STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525700	A. Building B. Wing	02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Congregational Home, Inc	13900 W Burleigh Rd Brookfield, WI 53005

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49435 Based on interviews and record review, the facility did not ensure that 1 (R1) of 1 allegations of neglect were reported to the State Survey Agency within the required reporting timeframe. On 11/25/24, R1 and R1's spouse (Spouse-N) filed a grievance with Social Worker (SW)-D regarding a care concern that occurred on 11/22/25. The grievance was investigated, and the written results and plan were given to R1, and Spouse-N. On 11/28/24, Spouse-N sent an email to SW-D, during the Thanksgiving holiday weekend, stating that R1 and Spouse-N believes that the incident that occurred on 11/22/24 was neglectful and abusive. Facility staff did not report the allegation of neglect to the State Agency until 12/2/24, when SW-D returned from the holiday weekend. Findings include: The facility's policy dated 11/26/24, titled, Abuse, documents, in part: [Name of facility] prohibits mistreatment of residents including: . Neglect . Residents (and resident representatives) will be educated regarding their rights specific to grievances, complaints, incidents, and facility procedures to investigate and resolve these issues . Upon learning of an incident, [Name of facility] will take the necessary steps to protect the resident from further incidents of misconduct or injury. [Name of facility] will thoroughly investigate all alleged violations and report as required to the Division of Quality Assurance (DQA) in a timely manner . It is the policy of [Name of facility] that abuse allegations (abuse, neglect, exploitation or mistreatment, .) are reported per Federal and State Law. The facility will ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, . are reported immediately but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency .). (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's undated facility policy titled, Grievance Policy and Guideline, documents, in part: [Name of facility] is committed to providing a safe and secure environment free of poor customer service or abuse. If a resident or resident representative is unhappy with any service treatment, or care within the [Name of facility], they are encouraged to discuss their concerns personally and promptly with their Social Worker/Grievance Officer, or Nurse Supervisor for quick resolution . Grievance officers are our Social Workers and can be seen in person or contacted by name at [phone number], or at below email address during regular business hours . The grievance report concern form should be completed and delivered to the Grievance Officer/Social Worker, or a designee/Nurse Supervisor in their absence. All effort will be made to resolve your grievance concern promptly within that same day. R1 was admitted to the facility on [DATE] with a diagnoses that includes Multiple Sclerosis, Demyelinating Disease of Central Nervous system, and Spastic Hemiplegia. R1's Quarterly Minimum Data Set (MDS) assessment dated [DATE], documents R1's cognition is intact. R1 is responsible for self. Surveyor reviewed the Facility Reported Incident (FRI) submitted to the State Agency by the facility on 12/2/24. The summary documents, in part: On 11/25/24, [SW-D] received a concern from [R1] and [Spouse-N] regarding an interaction with [Licensed Practical Nurse (LPN)-O] on 11/22/24 at approximately 11:30 PM. This involved [LPN-O] coming in to inform [R1] that staff were running late to assist with getting [R1] to bed, but they would be there soon .The incident was investigated and felt to be a customer service concern. [LPN-O] apologized to [R1] and [Spouse-N] on the evening of 11/25/24 and a copy of the concern form was reviewed with and given to [R1] and [Spouse-N]. On Monday 12/2/24, after the holiday weekend, [SW-D] received an email indicating that [Spouse-N] was not satisfied with the apology and [Spouse-N] feels that [LPN-O's] actions on 11/22/24 were a violation of rights as well as neglectful and abusive . On 2/4/25 at 12:05 PM, Surveyor interviewed R1 and Spouse-N. Spouse-N indicated that an email was sent to SW-D on 11/28/24 outlining why R1 and Spouse-N believed LPN-O was neglectful and abusive. Spouse-N provided Surveyor a copy of the email sent to SW-D on 11/28/24. On 2/5/25 at 9:08 AM, Surveyor interviewed Social Services Director (SSD)-G, who prepared and submitted the facility FRI to the State Agency. Surveyor asked when the email mentioned in the FRI was sent to the facility. SSD-G stated that it was sent over the holiday weekend. SSD-G stated that they inform residents to speak with nursing, supervisors or staff with concerns so that concerns can be addressed in time. Surveyor asked if anyone covers incoming emails. SSD-G stated no but indicated that residents are made aware of who to reach out to (supervisors and staff) so they can share concerns timely. SSD-G stated staff would then reach out to SSD-G and Nursing Home Administrator (NHA)-A. Surveyor asked for the facility's copy of the email mentioned in the FRI. SSD-G stated that the email was sent to SW-D and that SW-D would have a copy. On 2/5/25 at 9:14 AM, Surveyor interviewed SW-D. Surveyor asked SW-D for the facility's copy of the email that was mentioned in the facility FRI. SW-D stated SW-D would look for the email and get back to Surveyor. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/5/25 at 9:40 AM, SW-D returned to Surveyor and stated that after doing some digging SW-D did not find the email sent by Spouse-N. SW-D stated that SW-D has to delete emails after 30 days. SW-D stated SW-D does not have a copy of the email. Surveyor asked when the email was sent. SW-D stated that SW-D does not recall when it was sent, but does remember reading the email on Monday, 12/2/24. On 2/5/25 at 1:05 PM, Surveyor informed NHA-A and Director of Nursing (DON)-B of the concern that an allegation of neglect was sent by email over a holiday weekend and was not reported to the State Agency within the required time frame. NHA-A stated that NHA-A does not require staff to answer emails if they are not working. Surveyor informed NHA-A that the facility needs a process to address potential abuse/neglect concerns when they are brought forward to the facility. No additional information was provided as to why the facility did not ensure that R1's allegation of neglect was reported to the State Survey Agency within the required reporting timeframe.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49435 Based on interview and record review, the facility did not ensure that 1 (R1) of 1 residents reviewed with limited range of motion received appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. R1 informed surveyor that R1 does not always receive help from facility staff to complete stretches/range of motion (ROM) exercises 2 times a day as indicated in R1's Certified Nursing Assistant (CNA) Kardex. Facility staff do not document when stretches/ROM exercises are completed. R1 has a diagnosis of Multiple sclerosis with spasticity. R1 does not have a care plan with measurable goals and interventions related to spasticity and ROM. Findings include: The facility policy dated 2/22/24, entitled, ROM and/or Mobility, documents: Purpose/policy statement: Policy explanation and compliance guidelines: it is the policy of the [name of facility] to promote independence and quality of life by maintaining or improving a resident's quality of life. Policy: 1. Residents who are unable to ambulate independently may be assessed by the nurse and/or therapist for a walking or ROM program. 2. The walking or ROM program is added to the Kardex. 3. Use appropriate assistive device(s) per Kardex. 4. Information will be provided on the Kardex for communication to the staff. R1 was admitted to the facility on [DATE] with diagnosis that includes Multiple Sclerosis, Demyelinating Disease of Central Nervous system, Osteoporosis, Spastic Hemiplegia, Muscle weakness and Chronic Pain Syndrome. R1's Quarterly Minimum Data Set (MDS) assessment dated [DATE], documents R1's cognition is intact. R1 uses a wheelchair for mobility. R1 is dependent for toileting, lower body dressing, and transfers. On 2/4/25 at 11:35 AM, Surveyor interviewed R1. R1 informed surveyor that R1 is supposed to receive help from facility staff in completing stretching/ROM exercised 2 times a day. R1 stated that R1's care plan states that staff should complete the stretching/ROM exercises 2 times a day, but staff do not always perform the stretching/ROM exercises 2 times a day. R1 pointed to the wall in R1's sitting area. Surveyor observed a sign on the wall with detailed instructions indicating how staff should perform stretches/ROM exercises in the afternoon daily. R1 then pointed to the wall in R1's bedroom area. Surveyor observed a sign on the wall with detailed instructions indicating how staff should perform stretches/ROM exercises in the morning daily. Surveyor reviewed R1's Comprehensive Care Plan and did not locate documentation regarding stretching/ROM exercises. R1's progress note dated 10/17/24 documents: New orders received from resident's Neurologist, [MD-H], for PT [evaluation] and treat for spasticity. Order comments state: Daily Therapy for ROM. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's physician order dated 10/17/24 documents, [Physical Therapy (PT) Evaluation] and Treatment per plan of care. Surveyor noted R1 started PT on 10/29/24. R1's PT visit note dated 11/14/24 documents, in part: . Most of session was spent verbally going over and finalizing stretching program for [R1]. Final program to consist of knee flexion in supine and sitting, sitting at sit to stand, dorsiflexion stretch with band, and with manual pressure. R1's PT visit note dated 11/20/24 documents, in part: . Most of session was spent verbally going over stretching program with [R1]. [R1] tolerates all of these exercises well. Laminated copy posted in [R1's] room and copies given to nursing staff and social worker . R1's PT visit note dated 12/2/24 documents, in part: . Most of session spent observing CNA-E completing stretches and providing cues as needed. PT spoke to head of nursing, [Nursing Care Manager-C], about care plan. [Nursing Care Manager-C] has printed out plan for staff to complete . R1's CNA Kardex documents: Mobility- stretches to be done in the A.M. and stretches to be done on P. M. shift; see attached. Attached to the CNA Kardex is the detailed instructions signs that are posted in R1's room. The signs document: Morning Stretches. Bending [R1's] knee: Lift [R1's] leg into the air and put your elbow under [R1's] knee. Use that arm to pull [R1's] knee towards [R1's] head and push down on [R1's] foot with the other arm to bend [R1's] knee. It is much easier to bend [R1's] knee this way. Do this 10 times on [R1's] right, 10 times on [R1's] left, and then 10 times on the right again as that leg is tighter. Sitting in sit to stand: Let [R1] sit in the sit to stand with [R1's] knee bent for 5 minutes before transferring to the commode. This helps stretch [R1's knees and work on core strength. Afternoon Stretches. Stretching [R1's] ankle and foot: Straighten [R1's] knee. Use your forearm to bend [R1's] ankle. This will stretch out [R1's] ankle and the bottom of [R1's] foot. This will also make it easier on your hands. Using band to stretch out [R1's] ankle and foot: Put the middle opening of the band around the end of [R1's] foot. [R1] will hod the ends of the band and pull up. You will need to hold [R1's] ankle to keep her from lifting [R1's] whole leg up. Surveyor reviewed R1's electronic medical record. Surveyor did not locate any documentation indicating the stretches/ROM exercises were being completed by staff. On 2/4/25 at 11:31 AM, Surveyor interviewed CNA-E, who was mentioned in the PT visit note on 12/2/24. CNA-E indicated that stretches/ROM exercise instructions are in R1's CNA Kardex. CNA-E stated CNA-E completes R1's stretches/ROM exercises when CNA-E is working. Surveyor asked where CNA-E would document that stretches are being completed. CNA-E indicated facility staff do not document that the stretches/ROM exercises are completed but indicated that instructions are on the CNA Kardex, so staff know what to do. Surveyor asked if CNA-E has instructed other CNA's on how to complete the stretches/ROM exercises. CNA-E stated yes. CNA-E stated that some CNAs are scared to do the stretches/ROM exercises. On 2/4/25 at 2:34 PM, Surveyor interviewed CNA-M. Surveyor asked where CNA-M would find if stretches/ROM exercises needed to be completed on a resident. CNA-M stated it would be on the care card/CNA Kardex. Surveyor asked where CNA-M would document that stretches/ROM exercises are documented completed. CNA-M stated they are not documented in the electronic medical record. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/4/25 at 4:05 PM, Surveyor interviewed CNA-F. Surveyor asked when R1's stretches/ROM exercises are completed. CNA-F stated that the first shift CNA's will do the stretches/ROM exercises. Surveyor asked if any are completed on 2nd shift. CNA-F stated I don't know. CNA-F stated that CNA-F will raise R1's legs to put lotion on R1's legs. Surveyor asked where Surveyor would find documentation that stretches/ROM were completed. CNA-F indicated that the CNA Kardex has the information CNA-F needs to care for R1. CNA-F indicated that R1 will let you know what R1 wants and needs and will tell you what has and has not been completed. On 2/4/25 at 2:10 PM, Surveyor interviewed Nursing Care Manager-C. Surveyor asked who completes stretches/ROM exercises for R1. Nursing Care Manager-C stated that CNAs do them. Nursing Care Manager-C indicated nurses can do them as well, but usually the CNA completes them. Surveyor asked where staff document that the stretches/ROM exercises are completed. Nursing Care Manager-C stated they are not documented as completed but that they are part of the care plan. Nursing Care Manager-C stated that Nursing Care Manager-C supposed that they should be documented. Nursing Care Manager-C stated that the facility does not have a restorative program and if a resident has instructions on the care card/CNA Kardex, that is what the CNA should do. Surveyor asked how Nursing Care Manager-C knows stretches are being completed. Nursing Care Manager-C stated that R1 will tell Nursing Care Manager-C if they are not being completed. Nursing Care Manager-C stated that in the past, R1 has told Nursing Care Manager-C that a facility CNA was not completing the stretches/ROM exercises with R1. Nursing Care Manager-C addressed the situation with that CNA and completed education. Nursing Care Manager-C again stated R1 would tell someone if they are not being completed. Surveyor noted Nursing Care Manager-C indicated in the interview that stretches were not always completed as documented in the CNA Kardex. On 2/5/25 at 10:06 AM, Surveyor interviewed Director of Nursing (DON)-B. Surveyor asked who is responsible for completing stretches/ROM exercises. DON-B stated that the PT will set up a program and CNAs will complete the stretches/ROM exercises as directed by the PT. DON-B indicated that the facility does not have a restorative program, but they follow PT instructions. Surveyor asked where the stretches/ROM exercises are documented. DON-B indicated that staff do not document if the stretches/ROM exercises are completed. Surveyor asked how DON-B would know if stretches/ROM exercises are being completed for R1. DON-B stated that R1 will tell staff if they are not being completed. Surveyor informed DON-B of the concern that R1 is stating that R1 is not always getting help with stretches/ROM exercises as directed in the CNA Kardex and there is no documentation indicating that the stretches/ROM exercises are being completed. Surveyor asked if R1's stretches/ROM of exercises should be included in the comprehensive care plan with measurable goals and other interventions. DON-B stated that it should be care planned. Surveyor informed DON-B that R1 does not have a care plan with measurable goals regarding R1's stretches/ROM exercises for spasticity. On 2/5/25 at 1:05 PM Surveyor informed Nursing Home Administrator (NHA)-A of the concern R1 informed Surveyor that stretches/ROM exercises are not always completed as indicated on the CNA Kardex. There is no documentation indicating that the stretches/ROM exercises are being completed as indicated on the CNA Kardex. There is no comprehensive care plan with measurable goals regarding R1's stretches/ROM exercises. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	No additional information was provided as to why the facility did not ensure R1 received appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20483 Based on observation, record review, and interview, the facility did not ensure that 1 (R2) of 2 residents reviewed received adequate supervision and asssitive devices to prevent accidents. * R2 suffered falls that were not thoroughly investigated, with fall interventions and revisions to the fall care plan post fall review & IDT (interdisciplinary team) not implemented. Findings include: The facility's policy titled, Falls and modified 4/3/23 under Policy documents To follow the intent of HFS 132 and Federal regulations F323 sic (F689) Congregational Home will provide an environment that is free from hazards over which the facility has control and will provide appropriate supervision to each resident to prevent avoidable falls. Under Procedure documents 10. The Charge Nurse caring for the resident that has fallen will complete the following forms: * Skilled Nursing Fall Incident Form A note from appropriate licensed and direct care staff providing care to the resident prior to fall and any witnesses if applicable. * With head trauma the Charge Nurse will complete Evaluation if the resident will require further medical work up and be transported to the Hospital emergency room . * Head Trauma Craniotomy Check Flow Sheet will be initiated with all unwitnessed falls. 11. The Charge Nurse will initiated an intervention help reduce risk of future falls. 12. The Charge Nurse will update POC (plan of care) and the CNA (Certified Nursing Assistant) Care Plan. 13. The Nurse Care Manager/RN (Registered Nurse) Supervisor on duty at time of fall will review all Charge Nurse follow up and documentation including: *Care plans. *Nursing notes. *And assure the new intervention/s and any ongoing interventions to prevent future falls are appropriate. 1.) R2's diagnoses includes unspecified dementia severe with psychotic disturbances, anxiety disorder, epilepsy, atrial fibrillation, hypertension, and depressive disorder. The Falls CAA (care area assessment) dated 6/28/24 documents under the analysis of findings for nature of problem/condition: Morse fall scale score of 19, High risk for falls. Hx (history) of 2 recent falls. See delirium, cognitive, communication, pain CAA for details. Dx (diagnosis) of new seizures, vascular dementia. BIMS (brief interview mental status) score 3/15. Less and less awareness of safety, ability limitations, non ambulatory. Full body lift for transfers up in Broda chair. PRN (as needed) oxycodone medication therapy. Polyneuropathy see NP (Nurse Practitioner) note 6/10/24. Under the Care Plan Considerations section it documents: Newly assigned to hospice. Ongoing decline in mobility & strength, cognitive communication skills. Potential for falls. Goal is for comfort. No falls, injury. Nursing to anticipate and assist with mobility and ADL (activities daily living) deficits, monitor for safety 1:1 PRN (as needed), encouraging to be in a more supervised area. Bed canes for bed mobility, confusion and forgetful. Ensure has hearing aids. Thick full mat to side of bed. Dycem to recliner. Gripper socks. Check and change for incontinence cares. See falls care plan. The Quarterly MDS (minimum data set) with an assessment reference date of 9/13/24 has a BIMS score of 3 which indicates that R2 has severe cognitive impairment. R2 has fallen since prior assessment with 2 or more falls, no injury and 2 or more with injury (except major). (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Quarterly MDS with an assessment reference date of 12/13/24 has a BIMS score of 3 which indicates severe impairment. R2 is assessed as being dependent for toileting hygiene, roll left & right, & chair/bed to chair transfer. R2 is assessed as always incontinent of urine and bowel. R2 has fallen since prior assessment with 2 or more falls, no injury and 2 or more with injury (except major). R2's fall care plan initiated 6/1/24 and revised 9/27/24 documents the following interventions: *Continue interventions on the at risk plan initiated 6/1/24. *For no apparent acute injury, determine and address causative factors of the fall, initiated 6/1/24. *New Intervention post fall on 6/3/24: When resident is up out of bed to be in Broda chair for safety precautions, initiated 6/3/24. *New Intervention post fall on 6/25/24: Increased frequency of check and change to: Check and Change every 2 hours and as needed, initiated 6/25/24. *New Intervention post fall on 6/26/24: Staff to perform safety checks on resident every 30 minutes for safety measures and fall prevention, initiated 6/26/24. *New Intervention post fall on 7/1/24: Staff to follow residents current toileting plan: Staff to check and change resident every 2 hours and PRN (as needed), initiated 7/9/24 & revised 2/4/25. *State X-ray to left post UWF (unwitnessed fall) on 7/1/24 d/t (due to) raised red firm area of skin to top of left foot. X-Ray Impression Left Foot: No acute abnormality is seen involving the left foot, initiated 7/1/24. *New Intervention post fall on 7/3/24: Reviewed residents current behavioral medication with [Name] psych NP (Nurse Practitioner). Updated psych NP regarding resident continued anxiety/agitation/restlessness with frequent attempts made by resident to get up out of Broda chair resulting in fall. Reviewed Behavioral medication regimen with [Name] psych NP with new orders obtained on 7/3/24 for: Depakote 250 mg (milligrams) BID (twice daily) along with new orders for CBC (complete blood count) & CMP (comprehensive metabolic panel) on 7/8/24, initiated 7/3/24. *Ensure Broda chair is slightly reclined when resident is in Broda chair, initiated 7/24/24. *New Intervention Post fall on 7/24/24: Ensure Broda chair is slightly reclined when resident is in Broda chair, initiated 7/24/24. *New Intervention post fall on 7/24/24: If resident becomes restless have staff first check if resident needs her briefs changed. Resident is frequently restless when her briefs are soiled or when she has to have a BM (bowel movement), initiated 7/25/24. *Intervention 7/29/24: Educated activities staff if resident becomes restless during an activity please notify nursing staff so resident can be toileted. If resident becomes restless have staff first check if resident needs her briefs changed. Resident is frequently restless when her briefs are soiled or when she has to have a BM (bowel movement). Staff also educated when resident is up in Broda chair to be slightly reclined d/t Broda chair wasn't reclined on 7/29/24 when fall occurred, initiated 8/9/24. *New Intervention 8/5/24: Nursing staff educated on importance of reading resident care cards at the start of every shift to make sure all interventions are being followed appropriately, initiated 8/5/24 and revised 2/4/25. *Thick fall mat on side of bed when occupied and unattended, initiated & revised 9/4/24. *Intervention post fall on 9/11/24: Reviewed psychotropic medication regimen at behavioral health meeting with [Name] psych NP on 9/12/24 with new & changed psychotropic medications orders obtained per psych NP to decrease residents current behaviors including decreased anxiety/agitation with decreased falls r/t (related to) restless behaviors, initiated 9/12/24. *Monitor/document/report PRN x (times) 72h (hour) to D for s/sx (signs/symptoms): Pain, bruises, Changes in mental status, New onset: confusion, sleepiness, inability to maintain posture, agitation, initiated 9/11/24 & revised 9/27/24. *Neuro-checks x (times) Q15min (every 15 minutes) x 4, Q1hr x 4, Q4 hrs x 4, Q8 hrs x 4 per facility protocol, initiated 9/11/24 & revised 9/27/24. *Vital signs x 15 min x 4, 1 hr x 4, Q4 hrs x 4, Q8hrs x 4 per facility protocol, initiated 9/11/24 & revised 9/27/24. (continued on next page)

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	525700	A. Building B. Wing	02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Congregational Home, Inc	13900 W Burleigh Rd Brookfield, WI 53005

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Broda Operating Manual Centric Tilt Semi Recliner provided to Surveyor on 2/5/25 by DON (Director of Nursing)-B under the section 2.5 Hazards for 2.5.1 Position of Chair - Danger of Falling documents After a resident is transferred into a chair, assess the amount of tilt required. We recommend that the chair's seat be tilted sufficiently to prevent the resident from sliding or falling forward off the chair. The amount of seat tilt used should be determined by the resident's caregiver who is responsible for seating. R2's incident note dated 7/22/24 at 11:03 a.m. and written by LPN (Licensed Practical Nurse)-P documents: Date, Time and Location of Fall: 7/22/24 at 0750 (7:50 a.m.) in the common TV area on west hall. Vitals, including POX (pulse oximetry), Blood Sugar and Orthostatic BP (blood pressure): BP: 148/91, P (pulse): 103, R (respirations) 16, POX: 93% RA (room air), T (temperature): 97.4. Describe the fall: Writer was called to the common TV area on west hall d/t (due to) resident slid out of her Broda chair on to the floor in front of her chair. Were there any injuries? If so, describe: No injuries noted. Date/Time/Name of Physician Update: 7/22/24, 0830 (8:30 a.m.) [Name] NP. Date/Time/Name of Family update: 7/22/24 0800 (8:00 a.m.) [Name] daughter POA (power of attorney). R2's fall on 7/22/24 was not thoroughly investigated as there was no CNAs (Certified Nursing Assistant) statements on the post fall report . There were no statements as to who last saw R2 or what was R2 doing. The post fall report or the IDT (interdisciplinary team) incident follow up did not indicate whether prior interventions were in place at the time of the fall. The facility implemented a new intervention of ensure Broda is slightly in the reclining position. R2's fall care plan was not revised with this intervention until 7/24/24 after R2 had another fall. In addition, according to the manufacturers information recommend the chair's seat be tilted sufficiently to prevent the resident from sliding or falling forward. There is no documentation as to the tilt of R2's Broda chair prior to the fall. R2's incident note dated 7/24/24 at 23:39 (11:39 p.m.) written by LPN-R documents Date, Time and Location of Fall: 7/24/24, 2015 (8:15 p.m.), [NAME] unit bird lounge. Vitals, including POX, Blood Sugar and Orthostatic BP: See charted vitals. Describe the fall: Unwitnessed fall. Resident attempted to self transfer out of her Broda chair without staff assistance and fell on to the floor. Were there any injuries? If so, describe: No. Date/Time/Name of Physician Update: 7/24/24, 2044 (8:44 p.m.), [Name] Hospice. Date/Time/Name of Family update: 7/24/24, 2055 (8:55 p.m.) [Name] POA. R2's fall on 7/24/24 was not thoroughly investigated as there are no statements included in the post fall report as to who last saw R2 or what was R2 doing. The post fall report or the IDT (interdisciplinary team) incident follow up does not indicate whether prior interventions were in place including the positioning of R2's Broda chair. New interventions included in the post fall report documents If resident becomes restless have staff first check if resident needs her briefs changed. Resident frequently restless when briefs soiled or when needs to have BM. Ensure Broda chair is slightly reclined when resident is up in Broda chair for safety. The intervention of checking R2's incontinence product was placed on the fall care plan until 7/29/24, five days later and the intervention of reclining R2's Broda chair was recommended after R2's fall on 7/22/24. R2's post fall report was not signed by the Nurse Manger until 8/6/24 and DON (Director of Nursing)-B did not sign this report until 8/19/24. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R2's incident note dated 7/29/24 at 15:19 (3:19 p.m.) written by LPN-Q documents Date, Time and Location of Fall: 7-29-24 1130 in TV room on west. Vitals, including POX, Blood Sugar and Orthostatic BP: 137/66, 97. 2, 76, 18, 925. Describe the fall: resident slid out of chair to the floor during activities. Were there any injuries? If so, describe: no injuries. Date/Time/Name of Physician Update: 7-29-24 1225 (12:25 p.m.) [Physician name]. Date/Time/Name of Family update: 7-29-24 1225 (12:25 p.m.) [POA name]. R2's post fall report and IDT incident follow up for R2's fall on 7/29/24 documents R2's Broda chair wasn't reclined according to R2's plan of care when R2's fall occurred. There is no documentation as to whether other prior interventions were in place at the time of R2's fall. R2's post fall report was not signed by the Nurse Manger until 8/9/24 and DON (Director of Nursing)-B did not sign this report until 8/19/24. R2's incident note dated 8/5/24 at 15:38 (3:38 p.m.) written by LPN-J documents Date, Time and Location of Fall: 8/5/2024, 1430 (2:30 p.m.), canary lounge. Vitals, including POX, Blood Sugar and Orthostatic BP: 132/74, 76, 16, 97.9, BG= (blood glucose equals) 118, 97%. Describe the fall: unwitnessed fall in canary lounge from Broda chair to the floor. Were there any injuries? If so, describe: no injuries. Date/Time/Name of Physician Update: [Name] NP. Date/Time/Name of Family update: [POA name], 8/5/2024, 1530 (3:30 p.m.). R2's post fall report 8/5/24 and IDT incident follow up dated 8/26/24 for R2's fall on 8/5/24 includes documentation of Resident with frequent falls occurring d/t (due to) resident attempting to get up out of her Broda chair without any staff assistance at shift change resulting in an unwitnessed fall occurring Resident is supposed to be with a staff member at shift change and is not supposed to be left alone, unwitnessed fall occurred d/t resident being left alone at shift change and resident attempted to self transfer out of her Broda chair resulting in an unwitnessed fall occurring. Surveyor noted R2's CNA (Certified Nursing Assistant) Visual/Bedside Kardex Report as of 7/24/24 under the safety section includes *At shift change someone needs to be with resident. Resident not to be left alone at shift change. R2's post fall report was not signed by the Nurse Manger until 8/26/24 and DON (Director of Nursing)-B did not sign this report until 9/3/24. R2's incident note dated 9/11/24 at 23:06 (11:06 p.m.) written by LPN-R documents Date, Time and Location of Fall: 9/11/24, 1910 (7:10 p.m.), [NAME] unit Bird Lounge. Vitals, including POX, Blood Sugar and Orthostatic BP: See charted vitals. Describe the fall: Resident found by staff sitting upright on the floor next to her Broda chair. Were there any injuries? If so, describe: Bump/hematoma to left side of forehead. Date/Time/Name of Physician Update: 9/11/24, 1950 (7:50 p.m.), On call physician [Name] with [medical group]. Date/Time/Name of Family update: 9/11/24, 2111 (9:11 p.m.), [Name] POA. R2's fall on 9/11/24 was not thoroughly investigated as there are no statements included in the post fall report as to who last saw R2 or what was R2 doing. The post fall report or the IDT (interdisciplinary team) incident follow up does not indicate whether prior interventions were in place including the positioning of R2's Broda chair. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R2's incident note dated 10/7/24 at 20:13 (8:13 a.m.) written by LPN (Licensed Practical Nurse)-J documents Date, Time and Location of Fall: 10/7/2024, 2000 (8:00 p.m.), [Room number]. Vitals, including POX, Blood Sugar and Orthostatic BP (blood pressure): 136/74 84 20 97.3 97%. Describe the fall: resident rolled from bed to mat on floor then from mat to floor. Were there any injuries? If so, describe: no injuries. Date/Time/Name of Physician Update: 10/7/2024 [name of medical group]. Date/Time/Name of Family update: 10/7/2024, 2030 (8:30 p.m.) [Name]. R2's post fall report & IDT incident follow up for 10/7/24 documents an intervention of Encourage nursing staff to monitor patient more frequently and toilet in between every 2 hour rounds. R2's fall care plan was not revised to include this intervention. R2's incident note dated 10/24/24 at 17:55 (5:55 p.m.) written by LPN-J documents Date, Time and Location of Fall: 10/24/24, 1700 (5:00 p.m.), west dining room. Vitals, including POX, Blood Sugar and Orthostatic BP: 100/52, 97.9, 16, 67, 97%. Describe the fall: resident slid out of Broda chair and onto Broda foot rest. Were there any injuries? If so, describe: no injury. Date/Time/Name of Physician Update: 10/24/24 [Physician name] 1715 (5:15 p.m). Date/Time/Name of Family update: 10/24/24, [POA name], 1715 (5:15 p.m.). R2's fall on 10/24/24 was not thoroughly investigated as there are no statements included in the post fall report as to who last saw R2 or what was R2 doing. The post fall report or the IDT (interdisciplinary team) incident follow up does not indicate whether prior interventions were in place including the positioning of R2's Broda chair. The post fall report and IDT incident follow up documents an intervention of provide activities for resident to do independently. R2's fall care plan was not revised to include this intervention. The Nurse Manager & DON-B did not sign the post fall report until 1/12/25. R2's incident note dated 11/9/24 at 07:32 (7:32 a.m.) written by LPN-T documents Date, Time and Location of Fall: 11/9/24 @ (at) 0418 (4:18 a.m.) Canary Lounge. Vitals, including POX, Blood Sugar and Orthostatic BP: T-96.8, P-69, R-16, B/p-145/75, POX 98% RA, BG-120. Describe the fall: Unwitnessed Fall/slide out of Broda chair. Hit head on leg of table. Neuro check negative. ROM WNL. Tenderness to top of head. Were there any injuries? If so, describe: yes; 1.0 cm (centimeter) x 1.0 cm round wound to top of scalp; cleansed et Band-Aid applied. Date/Time/Name of Physician Update: 11/9/24 @ [physician name] [medical group name]. Date/Time/Name of Family update: 11/9/24 @ 0729 am POA/[name]. R2's fall on 11/9/24 was not thoroughly investigated as there are no statements included in the post fall report as to who last saw R2 or what was R2 doing. The post fall report or the IDT (interdisciplinary team) incident follow up does not indicate whether prior interventions were in place including the positioning of R2's Broda chair. The IDT incident follow up documents an intervention of Resident will be monitored more frequently while awake and when in bed for safety. R2's fall care plan was not revised to include this intervention. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R2's incident note dated 11/24/24 at 04:04 (4:04 a.m.) written by RN-I documents Date, Time and Location of Fall: 11/24/24 at 04:04 (4:04 a.m.) in dining room, slid out of Broda chair. Vitals, including POX, Blood Sugar and Orthostatic BP: VSS 97.7-86-18 BP 156/86 lying, & 141/86 sitting. SPO2 95% RA, blood glucose at 131. Describe the fall: Resident fell in dining room area, slid out of Broda chair, sitting upright on buttocks on floor. RN [Name] down to assess, AROM (active range of motion) to all extremities WNL (within normal limits), PERLA (pupils equal, round and reactive to light and accommodation) Neuro check negative. Client whimpering intermittently while being hoyer lifted off the floor with 3 staff. No injury noted. Anxiety with confusion. Were there any injuries? If so, describe: None. Date/Time/Name of Physician Update: Call to [Name] hospice spoke with [hospice name] representative [name], about fall without injury. He will have RN from [hospice name] return call this morning sometime. Date/Time/Name of Family update:. R2's post fall report for fall on 11/24/24 at 4:04 a.m. documents R2 was being watched by [name of staff] who stepped into a room in dining room area. R2's fall care plan was not revised to include the new intervention of not to be left alone in Broda chair if restless agitated follow all nurse directives. All shift to follow this directives. R2's incident note dated 11/24/24 at 12:42 (12:42 p.m.) written by Graduate RN-S documents Date, Time and Location of Fall: 11/24/24 11:52 (11:52 p.m.) Commons area. Vitals, including POX, Blood Sugar and Orthostatic BP: T 97.7, P 84, R 16, BP 137/75, O2 (oxygen) 94% RA. Describe the fall: Unwitnessed. Pt (patient) was found c (with) back against couch. Were there any injuries? If so, describe: No apparent injuries noted. ROM (range of motion) of all extremities WNL (within normal limits). Reported soreness to btx (buttocks). Date/Time/Name of Physician Update: 11/24/24 12:15 [Name] Hospice. Staff nurse contacting [medical group name]. Date/Time/Name of Family update: 11/24/24 12:23 Daughter [name]. R2's fall on 11/24/24 at 11:52 p.m. was not thoroughly investigated as there are no statements included in the post fall report as to who last saw R2 or what was R2 doing. The post fall report or the IDT (interdisciplinary team) incident follow up does not indicate whether prior interventions were in place including the positioning of R2's Broda chair. On 2/5/25, at 7:10 a.m., Surveyor observed R2 dressed for the day in a Broda chair slightly reclined back sleeping in the lounge area with the bird aviary. At 7:18 a.m. Surveyor observed R2 is now awake. At 7:28 a.m. R2 continues to be sitting in a Broda chair in the lounge area. R2 removed the blanket off and has moved her feet off the Broda foot rest. CMA (Certified Medication Assistant)-U approached R2, covered R2 with the blanket and moved her feet back onto the foot rest. At 7:35 a.m. RN-L approached R2 asking if she was hot as R2 had taken off one of her blankets and tucked the hoyer sling on the right side back in. Surveyor observed R2 continued to be sitting in the Broda chair in the lounge with the bird aviary until 8:23 a.m. when CNA (Certified Nursing Assistant)-V wheeled R2 out of the lounge area into the dining room and placed R2 at a table. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/5/25 at 9:37 a.m., Surveyor observed R2 continues to be sitting in the Broda chair at a table in the dining room. At 9:38 a.m. R2 is wheeled into the lounge area from the dining room. At 9:40 a.m. a Life Enrichment staff member asked R2 if she wanted a warm blanket telling R2 let me put music on and then will get you a blanket. Music was placed on and then at 9:41 a.m. the Life Enrichment staff member wheeled R2 out of the lounge down the hall and returned back to the lounge with a blanket on at 9:43 a.m. At 9:48 a.m. CNA-V wheeled R2 out of the lounge and into R2's room. CMA-U wheeled a hoyer lift in. Surveyor observed CNA-V & CMA-U transfer R2 into bed using the hoyer lift. At 9:54 a.m. CNA-V informed R2 she was going to pull her pants down. Surveyor observed CNA-V provide incontinence care to R2 who was incontinent of urine & bowel. After cares were provided, CNA-V and CMA-U transferred R2 back into the Broda chair, CNA-V tucked the sling into the Broda chair and remade R2's bed. R2 was then wheeled into the lounge. On 2/5/25, at 10:08 a.m., Surveyor asked CNA-V if she got R2 up this morning. CNA-V replied R2 was up when she came in. Surveyor asked CNA-V what time her shift starts. CNA-V replied 6:30 a.m. CNA-V explained to Surveyor hospice usually comes in Monday & Wednesday and they get R2 washed & dressed. Surveyor asked CNA-V how often R2 is to be changed. CNA-V replied every two hours, if she is fussy then know to change her as she may be wet or pooped. Surveyor asked if R2 is suppose to be checked & changed every two hours and was up already when she got here why wasn't R2 checked & changed earlier. CNA-V informed Surveyor she was busy and breakfast came at 8:30 or 8:45 a.m. Surveyor noted CNA-V wheeled R2 into the dining room at 8:23 a.m. the approximate time R2 should have been checked & changed. On 2/5/25, at 10:38 a.m., Surveyor asked RN-L to explain their fall process. RN-L informed Surveyor a RN has to do the post fall assessment and the resident is not moved until a RN assesses the resident. Vital signs & Neuro checks are completed, the doctor, family & NHA are notified. An incident report is filled out, anyone working with the resident fills out a statement, and a picture is drawn of what they see. Surveyor inquired if the fall is discussed as a team. RN-L informed Surveyor she believes the unit manager is involved but is not sure who is involved as she is not. Surveyor asked how the CNA's are notified of changes to a resident's care plan. RN-L informed Surveyor the Kardex is updated and also stays on the 24 hour report board to be communicated through report. Surveyor asked who revises the care plans. RN-L informed Surveyor the Unit Manager and as a RN she can update the care plan. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/5/25, at 11:14 a.m., Surveyor asked NCM (Nurse Care Manager)-K to explain their fall process. NCM-K informed Surveyor no one touches the resident until a RN assesses the resident, Neuro checks, range of motion, and vital signs are obtained. The physician and family are notified. An incident report is filled out by the nurse assigned to the resident and this is brought to morning meeting where they go over the report as the IDT. Surveyor asked if staff statements are obtained. NCM-K informed Surveyor they are on the incident report. Surveyor asked if they look to see if prior interventions were in place at the time of the fall. NCM-K replied I do. Surveyor inquired who updates the care plan. NCM-K replied she does or any other manager. Surveyor informed NCM-K since 7/3/24, R2 has had 14 falls. Surveyor informed NCM-K there are multiple falls where the post fall assessment and/or IDT follow up doesn't indicate when R2 was last seen, what she was doing or whether prior interventions were put into place. R2's care plan was not always revised to include interventions. NCM-K informed Surveyor she was not the manager during this time and its hard for her to respond. NCM-K informed Surveyor there were two different managers before her and they are no longer with the facility. NCM-K informed Surveyor she is responsible at this point and will make sure the care plans are updated. Surveyor then informed NCM-K R2 has a fall intervention that she should be checked and changed every two hours and this didn't occur this morning. NCM-K informed Surveyor if she is to be checked and changed every two hours this should happen. On 2/5/25, at 1:00 p.m., during the meeting with NHA (Nursing Home Administrator)-A and DON-B Surveyor asked how should a residents Broda chair be positioned. NHA-A replied depends and explained if they are eating upright, leaving the table or relaxing a little titled back. S urveyor informed NHA-A & DON-B R2's falls weren't thoroughly investigated as there are no staff statements as to who last saw R2, what was R2 doing and whether prior interventions were in place at the time of the fall. R2's fall interventions were not always followed and the care plan was not always revised to include new interventions. No additional information was provided as to why R2's falls were not thoroughly investigated, with fall interventions and revisions to the fall care plan post fall review & IDT (interdisciplinary team) not implemented.