the above concerns.
F 0755 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility did not ensure a resident received a prescribed medication. This was observed with 1 (R2) of 1 residents reviewed for medications. R2 had a prescription that was not administered for 8 days due to being unavailable. Findings include: The facility's policy and procedure for Ordering And Receiving Non-Controlled Medications dated 9/10 were reviewed by Surveyor. The policy indicates that medications are received from the provider pharmacy on a timely basis. The nursing care center maintains accurate records of medication order and receipt. R2's medical record was reviewed due to a complaint intake. R2 resided in the facility from [DATE] - 10/30/19. R2's admission physician orders [REDACTED]. R2's MAR (Medication Administration Record) for October 2019 indicates from 10/23/19 - 10/30/19 this medication was unavailable at the 4:00 PM dose time. The MAR indicated [REDACTED]. R2's IDT (interdisciplinary notes) do not include information on why this medication was not available. On 3/11/20 at 12:10 PM Surveyor spoke with DON-B (Director of Nurses). R2's October MAR indicated [REDACTED]. R2's MAR indicated [REDACTED]. DON-B did not have any further information at this time.