

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/22/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525625	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 05/10/2014
NAME OF PROVIDER OR SUPPLIER  LAKELAND HEALTH CARE CTR			STREET ADDRESS, CITY, STATE, ZIP CODE 1922 CTY RD NN ELKHORN, WI 53121		
(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) COMPLETION DATE	
F 000	INITIAL COMMENTS  Surveyor: 13472  This was a self report complaint survey conducted at Lakeland HCC from 5/09/14 to 5/10/14.  # of federal citations issued: 1  The most serious citation is F323 cited at a scope/severity level of G (actual harm/isolated).  Census: 119 Sample size: 2 Survey coordinator: #13472	F 000			
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES  The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.  This REQUIREMENT is not met as evidenced by: Surveyor: 13472  Based on record review and staff interview, the facility did not ensure that each resident received adequate supervision to prevent accidents in 1 of 2 residents (Resident #1). Resident #1 is identified as being at risk of falls and as having a history of frequent self-transfers. On 4/29/14, Resident #1 experienced an increase	F 323			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

*Bernadette Janiszewski*

TITLE

*Nursing Home Administrator*

(X6) DATE

*6/2/2014*

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.

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F 323	Continued From page 1 in confusion, was left unattended in the dining room, self-propelled her wheelchair from the dining room to her bathroom, and attempted to self-transfer to the toilet. Resident #1 fell during the self-transfer and sustained a left femur fracture. On 4/29/14, when Resident #1 was experiencing an increase in confusion, the facility did not assess the Resident for increased supervision or provide adequate supervision to prevent Resident #1 from self-transferring. Findings include: On 5/09/14, Surveyor #13472 reviewed Resident #1's clinical record and the facility's fall investigation. The quarterly Minimum Data Set (MDS), dated 12/18/13, and the annual MDS, dated 3/20/14, indicate Resident #1 has moderately impaired cognition, transfers and uses the toilet with limited assistance of one staff, has occasional bladder incontinence, and has a history of falls without injury. The falls risk assessment, dated 3/28/14, indicates Resident #1 is at risk for falls due to history of falls, changing cognitive status, poor safety awareness and attempts to self-transfer. The plan of care for impaired physical mobility, dated 9/21/13, includes the approach to assist Resident #1 with transfers and ambulation with contact guard assist, gait belt and walker. The plan of care for potential for trauma-falls, related to impaired balance and history of falls, includes the approaches to remind the resident of need to ask/wait for assist with ambulation/transfers and to clip call light to night gown during periods of increased confusion. The plan of care does not include approaches for staff to utilize, to ensure adequate supervision and to prevent accidents, when Resident #1 has increased confusion and is being left unattended	F 323			

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F 323	Continued From page 2 in the dining room (where no call light is available). There were no nursing notes for the night shift of 4/28/14. The nursing progress note, dated 4/29/14 at 8:39 a.m., indicates night shift reported that Resident #1 had urinary frequency and increased confusion. There were no nursing notes on 4/29/14, from 8:39 a.m. through 2:41 p.m., that describe Resident #1's confusion, that indicate if the Resident was assessed for increased supervision, or indicate if the Resident was provided with adequate supervision to prevent accidents. The nursing progress note, dated 4/29/14 at 2:41 p.m., indicates Resident #1 had a fall in the bathroom and was observed on the floor. The note indicates Resident #1 was confused, no increase from this a.m. The note indicates Resident #1 was transferring to the toilet, got up to wipe self and pull pants up when she fell. The note indicates the resident complained of left thigh pain and was unable to bear weight on left leg. The note indicates the CNA noted the bathroom door was shut and went to check on the resident. The note indicates the resident was wearing nonskid slippers and staff had been monitoring the resident closely due to increased confusion. The nursing progress note, dated 4/29/14 at 3:11 p.m., indicates Resident #1 was transferred to the hospital for evaluation. The hospital admission note, dated 4/29/14, indicates Resident #1 was admitted to the hospital with left femur fracture. The note indicates the plan is for a hemiarthroplasty which will eventually return Resident #1 to her prior level of function. The Fall Management Investigation, dated 4/29/14, indicates Resident #1 fell in the	F 323			

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F 323	Continued From page 3 bathroom at 1:40 p.m. The investigation indicates the fall was not observed and that Resident #1's mental status was disoriented and restless. The nursing progress note, dated 4/30/14, at 5:01 p.m., indicates the team reviewed the fall of 4/29/14. The note indicates staff noted that Resident #1 was not her usual mentation during the day and was disoriented. On 5/09/13, at 9:45 a.m., Surveyor #13472 spoke with Certified Nursing Assistant (CNA)-C who indicated she worked the dayshift of 4/29/14, and was assigned to 7 residents. CNA-C indicated that on the date Resident #1 fell (4/29/14) she received report from the night shift CNA that Resident #1 had increased confusion. CNA-C indicated that Resident #1 had a significant increase in confusion throughout the dayshift, including visual hallucinations. CNA -C indicated that after lunch, on 4/29/14, when she was assisting the other residents that were assigned to her to the bathroom, Resident #1 was left sitting at the table in the dining room. CNA-C indicated that after she completed assisting another resident with toileting, she came back to the dining area and Resident #1 was not there. CNA-C indicated she noted Resident #1's bathroom door was shut, which meant she took herself to the bathroom. CNA-C indicted that at 1:30 p.m., she found Resident #1 on the floor in the bathroom, that her pants were on and that she was not incontinent. CNA-C indicated that 2 CNAs were assigned to the Household B West Wing of the facility at the time Resident #1 attempted to self-transfer to the toilet, and that the 2nd CNA was also assisting another resident with toileting at the time Resident #1 fell. CNA-C indicated Resident #1 could self propel herself in the wheelchair, and her transfer and	F 323			

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F 323	Continued From page 4 ambulation status prior to the fall was stand by assistance with the use of a gait belt. CNA-C indicated that on 4/29/14, when Resident #1 was experiencing an increase in confusion, nursing staff had not made any changes to the resident's level of supervision. On 5/09/14, at 11:00 a.m., Surveyor #13472 spoke with RN-D who indicated she worked the dayshift on 4/29/14. RN-D indicated that on the day Resident #1 fell (4/29/14), she received report from the night shift nurse that Resident #1 had increased confusion and was getting "up and down" during the night due to urinary frequency. RN-D indicated that Resident #1 had a significant increase in confusion throughout the dayshift, including hallucinations. RN-D indicated staff was unable to get Resident #1 to understand what they were trying to say and that "something was just not right." RN-D indicated the physician was called and orders were obtained for a urinalysis. RN-D indicated CNA staff was directed to "watch the resident close for safety" but that an increase in staff to provide supervision was not obtained. RN-D indicated that on 4/29/14, after lunch, CNA staff were assisting other residents with toileting, and were checking on Resident #1 between the toileting of other residents when the fall occurred. RN-D indicated the CNAs can be in a resident's room for toileting assistance for 5 to 10 minutes. RN-D indicated she was administering medications on Household B, which has 2 hallways, during the time that Resident #1 fell and that she did not observe Resident #1 leaving the dining room. On 5/09/14, at 11:40 a.m., Surveyor #13472 spoke with CNA-E who indicated she worked the dayshift on 4/29/14. CNA-E indicated she was assigned to work as a 1:1 staff with another resident. CNA-E indicated she left Resident #1's	F 323			

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F 323	Continued From page 5 unit at 12:00 for lunch and then was assigned to a different unit to assist with lunch. CNA-E indicated she was not on the unit when Resident #1 fell. CNA-E indicated Resident #1 was confused on 4/29/14. CNA-E indicated Resident #1 required assistance with toileting but would frequently self-transfer to the toilet without asking for assistance. On 5/09/14, at 3:00 p.m., Surveyor #13472 spoke with Resident #1. The Resident was unable to recall the fall that occurred on 4/29/14. On 5/10/14, at 11:00 a.m., the surveyor spoke with the Director of Nursing-B who indicated the facility completed a thorough investigation of the fall and concluded that the facility completed the investigation with no significant findings. The DON indicated that based on the investigation of the fall, Resident #1 was more confused the day of the fall and staff was in contact with the physician to obtain a urinalysis. The DON indicated there was no evidence that the nurse thoroughly assessed the Resident for the need for increased supervision, and that no new approaches were added to the plan of care to provide increase supervision and prevent accidents.	F 323			

Scott Walker  
Governor



DIVISION OF QUALITY ASSURANCE  
SOUTHEASTERN REGIONAL OFFICE  
819 NORTH SIXTH STREET, Rm. 609B  
MILWAUKEE WI 53203-1606

Kitty Rhoades  
Secretary

State of Wisconsin  
Department of Health Services

Telephone: 414-227-5000  
FAX: 414-227-4139  
dhs.wisconsin.gov

August 7, 2014

E-MAIL

Bernadette Janiszewski, Administrator  
Lakeland Health Care Center, License # 2416  
1922 Cty Rd Nn  
Elkhorn, WI 53121

RE: Survey Type: Complaint Investigation  
Survey Date: May 10, 2014  
Survey Event ID: HED011

Dear Ms. Janiszewski:

The Division of Quality Assurance (DQA) assists the Centers for Medicare & Medicaid Services (CMS) by surveying skilled nursing facilities to determine whether they meet the requirements for nursing homes participating in the Medicare and Medicaid programs. On May 10, 2014, DQA conducted a complaint investigation and issued the Statement of Deficiencies (Form CMS-2567) as listed above.

A revisit survey was conducted on June 26, 2014 and based on your acceptable plan of correction; we have determined your facility to be in substantial compliance with the participation requirements effective June 10, 2014.

If you have any questions, please contact me at the address in the letterhead, or telephone at (414) 227-4563.

Sincerely,

  
/CAL

Jean Rucker  
Regional Field Operations Director  
Bureau of Nursing Home Resident Care

cc: Centers for Medicare & Medicaid Services

## PLAN OF CORRECTION

Name - Provider/Supplier:	
Lakeland Health Care Center	
Street Address/City/Zip Code:	
1922 Cty Rd Nn, Elkhorn, WI 53121	
License/Certification/ID Number (X1):	525625
Survey Date (X3):	05/10/2014
Survey Event ID Number:	HED011

ID Prefix Tag (X4)	Provider's Plan of Correction (Each corrective action must be cross-referenced to the appropriate deficiency.)	Completion Date (X5)
F323	We have submitted an Informal Dispute Resolution Request. We provided information that further clarifies the facts. We did thoroughly assess the resident and provided increased supervision.	
	At the time of the fall we were in the middle of a computer conversion. Staff did not paint a complete picture of what occurred through their documentation. We are working with our I.T. Department to make sure the computer system works properly and that staff is trained and comfortable using this system.	6/10/2014
	Nurse managers and charge nurses are thoroughly reviewing staff documentation each week to be sure documentation is complete. This includes nurse and CNA charting.	6/10/2014
	Meal service at our facility is provided by CNAs. The CNA assigned to meal service will be included in the shift-to-shift report. All staff working in a neighborhood will be aware of all concerns about the residents who reside in the neighborhood. When there is a heightened awareness of a problem in the dining room this team will ensure that the resident is not left alone.	6/10/2014
	Our <i>Change in Resident Status Notification</i> policy and procedure has been updated to reflect that a change in condition in the resident's physical, mental or psychosocial status will be communicated to all direct care staff assigned to the resident during shift-to-shift report. Staff will be educated regarding the importance of communicating changes in condition with direct care staff, licensed staff and the falls committee.	6/10/2014
	Staff will be educated regarding F323. Education will include the importance of communicating a resident change in condition, the components of a proper investigation, implementation of appropriate interventions, and the importance of timely documentation.	6/10/2014
	A monitoring system (checklist) will be implemented to ensure all components of a fall are acted on. The tool will be initiated at the falls review during care conferences to ensure all pieces are in place	6/10/2014

## PLAN OF CORRECTION

Name - Provider/Supplier:	
<b>Lakeland Health Care Center</b>	
Street Address/City/Zip Code:	
<b>1922 Cty Rd Nn, Elkhorn, WI 53121</b>	
License/Certification/ID Number (X1):	<b>525625</b>
Survey Date (X3):	<b>05/10/2014</b>
Survey Event ID Number:	<b>HED011</b>

<b>from beginning to end. Examples: Was the falls observation tool initiated and complete? Was there documentation by the nurse and did it tell the full story? Were interventions in place and appropriate? Were the interventions added to the care plan? Were interventions communicated to staff? In what manner?</b>	
<b>The Quality Improvement Committee will monitor the corrective action by conducting quarterly audits and submitting findings to the Quality Assurance Committee. These audits will include stats regarding where our falls are occurring - are we seeing patterns?</b>	<b>6/10/2014</b>
<b>Our nurse managers will be educated in the survey process. They will understand the importance of sharing additional information with the surveyor while he/she is in our building.</b>	<b>6/10/2014</b>
<b>For Resident #1 listed on the SOD, we have implemented the use of hipsters to be used as an intervention to prevent injury. Post meal toileting has been added to the plan of care. She is receiving therapy for gait training.</b>	<b>5/25/2014</b>

The individual signing the first page of the SOD (CMS-2567) is indicating their approval of the plan of correction being submitted on this form.