

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0014913	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 01/08/2018
NAME OF PROVIDER OR SUPPLIER FAITH GARDENS		STREET ADDRESS, CITY, STATE, ZIP CODE 35 TOWER DRIVE SUN PRAIRIE, WI 53590		
(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 01/03/2018, Surveyors conducted a self-report review at Faith Gardens. 4 deficiencies were identified. The self-report was substantiated. Census: 12	N 000	DISCLAIMER: Facility does not necessarily agree with all facts and allegations contained in the Statement of Deficiency, but provides this Plan of Correction in good faith and because it is required to by state law. Division of Quality Assurance Bureau of Assisted Living FEB 06 2018 Southern Regional Office Madison, WI State Survey from 12/29/17 response:	
N 214	83.15(3)(a) Administrator shall supervise daily operation The administrator shall supervise the daily operation of the CBRF, including but not limited to, resident care and services, personnel, finances, and physical plant. The administrator shall provide the supervision necessary to ensure that the residents receive proper care and treatment, that their health and safety are protected and promoted and that their rights are respected. This Rule is not met as evidenced by: Based on interview and record review the facility administrator did not adequately supervise the daily operations of the facility, including but not limited to, resident care and services. The administrator did not provide the supervision necessary to ensure that the residents receive proper care and treatment, that their health and safety are protected and promoted and that their rights are respected. The facility is licensed to care for 17 (seventeen) individuals within the following specialty	N 214	Regarding Administrator Supervision or daily activities: Administrator and /or Health Services Coordinator are supervising the daily cares and personnel daily. This will be reflected in the E-MAR. Observations are reviewed daily to ensure all appropriate needs of residents are being upheld. The Administrator has arranged an on call system for weekends or days when HSC is not available; ensuring that all observations and needs for residents are being overseen. In addition the Facility RN Consultant will follow up with bi-monthly reviews of facility, facility notes and any follow up recommendations. The RN Consultant will assist the Administrator on a regular (monthly or less) basis to facilitate and ensure appropriate supervision. Elopement drill was completed with staff on 1/3/18. Follow up from RN and Administrator reviews will be completed monthly with Licensee. The people responsible for continued regulatory compliance are the Administrator and Health Services Coordinator.	
		Completion Date: 2/19/2018		

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

TITLE

(X6) DATE

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2/18/18
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N 214	Continued From page 1 programs: Physically disabled, Advanced Aged, Emotionally Disturbed/Mental Illness, Irreversible Dementia/Alzheimer's and Terminally Ill. The census at the time of entrance was 12 (twelve). On 01/03/2018 Surveyors conducted a Self-report review at the facility. As a result of this review, a total of 4 (four) violations of Chapter DHS 83 were issued. The following violations were issued (including this violation): * 83.32(3)(n) Rights of Residents: Safe Environment Resident 1 exhibited exit seeking behaviors and was identified as a 'wanderer.' Resident 1 exited a door, undetected by staff. Staff began a search and subsequently found Resident 1 outside, laying on the ground, behind a local business; Resident 1 was deceased. The facility door alarm system was not activated during the time of the incident and facility staff did not complete the assigned daily task for hourly or 30 (thirty) safety checks. * 83.38(1)(b) Supervision The facility did not provide Resident 1 with a level of supervision appropriate to meet his/her needs for safety related to elopement attempts, wandering into peers rooms and removing their belongings, sleeping in peers beds and removing food and drink items from peers. * 83.38(1)(i) Behavior Management Resident 1 displayed behaviors including wandering, exit seeking, entering peers rooms	N 214	Regarding Rights of Residents; Safe Environment 83.32(3)(n) Facility had an alarm specialist assess the alarm and review system with Administrator, Owner and HSC on 1/2/18. Alarm system was working properly. Front doors are now double alarmed. The exterior foyer door has an alarm everytime someone opens the door. The interior foyer door has a loud alarm in which staff are instructed to maintain it in an on position at all times. Staff have been retrained on the alarm system and policies on 1/3/18. In addition, all new staff will receive the same training. All residents ISP's were reviewed between 1/2/18 and 1/10/18 to ensure accuracy and resident safety. Residents were observed for changes in mood, behavior and condition after the incident occurred to ensure their well-being for a period of two weeks. Staff were retrained on 1/3/18 with regards to behavior management, how to complete rounds, how to give report and shift beginning and end policies and procedures and proper protocol regarding such. An elopement drill was completed after the 1/3/18 meeting to ensure protocols were understood and followed. New measures were initiated with residents that are at risk for wandering (within and outside). Protocols include a physical sign off of residents whereabouts hourly for specific residents. Additional alarms were ordered for resident rooms indicating movement	

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N 214	Continued From page 2 and removing their belongings, sleeping in peers beds. The facility did not provide services to manage the resident's behaviors that may be harmful to themselves or others. On 01/03/2018 at 12:00 PM, Surveyors expressed concerns to Administrator (Adm) B and RN (Registered Nurse) I regarding administrative oversight at the facility. Adm B acknowledged an understanding of the concerns. RN I informed Surveyors that since the incident of December 29th, the facility management started to review and revise policies/procedures, creating a binder with identified wanderers, developing an elopement assessment tool and looking at upgrading the facility door alarm monitoring systems. Summary The facility administrator failed to provide the supervision necessary to ensure that the residents receive proper care and treatment, that their health and safety are protected and promoted, and that their rights are respected.	N 214	in and out of bed, about the room, etc. Alarms were installed on 1/10/18 and staff were trained and alerted to proper protocol. Said alarms are mobile and wireless (and tested for accuracy throughout the building) for staff to carry with them, should they need to during certain times of the day. A Door Alarm Policy was written and established on 1/3/18 with staff trained on said policy. See attached. Administrator will also be responsible for checking the timers for the exterior lights monthly to ensure timing is such that lights are on during dusk, dark and twilight hours. Task shall be completed and indicated as such using facility's electronic charting system. Completion Date: 2/19/2018	
N 358	83.32(3)(n) Rights of Residents: Safe environment In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Safe environment. Live in a safe environment. The CBRF shall safeguard residents from environmental hazards to which it is likely the residents will be exposed, including both conditions that are hazardous to anyone and conditions that are hazardous to the resident because of the residents' conditions or disabilities.	N 358		

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N 358	Continued From page 3 This Rule is not met as evidenced by: Based on record review and interviews, the facility did not safeguard 1 of 1 resident from environmental hazards to which it is likely the residents will be exposed. Resident 1 exhibited exit seeking behaviors and was identified as a 'wanderer.' Resident 1 exited a door, undetected by staff. Staff began a search and subsequently found Resident 1 outside, laying on the ground, behind a local business; Resident 1 was deceased. Facility staff did not engage the front door alarm system that would have alerted facility staff to Resident 1's actions. Findings include: The Department received a self-report, dated 01/02/2018, which indicated, "This self-report is regarding resident [Resident 1] and an incident that occurred from resident elopement and resulted in the police being called to the facility and the death of the resident noted..." On 01/03/2018, Surveyors conducted a self-report review at the facility. The facility is licensed to care for 17 (seventeen) individuals with special program needs of: Physically Disabled, Advanced Aged, Emotionally Disturbed/Mental Illness, Irreversible Dementia/Alzheimer's and Terminally Ill. Observation Upon arrival to the facility, 01/03/2018 at 6:30 AM, the facility front entrance was dark, two sconce lights located on the exterior brick, flanking the entrance door, were not lit, no	N 358		

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N 358	Continued From page 4 spotlights or lighting noted in exterior front entrance area. Surveyors did note a columned driveway light under the canopy area. Photos 1 and 3 Surveyors noted the location of the facility parking area, which backs up to a local business. The local business spotlight was on. Photo 2 Upon opening the exterior door, no alarms sounded. This door led the surveyors to a vestibule or foyer area. The second interior door had a portable attached 'white' door alarm, this interior door was locked and the surveyor rang the outer doorbell to which facility staff, Care Specialist (CS) C, opened the interior door, and an audible alarm sounded. This audible alarm ceased to sound when the door closed. Photos 4 and 5. Upon response, Surveyor questioned CS C about the alarm system. CS C informed Surveyors that the patio and side door were alarmed and staff would need to manually shut the alarms off by a key pad that was located in the kitchen/pantry area. Surveyors then proceeded to check all exit doors in the facility. Upon opening the door leading to the patio, an alarm sounded, CS C then entered the kitchen/pantry area and manually entered a code into a touch key pad, which then ceased the alarm and CS C then re-set that alarm. Surveyor then checked the facility side door, located by room 17, upon opening this door, an alarm sounded. CS C then arrived in the area and informed the Surveyors that s/he would go and shut the alarm off and re-set it.	N 358		

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N 358	Continued From page 5 At 7:25 AM, Surveyors opened the facility front door, no alarm sounded. Surveyor questioned CS C as to why the front entrance door failed to sound upon opening. CS C stated, "Well, we all heard the alarm, I had to deactivate it. Would be a first alarm, then a second alarm. Front door is connected to a bigger alarm, it might be the front door instead of the second door being connected". (Upon further request for a clarification of [his/her] description regarding the front door alarm system, CS C became more anxious and frustrated and could not provide additional information). Surveyors, with CS C present, re-opened the entrance front door and no alarm sounded. The interior entrance door, the 'white' door alarm did sound upon opening. CS C then entered the kitchen/pantry area and stated, "I did re-set the alarm three times, so its deactivated. Now alarm said ready, see if it goes off." Surveyor checked the alarm monitoring system in the kitchen/pantry area and it indicated "ready, chime." Surveyors then opened the front entrance door again and this time upon opening a 'chime' was heard. This chime ceased upon closing the door. Record review Resident 1 is deceased; Surveyor conducted a closed record review. Resident 1 was admitted to the facility on 10/28/2017 from another assisted living facility. Resident 1's diagnosis include Dementia. Resident 1's power of attorney for health care was activated in 2016. This activation certifies that Resident 1 was unable to receive and evaluate information effectively or to communicate decisions to such an extent that the	N 358		

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N 358	Continued From page 6 patient lacks the capacity to manage his or her health care decisions. An Individual Service Plan (ISP) and Evaluation/Assessment, dated 09/28/2017, prior to Resident 1's admission to the facility, includes: Wandering - Comments: Gotten out of building 2-3 x (times) per [daughters]/RA [Resident Assistant] at facility resident currently resides in...Specific behaviors: Hoarding/squirreling or hiding items...Exit seeking... Resident 1's updated ISP/Care plan, dated 11/15/2017, includes: Cognitive Status - Self Concepts/Orientation - Partial Assist - Redirection/reminders needed multiple times daily. Needs supervision outside of house...Current status: Resident easily disoriented needing multiple reminders daily as to either date, time or place due to dementia diagnosis...needs supervision when outside of the house as resident is easily confused and is an elopement risk (Responsible staff is to do hourly safety checks on resident to ensure [his/her] safety). Wandering - Wanders/trespasses into other rooms during daytime, easily redirected...Wandering-Redirection In House - Resident wanders in house in others rooms during the daytime, but is easily redirected by staff. Current status: tendency to wander into other resident rooms throughout the day/daily...would take belongings of other residents, and place them in [her/his] room...Wandering - Partial Assist - Monitor and cue resident regularly to prevent wandering episodes outside. Current status: Resident wanders outside weekly, and has gotten out of (prior) facility where resident once (resided) 2-3 times prior to moving here per family...staff to monitor resident hourly to ensure safety...staff is	N 358		

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N 358	Continued From page 7 to make sure front door is armed/on at all times. Desired Goals...to maintain low to non-existent wandering episodes...to provide proper supervision to help prevent future wandering episodes by monitoring regularly and reacting to alarms appropriately. Specific behaviors - Resident exhibits signs of the following tendencies requiring a need for staff intervention: Not sleeping at night/up while others are sleeping. At times resident would wander up and down the halls of facility...Exit seeking - this behavior has been previously noted in care plan... Documentation includes: (times of entry reflect actual time staff documented their observations that occurred sometime during their work shift). * 11/04/2017 - 7:45 PM - Resident been in every other resident room all evening, [s/he] also been at the back door numerous times trying to get out very easy redirect but keeps on with the same things all evening...10:15 PM - It was noted that resident trying to leave out back door, but easily redirected. 1 hour checks put into place for safety. * 11/05/2017 - 8:00 PM - All evening resident was in and out of other residents room getting them upset. [S/he] been trying to also leave out the back door all evening also... * 11/07/2017 - 10:00 PM - resident opened the back door several times and going from room to room... * 11/19/2017 - 8:45 PM - Resident wonder [sic] all evening long... * 11/30/2017 - 9:30 PM - walked in and out of every room constantly, staff had to keep	N 358		

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N 358	Continued From page 8 redirecting [her/him] to [his/her] room... * 12/17/2017 - 8:15 PM - Resident was wandering and getting into everything like other house mates room, trying to leave out the doors etc. PRN (as needed medication) given and didn't help at all...doesn't listen or following [sic] directions at all... * 12/18/2017 - 7:30 PM - trying 4 times to leave the building, resident was redirected back in... * 12/27/2017 - 7:15 AM - Resident walked around trying to escape the entire night. * 12/29/2017 - 9:45 AM - Around 8ish [sic] staff did not see resident inside facility after checking all the rooms inside facility. Staff member then looked outside and seen something across parking lot on the ground...staff member ran outside to see what it was and verified it was resident...called 911. 2:30 PM - Staff did rounds, staff noticed that resident wasn't in room. Staff then checked all other resident's room and bathrooms'. Resident was found behind jimmy john's deceased.... A review of the facility computerized Daily Tasks (these tasks are specific for each resident's assessed needs and are listed in the computer as 'to-do' tasks, staff are directed to initial each task upon its completion). A review of Resident 1's daily task sheets, from 12/27 - 12/29/2017, includes: 1 Hour Checks - Resident wanders in house into other resident rooms taking personal items. Responsible staff to redirect. Surveyor reviewed these daily tasks reports and questioned Adm B regarding facility expectations	N 358			

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N 358	Continued From page 9 regarding the documentation of daily tasks. According to Adm B the "daily tasks are identified needs of a resident, for example toileting needs every 2 hours, then staff should document by placing their initials and time they completed that task. If hourly checks then staff would document hourly that they observed that resident." Surveyor reviewed Resident 1's daily task sheets from 12/27 - 12/29/2017, specifically for the hourly checks and noted no staff initials indicating that these hourly checks had been completed as assigned. Administrator B indicated that following the documented incident of 12/27/2017 when Resident 1 attempted to "escape all night," 30 minutes checks were added to daily task assignment. Upon review these 30 minutes checks did not take place. Interviews On 01/03/2018 at 4:01 PM, Surveyor conducted a phone interview CS F regarding the events of 12/29/2017 leading up to the discovery of Resident 1 leaving the facility and subsequent death. CS (Care Specialist) F informed Surveyor that [s/he] had arrived (facility time card report indicates that CS F punched in for work on 12/29/2017 at 7:06 AM). "6 minutes late for work, ran inside. I was in such a hurry, I wasn't thinking about anything. The second door, interior door was propped open, rug stopped it from closing. This happened every time that night shift person (CS G) worked, you would arrive with door propped open." Surveyor questioned CS F as to how often the AM shift checked on Resident 1's whereabouts.	N 358			

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N 358	Continued From page 10 CS F stated, "Was every two hours then I was told it switched to every hour. That morning, Friday, December 29th, I went down to help (resident name), then while getting ready for breakfast, I asked, 'where's [Resident 1].' [HSC E] said 'don't worry [s/he's] around here somewhere, [s/he] sleeps in other resident rooms and one time they found [her/him] in the maintenance room.' We all started looking and I was standing by the window and said [s/he's] outside. We ran over to [her/him]. [Resident 1] was laying on [her/his] right side by the back of Jimmy John. I took a double look. [S/he] had on socks, blue bottoms, long sleeve top mix/match orange color. I did not touch [her/him], but knew [s/he] was gone. [Her/his] fingertips were raw and bloody and [s/he] had a runny nose that was 'popsicle' like. It was horrible." Surveyor questioned if CS F ever witnessed Resident 1 attempting to leave the building. CS F stated, "Never saw [her/him] outside on AM's. But PM shift, [staff name], informed us [s/he] had more sundowning and would try to get out. I heard that [Resident 1] tried the 'bookcase' door (facility side door) quite a bit and tried the patio door and tried to get out the patio gate once." CS F continued, "One time [Resident 1's] daughter [name] came in and saw the door propped open and questioned why the door was propped open, [s/he] said that they liked the smaller facility and the alarms on the door, that's why they chose the place." Surveyor questioned CS F regarding the facility door alarms. CS F stated, "The interior door, white alarm, hadn't been working, it had a bad battery. [Adm B] bought 4 of them (new white alarms), then found out it just needed a new	N 358		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0014913	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 01/08/2018
NAME OF PROVIDER OR SUPPLIER FAITH GARDENS			STREET ADDRESS, CITY, STATE, ZIP CODE 35 TOWER DRIVE SUN PRAIRIE, WI 53590		
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N 358	Continued From page 11 battery. That took a month or more. The side door and the patio door are always alarmed." On 01/04/2018 at 9:26 AM, Surveyor conducted a phone interview with CS G. CS G confirmed that [s/he] had worked the night shift on 12/28/2017 - 12/29/2017. Surveyor questioned if any residents were typically up at night. CS G stated, "Yes, three residents [Residents 1, 3 and 4]. [Resident 1] was one of them, [s/he] would walk around, picks stuff up and was busy touching things. [Resident 1] would go into other resident rooms...All residents need help but at different degrees. I spent most of my time with [Residents 1, 3 and 4]. [Resident 2] smokes. We need to shut off alarms for [him/her] to go in/out of patio doors. [S/he] also likes coffee." Surveyor questioned the front door system and how/if the doors were alarmed on December 28/29th. CS G stated, "The white alarm on interior door is never on, it was not activated. Residents cannot open door, the latch is hard for them to push on it, so normally not on. Side door alarm always on. Patio door alarm always on. Reason the exterior front door not on is people go in/out, and the alarm would go off all the time." Surveyor questioned if the interior entrance door was opened on the night of December 28/29th. CS G stated, "Yes, I opened interior door for the AM shift. If you push it far enough, the rug holds it open. I believe that morning I did the same thing." CS G continued, "I thought about it, honestly the last time I saw [Resident 1] was 4 AM. At midnight, I checked [her/him] and [s/he] was sleeping. At 4 AM, I checked [her/him], [s/he] was	N 358			

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N 358	Continued From page 12 up and I helped [her/him]." Surveyor questioned if CS G conducted hourly checks as per Resident 1's care plan. CS G stated, "No. At midnight [s/he] was sleeping. Then at 4 AM [s/he] was up and I noted that. My last round, my final round was 6 AM. I did not see [her/him] in [her/his] room, but that is not uncommon. No alarms went off. The night before, on the 27th, [s/he] tried numerous times to get out the side door." Surveyor questioned if the exterior main front door (door leading directly to the outside) was alarmed or not. CS G stated, "No, it wasn't alarmed that night. Alarm is never on at the front door, it's not connected to the chime system that's in the kitchen. They all knew that door we never turned it on, both employees and management knew it." Surveyor questioned as to why the door was not alarmed. CS G stated, "There are two leather chairs by the fireplace. I usually pull them over and station them by the front door and watch them (residents). [Resident 1] wandered in anyone's room, picking stuff up and laying in other resident rooms." On 01/08/2017 at 1:45 PM, Surveyor conducted a phone interview with CS H. CS H confirmed that [s/he] was working on the morning of December 29th. Surveyor questioned if the facility doors were opened or unlocked for entrance. CS H stated, "First door, the exterior door was unlocked, walked right in. The second door was propped open. During the day it was usually propped open with a white bucket, but not on that day, if you open the door wide enough, the cement and carpet would catch it and it remained	N 358		

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N 358	Continued From page 13 opened. That's how it was opened that morning." Surveyor questioned approximately how often CS H observed the interior door propped open. CS H stated, "Everyday you worked. It was propped because so many people came in/out, including employees." On 01/04/2018 at 2:55 PM, Surveyor conducted a phone interview with Alarm system technician (AST) J. According to AST J [s/he] was contacted by the facility on 01/03/2018 and had arrived to the facility approximately a 1/2 hour after receiving the call, at approximately 2:30 PM. AST J stated, "When I arrived the exterior door was not armed (for continuous alarm), nor was the chime activated. I did show 3 staff how to disarm and re-arm the system." Surveyor questioned as to how this alarm monitoring system functioned. AST J offered an overview of the system, stating, "The only door affected by the system is the front entrance door. The interior door has a battery operated alarm. If the front entrance door is 'unarmed' the only thing that would happen is the door would chime, but this chime shuts off when the door is closed. If a person turns off the chime mode, you won't hear a 'beep, beep' sound when the door is opened. When you turn the chime mode back on, it would 'beep, beep' when opened." AST J continued, "If the door is 'armed' you would hear an alarm, loud squeal continuous sound until someone physically goes to the key pad, enters the code to shut it off (or disarm it) and then enter code to rearm the alarm. The front	N 358		

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N 358	Continued From page 14 door must be 'armed' in order to hear a continuous alarm, that could only be stopped by physically going to the key pad and disarming the alarm. But then a person must 'rearm' for the alarm to reactivate." The facility self-report indicates that the alarm system company (name) also conducted a check of the facility alarm system on 01/02/2018 and "assisted in double alarming the front door and indicated that the alarms were set appropriately for other doors." The on-site visit of 01/02/2018, was confirmed by AST J. During the facility exit conference, Surveyors reviewed above concerns with Adm B and RN I related to the incident of December 29, 2017 and Resident 1's ability to exit the facility undetected and subsequent death. Summary The facility did not provide Resident 1 with a safe environment when facility staff did not engage the front door alarm system that would have alerted facility staff to Resident 1's actions. Cross reference: N0214 DHS 83.15(3)(a) Administrator Shall Supervise Daily Operations N0426 DHS 83.38(1)(b) Supervision N0433 DHS 83.38(1)(i) Behavior Management	N 358	Regarding Supervision 83.38(1)(b) Supervision on residents and resident needs will be met through observation reviews and daily supervision by Adminstraor, Health Services coordinator or designated individual. An inservice was completed on 1/3/18 of resident ISP's as well as reporting changes in condition, elopement attempts and updated/new policies and procedures. Policies regarding shift rounds, reporting, missing resident and elopement policies, and alarm policies have been reviewed and inserviced to the staff. Resident's whom exhibit wandering behaviors will have an elopement assessment completed by the RN Consultatnt by 2/12/18. A binder will be available identifying residents who exhibit wandering behaviors and specific interventions and information pertaining to that individual in the event of an emergency. Individual alarms have been put in place for a person who displays a potential risk for eloping (1/10/18). Completion Date: 2/19/2018	
N 426	83.38(1)(b) Supervision. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the	N 426		

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N 426	Continued From page 15 resident's highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Supervision. The CBRF shall provide supervision appropriate to the resident's needs. This Rule is not met as evidenced by: Based on interview and record review, the CBRF did not provide supervision appropriate for 1 of 1 sampled residents [Resident 1]. Resident 1 exited the facility undetected by staff and was found lying outside, behind the back of a local business, deceased. DHS 83.02 - Definitions - (54) defines "Supervision" - means oversight of a resident's daily functioning, keeping track of a resident's whereabouts and providing guidance and intervention when needed by a resident. A review of the facility's Resident Rights, undated, includes: To be valued as an individual, to maintain and enhance your self-worth... To expect the facility to accommodate individual needs and preferences... Findings include: The Department received a self-report, dated 01/02/2018, which indicated, "This self-report is regarding resident [Resident 1] and an incident that occurred from resident elopement and resulted in the police being called to the facility and the death of the resident noted..." This report also indicated, "this report concludes the investigative findings of an elopement resulting in	N 426		

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N 426	Continued From page 16 death for a resident on Friday, December 29, 2017...[Resident 1] was admitted 10/28/2017 - Brief History - include that [Resident 1] is in a wheelchair and needs assistance with all ADL's including getting in and out of bed. [S/he] is [his/her] own person and is able to leave the community on [her/his] own.... (This statement is incorrect, documentation received by the facility, indicates that Resident 1 was not his/her own person, but that Resident 1's POA (power of attorney) for healthcare was activated in 2016. This activation form indicates that two physicians had examined Resident 1 and certified that [s/he] meets the statutory definition of incapacity, in that the patient is unable to receive and evaluation information effectively or to communicate decisions to such an extent that the patient lacks the capacity to manage his or her health care decisions). A facility Universal Resident Assistant - Job Description, includes: Primary Responsibilities: 3). Adhere to each resident's individual service plan, notify the Resident Services Director and Wellness Nurse of any changes in the resident's condition... On 01/03/2018, Surveyors conducted a self-report review at the facility. The facility is licensed to care for 17 (seventeen) individuals with special program needs of: Physically Disabled, Advanced Aged, Emotionally Disturbed/Mental Illness, Irreversible Dementia/Alzheimer's and Terminally Ill. The facility census on the day of survey was 12. Observation	N 426			

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N 426	Continued From page 17 Upon arrival to the facility, 01/03/2018 at 6:30 AM, the facility front entrance was dark, two sconce lights located on the exterior brick, flanking the entrance door, were not lit, no spotlights or lighting noted in exterior front entrance area. In the circular driveway area, surveyors noted several columned driveway lights. Photos 1 and 3. Surveyors noted the location of the facility parking area, which backs up to a local business. The local business spotlight was on. Photo 2 Upon opening the exterior door, no alarms sounded. This door led the surveyors to a vestibule or foyer area. The second interior door had a portable attached door alarm, this interior door was locked and the surveyor rang the outer doorbell to which facility staff opened the interior door, and an audible alarm sounded. Photos 4 and 5. Record review Resident 1 is deceased; Surveyor conducted a closed record review. Resident 1 was admitted to the facility on 10/28/2017 from another assisted living facility. Resident 1's diagnosis include Dementia. An Individual Service Plan (ISP) and Evaluation/Assessment, dated 09/28/2017, prior to Resident 1's admission to the facility, includes: Mobility - Walker - Wheelchair independently - no cueing - Comments - Uses walker majority of the time. Propel [herself/himself] in wheelchair...Grooming - Wake up time: by 8 am [ish], Bed time - 8-9 PM...night time wandering?...Personal hygiene/Continence -	N 426		

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N 426	Continued From page 18 Clepto[sic]/Shopper...Wandering - Comments: Gotten out of building 2-3 x (times) per [daughters]/RA [Resident Assistant] at facility resident currently resides in...Specific behaviors: Hoarding/squirreling or hiding items...Exit seeking...Hallucinates - see parents... Resident 1's ISP, signed by several staff members in October 2017, includes: Supervision - 24-hour supervision; Capacity for Self Care - Needs total assistance; Capacity for Self-direction - Makes needs known...Self-concepts/Orientation - Current status: Resident easily disoriented needing multiple reminders daily as to either date, time or place...Resident needs supervision when outside of the house as resident is easily confused, and is/is not an elopement risk (no indication of which one)...Wandering: Directions - Monitor and cue resident regularly to prevent wandering episodes outside...Current Status: Resident wanders outside weekly, however is easily redirected. Resident has on a Wanderguard and is monitored by staff regularly. Desired Goals...outcomes: Resident to maintain low to non-existent wandering episodes...staff to provide proper supervision to help prevent future wandering episodes by monitoring resident regularly and reacting to Wanderguard alarms appropriately. Wandering - Redirection In House: Resident wanders in house in others rooms during the daytime, but is easily redirected by staff. Current Status: Has a tendency to wander into other resident rooms during daytime hours...usually doesn't take anything and is easily redirected... Surveyor questioned Administrator B if the facility had a Wanderguard monitoring system in place and if Resident 1 wore a wanderguard bracelet as indicated in [his/her] October 2017 ISP. Adm B	N 426		

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N 426	Continued From page 19 stated, "No, the facility doesn't have a wanderguard system. The care plans are pre-made and then updated specifically for that individual. [Resident 1] never had a wanderguard." Resident 1's updated ISP/Care plan, dated 11/15/2017, includes: Cognitive Status - Self Concepts/Orientation - Partial Assist - Redirection/reminders needed multiple times daily. Needs supervision outside of house...Current status: Resident easily disoriented needing multiple reminders daily as to either date, time or place due to dementia diagnosis...needs supervision when outside of the house as resident is easily confused and is an elopement risk (Responsible staff is to do hourly safety checks on resident to ensure [his/her] safety). Wandering - Wanders/trespasses into other rooms during daytime, easily redirected...Wandering-Redirection In House - Resident wanders in house in others rooms during the daytime, but is easily redirected by staff. Current status: tendency to wander into other resident rooms throughout the day/daily...would take belongings of other residents, and place them in [her/his] room...Wandering - Partial Assist - Monitor and cue resident regularly to prevent wandering episodes outside. Current status: Resident wanders outside weekly and has gotten out of facility resident once resident 2-3 times prior to moving here per family...staff to monitor resident hourly to ensure safer...staff is to make sure front door is armed/on at all times. Desired Goals...to maintain low to non-existent wandering episodes...to provide proper supervision to help prevent future wandering episodes by monitoring regularly and reacting to alarms appropriately. Specific behaviors - Resident exhibits signs of the	N 426			

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N 426	Continued From page 20 following tendencies requiring a need for staff intervention: Not sleeping at night/up while others are sleeping. At times resident would wander up and down the halls of facility...Exit seeking - this behavior has been previously noted in care plan... (The use of a wanderguard system as identified in [Resident 1's] October 2017 care plan had been removed). Quarterly Nurse Report, dated 10/31/2017, includes: Description - A & O (alert and orientated) x (times) 1-2, pleasant, ambulates with ww (wheeled walker), wheelchair for longer distances...wanders throughout community enters others rooms...Behavioral Symptoms - Wandering...Does resident participate in or use any other the following? Elopement Precautions... Documentation includes: (times of entry reflect actual time staff documented their observations that occurred sometime during their work shift). * 11/04/2017 - 7:45 PM - Resident been in every other resident room all evening, [s/he] also been at the back door numerous times trying to get out very easy redirect but keeps on with the same things all evening...10:15 PM - It was noted that resident trying to leave out back door, but easily redirected. 1 hour checks put into place for safety. * 11/05/2017 - 8:00 PM - All evening resident was in and out of other residents room getting them upset. [S/he] been trying to also leave out the back door all evening also... * 11/07/2017 - 10:00 PM - resident opened the back door several times and going from room to room...	N 426			

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N 426	Continued From page 21 * 11/09/2017 - 9:15 PM - was in and out of all rooms...Communication log entry - PM shift - [Resident 1's room number] was in and out of all rooms [s/he] can get in [s/he] was found in [room number] chair reclined all the way back, resident was restless. * 11/11/2017 - 2:45 PM - In and out of peers room, taking peers belongings...taking table mates napkins wiping nose and placing back on table...taking peers food and drinks...redirected 10 times or more times...entering [room number] going through closet and drawers...attempted to redirect with little to no success... Communication log - AM shift - check on [Resident 1] - doing a lot of wondering [sic].. * 11/12/2017 - 2:15 PM - In and out of other peers rooms and taking their food and drinks... * 11/16/2017 - 8:45 PM - was in and out of other residents rooms taking stuff that didn't belong to [her/him] getting in other residents beds, staff had to remove [her/him] and redirect... * 11/17/2017 - 9:45 PM - A lot of walking around facility getting into peers things. Resident got into [staff title] purse and removed all items and took to [her/his] room... * 11/19/2017 - 8:45 PM - Resident wonder [sic] all evening long... * 11/22/2017 - 8:45 PM - was in and out of every room [s/he] can go in...in out of different beds, staff constantly finding [her/him] in a lot of beds redirecting [her/him] to room or TV room...wouldn't stop going in and out of rooms picking up other residents things, staff constantly taking things from [her/him] that didn't belong... * 11/27/2017 - 10:15 PM - walked in and out of every room [s/he] could, laying in beds that weren't [her/his] or sitting in chairs in their	N 426			

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N 426	Continued From page 22 rooms... * 11/30/2017 - 9:30 PM - walked in and out of every room constantly, staff had to keep redirecting [her/him] to [his/her] room... * 12/07/2017 - 9:15 PM - was in and out of every room, staff had to kept [sic] putting stuff back in the rooms the items belong in... * 12/12/2017 - 8:45 PM - resident walked around the building in and out of residents rooms resident was constantly redirected to common area and [her/his] room... * 12/17/2017 - 8:15 PM - Resident was wandering and getting into everything like other house mates room, trying to leave out the doors etc. PRN (as needed medication) given and didn't help at all...doesn't listen or following [sic] directions at all... * 12/18/2017 - 7:30 PM - trying 4 times to leave the building, resident was redirected back in... * 12/20/2017 - 8:30 PM - was in and out of all room constantly taking things, staff had to redirect [her/him] constantly, resident would not stay in one place... * 12/27/2017 - 7:15 AM - Resident walked around trying to escape the entire night. * 12/29/2017 - 9:45 AM - Around 8ish staff did not see resident inside facility after checking all the rooms inside facility. Staff member then looked outside and seen something across parking lot on the ground...staff member ran outside to see what it was and verified it was resident...called 911. 2:30 PM - Staff did rounds, staff noticed that resident wasn't in room. Staff then checked all other resident's room and bathrooms'. Resident was found behind jimmy john's deceased.... A review of the facility computerized Daily Tasks	N 426			

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N 426	Continued From page 23 (these tasks are specific for each resident's assessed needs and are listed in the computer as 'to-do' tasks, staff are directed to initial each task upon its completion). A review of Resident 1's daily task sheets, from 12/27 - 12/29/2017, includes: 1 Hour Checks - Resident wanders in house into other resident rooms taking personal items. Responsible staff to redirect. Surveyor reviewed these daily tasks reports and questioned Administrator B regarding facility expectation regarding the documentation of daily tasks. According to Adm B the "daily tasks are identified needs of a resident, for example toileting needs every 2 hours, then staff should document by placing their initials and time they completed that task. If hourly checks then staff would document hourly that they observed that resident." Surveyor reviewed Resident 1's daily task sheets from 12/27 - 12/29/2017, specifically for the hourly checks and noted no staff initials indicating that these hourly checks had been completed as assigned. (Other tasks, such as grooming, toileting etc. did have staff initials and time that specific task was completed). Adm B stated, "Staff were instructed to complete the hourly checks and then to document this completion in the daily task report. [Resident 1] was up all night, walking the halls. Hourly checks should have been completed and then signed off." Adm B continued, "On December 28th, I had reviewed [Resident 1's] observation notes and noted the night before [s/he] was up all night. So I implemented 30 minute checks." Adm B attempted to show Surveyors via computer system, that if there was a change in a care plan,	N 426			

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NAME OF PROVIDER OR SUPPLIER FAITH GARDENS			STREET ADDRESS, CITY, STATE, ZIP CODE 35 TOWER DRIVE SUN PRAIRIE, WI 53590		
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N 426	Continued From page 24 a 'notification of change' would show up on the screen. A red 'pop up' alert would alert staff that there was a change in the care plan. Surveyor requested to review documentation that confirmed the implementation of these 30 minute checks and to see the 'red' pop-up alert. Adm B was unable to bring up the 'red' alert pop-in indicating that there was a care plan change for Resident 1. Interviews On 01/03/2018 at 7:10 AM, Surveyor questioned CS (Care Specialist) D if there were any in-house residents that currently utilized a wanderguard bracelet. CS D stated, "No, no residents with wanderguard's. There are alarms on every door, when you hear an alarm, jump straight to the doors, then me personally I do rounds. If they had a wanderguard bracelet, if they got close to door an alarm would go off." Surveyor checked the 3 facility exit doors and no wanderguard system was noted. (The use of a wanderguard system and bracelet was identified in Resident 1's October 2017 ISP as noted above). At 8:10 AM, Surveyor questioned CS D regarding her knowledge of Resident 1's care needs. CS D stated, "Can't tell you much about [her/him]. Dementia and wanderer. One time signed self out and tried to leave out of the front, but redirected and sat to watch TV. [S/he] would walk back and forth to living room and [her/his] room. [S/he] would go in other resident rooms, go 'shopping'. When we have meetings we talk about all residents, if didn't see [her/him] in room will catch [her/him] in other rooms, taking items and then we would give back to other person. Big thing	N 426			

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N 426	Continued From page 25 was [s/he] likes to wander off, leave building, and we need to keep an eye on [her/him]." Surveyor questioned if Resident 1 had a wanderguard bracelet. CS D stated, "Didn't notice wanderguard." Surveyor questioned as to how the staff knew the needs of the residents. CS D stated, "We read the IP's (individual plans) to know about them. Surveyor questioned what the facility rules were regarding checking on the residents whereabouts. CS D stated, "AM check every hour. PM check every 1 - 2 hours - not sure and Night, check all residents every hour." On 01/03/2018 at 9:10 AM, Surveyor interviewed HSC (Health Service Coordinator) E regarding Resident 1 and [her/his] knowledge regarding the events of December 29th, 2017. HSC E stated, That morning, I got here, checked in with everyone, said hi. I didn't see [Resident 1] and said 'Where's [Grandma/pa], we called [her/him] [Grandma/pa]. [CS F] said [s/he] would go check in [her/him] room and go get [her/him]. I was in back office, when [CS F] came out and said [Resident 1] was not in [her/his] room. We started checking the rooms. I checked [Resident 1's room] and walker and shoes were in there. [S/he] doesn't walk without walker and shoes, [s/he] stumbled when walking, so it was unusual to see it in the room, [s/he] took it everywhere. We searched all the rooms, including the mechanical room and rooms 15 and 16, which we typically keep locked." HSC E continued, "I called [CS G] and questioned if [Resident 1] was sent to the hospital and was told 'no', [s/he] was here. [CS F] then looked out window and saw something to the rear of the gas station. I bolted out the door. [CS F] said I think [s/he's] gone. I jumped on top	N 426			

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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

FAITH GARDENS

**35 TOWER DRIVE
SUN PRAIRIE, WI 53590**

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N 426	Continued From page 26 [her/him], [s/he] was so cold. I started rubbing [her/him] to warm up. I ran back into the building to get blankets and the cook called 911. Ran back and kept rubbing [Resident 1]. Then I called [Licensee A and Administrator B]. I was hysterical, screaming and yelling. The paramedic came and I moved, then lost it, threw up and lost it. I parked that morning, why didn't I see [her/him]?" Surveyor questioned as to what Resident 1 was wearing. HSC E stated, "P.J's, no shoes, socks on, top and bottoms p.j's. I called [Resident 1's] daughter and [name] answered and I told [her/him] there had been an incident with [Resident 1], that [s/he] got out of the facility. [Daughter's name] said, which hospital, I'll meet them. I said, no, your mom is deceased. [Daughter's name] said, 'What... that's the reason I had [her/him] there, that was my worst fear, [her/him] getting out." HSC E continued, "[Resident 1] loved to lay in bed. [S/he] would wander into other people's rooms and lay in their beds. [S/he] liked to go 'shopping' and put the stuff in [her/his] walker. We would take the stuff and put back into rooms. [Resident 1] tried to walk out twice, was observed by front door twice, first got to interior door, then exterior door, opened it and said it was too cold and returned in the building, then walked back to [her/his] room and covered with blankets." HSC E stated, "When family toured they wanted a smaller facility because [s/he] wandered and got out of the last facility. They told us [s/he] was a 'shopper' and to keep eyes and hands on [her/him]." (On 01/03/2018, following the facility exit conference, HSC E exited the facility with the	N 426		

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N 426	Continued From page 27 Surveyors and pointed out and confirmed the location where staff found Resident 1 lying outside, behind a local business, deceased. Photos 2 and 6). On 01/03/2018 at approximately 9:15 AM, Surveyor interviewed Administrator B regarding Resident 1's admission to the facility. Adm B stated, "First the family toured. The family mentioned that [Resident 1] had an incident at the current assisted living home (name), where [s/he] rolled out the back door in [her/his] wheelchair and was almost hit by a car. So the family decided to be pro-active and look for a smaller facility, and with winter coming they wanted a more secure environment." On 01/03/2018 at 12:00 PM, Surveyors reviewed concerns regarding Resident 1's ability to exit the facility without staff knowledge and concerns that facility staff did not have door alarms on and functioning nor did staff document the completion of hourly checks as per care plan. Surveyor questioned as to the facility plan for Resident 1's elopement risk prior to admission. Adm B stated, "Conduct hourly checks and door alarms should be on at all times." Surveyors questioned RN (Registered Nurse) I regarding [her/his] role and frequency at the facility. RN I stated, "I consult for the facility, work about one day a week. I oversee medications, medication delegation, inservice and whatever else needed." Surveyor questioned if RN I was contacted or made aware of Resident 1's attempts to exit the facility. RN I stated, "I was made aware of the incident this morning. Sweet [lady/man]. Staff would tell me that [s/he] liked to go into other peoples rooms. I was never made aware of any attempts to exit the building."	N 426			

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N 426	Continued From page 28 On 01/03/2018 at 4:01 PM, Surveyor conducted a phone interview CS F regarding the events of 12/29/2017 leading up to the discovery of Resident 1 leaving the facility and subsequent death. CS (Care Specialist) F informed Surveyor that [s/he] had arrived "6 minutes late for work, ran inside. (facility time card report indicates that CS F punched in for work on 12/29/2017 at 7:06 AM). I was in such a hurry, I wasn't thinking about anything. The second door, interior door was propped open, rug stopped it from closing. This happened every time that night shift person (CS G) worked, you would arrive with door propped open. I asked about the residents that day. [S/he] did not say anything about resident care. [S/he] was talking about the PM shift complaining that [s/he] was an hour late." Surveyor questioned CS F as to how often the AM shift checked on Resident 1's whereabouts. CS F stated, "Was every two hours than I was told it switched to every hour. That morning I went down to help (resident name), then while getting ready for breakfast, I asked, 'where's [Resident 1].' [HSC E] said 'don't worry [s/he's] around here somewhere, [s/he] sleeps in other resident rooms and one time they found [her/him] in the maintenance room.' We all starting looking and I was standing by the window and said [s/he's] outside. We ran over to [her/him]. [Resident 1] was laying on [her/his] right side by the back of Jimmy John. I took a double look. [S/he] had on socks, blue bottoms, long sleeve top mix/match orange color. I did not touch [her/him], but knew [s/he] was gone. [Her/his] fingertips were raw and bloody and [s/he] had a runny nose that was 'popsicle' like. It was horrible."	N 426			

AW

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N 426	Continued From page 29 Surveyor questioned if CS F ever witnessed Resident 1 attempting to leave the building. CS F stated, "Never saw [her/him] outside on AM's. But PM shift, [staff name], informed us [s/he] had more sundowning and would try to get out. I heard that [Resident 1] tried the 'bookcase' door (facility side door) quite a bit and tried the patio door and tried to get out the patio gate once." CS F continued, "One time [Resident 1's] daughter [name] came in and saw the door propped open and questioned why the door was propped open, [s/he] said that they liked the smaller facility and the alarms on the door, that's why they chose the place." Surveyor questioned CS F regarding the facility door alarms. CS F stated, "The interior door, white alarm, hadn't been working, it had a bad battery. [Adm B] bought 4 of them (new white alarms), then found out it just needed a new battery. That took a month or more. The side door and the patio door are always alarmed." On 01/04/2018 at 9:26 AM, Surveyor conducted a phone interview with CS G. CS G confirmed that [s/he] had worked the night shift on 12/28/2017 - 12/29/2017 (facility time card report indicates that CS G punched in for work on 12/28/2017 at 11:57 PM and punched out on 12/29/2017 at 7:27 AM). CS G informed Surveyor that [s/he] had been employed at the facility for "two years and primarily worked nights." CS G stated, "I got there late, around midnight or so." Surveyor inquired as to the CS G's night routine. CS G stated, "I work full time nights, shift is from 11:00 PM - 7:00 AM. I make rounds, most residents are sleeping. I check the incontinent	N 426			

Handwritten signature/initials

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N 426	Continued From page 30 residents every 2 hours other residents are checked less often as they are more independent." Surveyor questioned if any residents were up at night. CS G stated, "Yes, three residents [Residents 1, 3 and 4]. [Resident 1] was one of them, [s/he] would walk around, picks stuff up and was busy touching things. [Resident 1] would go into other resident rooms. [Resident 3] would go into other resident rooms. [Resident 4] does wander, but stays close to you, what I would do, [s/he] watches. At night we clean, mop floors and do laundry. All residents need help but at different degrees. I spent most of my time with [Residents 1, 3 and 4]. [Resident 2] smokes. We need to shut off alarms for [him/her] to go in/out of patio doors. [S/he] also likes coffee." Surveyor questioned the front door system and how/if the doors were alarmed. CS G stated, "The white alarm on interior door is never on, it was not activated. Residents cannot open door, the latch is hard for them to push on it, so normally not on. Side door alarm always on. Patio door alarm always on. Reason the exterior front door not on is people go in/out, and the alarm would go off all the time." Surveyor questioned if the interior entrance door was opened on the night of December 28/29th. CS G stated, "Yes, I opened interior door for the AM shift. If you push it far enough, rug holds it open. I believe that morning I did the same thing." CS G continued, "I thought about it, honestly the last time I saw [Resident 1] was 4 AM. At midnight, I checked [her/him] and [s/he] was sleeping. At 4 AM, I checked [her/him], [s/he] was up and I helped [her/him]."	N 426			

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FAITH GARDENS

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N 426	Continued From page 31 Surveyor questioned if CS G conducted hourly checks as per Resident 1's care plan. CS G stated, "No. At midnight [s/he] was sleeping. Then at 4 AM [s/he] was up and I noted that. My last round, my final round was 6 AM. I did not see [her/him] in [her/his] room, but that is not uncommon. No alarms went off. The night before, on the 27th, [s/he] tried numerous times to get out the side door." Surveyor questioned if the exterior main front door (door leading directly to the outside) was alarmed or not. CS G stated, "No, it wasn't alarmed that night. Alarm is never on the front door, it's not connected to the chime system that's in the kitchen. They all knew that door we never turned it on, both employees and management knew it." Surveyor questioned as to why the door was not alarmed. CS G stated, "There are two leather chairs by the fireplace. I usually pull them over and station them by the front door. [Resident 1] wandered in anyone's room, picking stuff up and laying in other resident rooms." Surveyor questioned as to the facility early morning routine. CS G stated, "Between 6-7 AM, is busy time, by myself, very busy. At 5:30 AM, [Resident 2] is up six times door alarm on/off for patio as [Resident 2] smokes. We have to go to the kitchen to shut it off. I need to stop what I'm doing, cut alarm off, check around and try to get people up. We're supposed to get 2-3 people up. Some people are ready and want to get up. I typically get two [resident names] up every morning. [Resident 5] is total assist with cares and takes a total of 30 minutes from start to finish. But I'm in/out of [her/his] room. [Resident 6] takes about 10 minutes, [s/he] is able to stand,	N 426		

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N 426	Continued From page 32 walk. I get [her/his] stuff out, do pericare and help [her/him] get dressed. Then the rest are whomever's willing to get up." Surveyor questioned as to how the staff communicate resident care needs or concerns with the on-coming shift. CS G stated, "Usually a verbal report. Give highlights of night, that morning (December 29th) [CS F and H] were working, everything was fine. That morning they didn't get there right at 7 AM - it was later. I left there around 7:30 AM." Surveyor questioned as to where CS G parked [her/his] vehicle. CS G stated, "In the first regular stall. I didn't see anything. Then approximately 8:30 I got a call from HSC (Health Service Coordinator) E asking me where was [Resident 1]. I said 'what do you mean? [S/he's] there.' [HSC E] said 'no', s/[he's] not, then [HSC E] went outside looked around and then [HSC E] started screaming and hung up." CS G also commented, "I've worked my whole life in health care, never thought anything like this would happen. On 01/08/2017 at 1:45 PM, Surveyor conducted a phone interview with CS H. CS H stated, "I just got terminated, no reason given." CS H continued, "I worked at the facility 1 or 2 times per week. On that Friday (12/29/2017), my girlfriend dropped me off under the canopy. I got there around 7:06. I was right behind [CS F]." (The facility time card report indicates that CS H punched in for work on 12/29/2017 at 7:06 AM). Surveyor questioned if the facility doors were opened or unlocked for entrance. CS H stated, "First door, the exterior door was unlocked,	N 426			

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N 426	Continued From page 33 walked right in. The second door was propped open. During the day it was usually propped open with a white bucket, but not on that day, if you open the door wide enough, the cement and carpet would catch it and it remained opened. That's how it was opened." Surveyor questioned approximately how often CS H observed the interior door propped open. CS H stated, "Everyday you worked. It was propped because so many people came in/out, including employees." Surveyor questioned if the management staff were aware that this interior door was propped opened. CS H stated, "Of course, all the time. Their office window is facing the door, they had to have seen it. I was never told to shut it or to put the alarm on. I know the alarm was not on the day of this incident." Surveyor questioned if staff rang a doorbell to be let into the facility. CS H stated, "The doorbell is located outside. That front door was unlocked, shut but unlocked. That door never made a noise when you entered, none whatsoever. I don't think that door was ever armed." Surveyor questioned CS H regarding Resident 1's needs related to [his/her] wandering. CS H stated, "[Resident 1] wandered in the building, [s/he] called it shopping. [S/he] would go in other rooms or in someone's bathroom. If not wandering, [s/he] would be lying in bed. I never witnessed [her/him] trying to get out. [S/he] never asked to leave. After this incident I asked [HSC E] about [Resident 1's] wandering and [s/he] said that [Resident 1] would sundown and try the doors on evenings. [Staff name] also mentioned that they caught [her/him] trying to go outdoors,	N 426			

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N 426	Continued From page 34 found [her/him] in-between doors, but brought [her/him] back in." Surveyor questioned as to what CS H recalled from the morning of December 29, 2017. CS H stated, "Well, we were getting people up. [CS F] told me who needed showers, so I went to complete a shower. Around 8 AM, after finishing the shower, [CS F] asked if I was going to pass meds. So I started the med pass. [CS F] started rounding people to the tables. [CS F] said that [s/he] couldn't find [Resident 1]. [HSC E] commented, 'don't worry, [s/he's] probably in someone's room or in their bed.' Then we dropped everything and started to check all the rooms, we swept all the building. [HSC E], [CS F] and I met in the front room and [HSC E] said we need to call 911. At that same time [CS F] said, "Oh, my god, is that [her/him] outside" and we all ran outside. [S/he] was laying on the ground, behind the BP gas station. I touched [her/his] face and knew [s/he] was gone. [Her/his] fingertips had blood on them. There was a path in the snow, like [s/he] fell or something and tried to crawl." CS H stated, "It was a horrible thing. Very tragic. I wouldn't wish that on anyone. [S/he] was there because [s/he] couldn't take care of [her/himself] and the system failed [her/him]." In review of WeatherUnderground.com's historical data, the temperatures/windchill readings in the Sun Prairie, WI area on December 29, 2017 were recorded as: * 3:53 AM - 9.0 degrees F (Fahrenheit) with a windchill of 0.6 degrees F; * 4:53 AM - 8.1 with no windchill; * 5:53 AM - 7.0 degrees F with a windchill of	N 426			

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Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0014913	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 01/08/2018
NAME OF PROVIDER OR SUPPLIER FAITH GARDENS		STREET ADDRESS, CITY, STATE, ZIP CODE 35 TOWER DRIVE SUN PRAIRIE, WI 53590		
(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 426	Continued From page 35 0.1 degrees F; * 6:47 AM - 3.2 degrees F with no windchill; * 7:53 AM - 8.0 degrees F with no windchill. Summary On December 29, 2017, sometime after 4:00 AM, Resident 1 eloped from the facility unbeknownst to facility staff. The facility did not provide Resident 1 with the documented and assessed need for required twenty-four hour supervision, activate facility front entrance door alarms, did not conduct hourly checks or implement 30 minute checks for resident safety. Resident 1 was found deceased behind a local business. Cross reference: N0214 DHS 83.15(3)(a) Administrator Shall Supervise Daily Operations N0358 DHS 83.32(3)(n) Rights of Residents: Safe Environment N0433 DHS 83.38(1)(i) Behavior Management	N 426	Regarding Behavior Management 83.38(1)(i) In addition to the aforementioned supervision and oversight of daily observations, tasks and cares, Administrator/HSC will/have completed monthly shift audits (working the shifts), allowing for first- hand experience with current resident needs and changes. If it is noted that resident has wandered or attempted elopement, prior to admission, Administrator or RN will complete Wandering Assessment, which will be reflected and interventions noted in the ISP. If an elopement or wandering behavior occurs of a current resident, a Wandering Assessment or Behavioral Screen will be completed within 24 hours of the attempt. At that time staff will implement specific interventions as set forth and documented by the Administrator and/or RN. Monitoring of these interventions will be completed by Administrator. During which time, Administrator and RN will evaluate effectiveness of the interventions and make changes with continued monitoring as needed. Wandering and Behavioral Screens will be completed initially as noted and upon change in condition and/or review of resident's Individual Service Plan.	
N 433	83.38(1)(i) Behavior management. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident's highest level of functioning. In addition to the assessed needs as determined under s. HFS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Behavior management. The CBRF shall provide services to manage resident's behaviors that may be harmful to themselves or others. This Rule is not met as evidenced by: Based on interview and record review the facility	N 433		

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FAITH GARDENS

**35 TOWER DRIVE
SUN PRAIRIE, WI 53590**

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N 433	Continued From page 36 did not provide services to adequately manage behavioral symptoms for 1 of 1 sampled resident (Resident 1). Resident 1 displayed behaviors including wandering, entering other peers' rooms without their permission and removing their belongings, sleeping in peers' beds, taking peers' food and drinks and exit seeking. The facility did not have an effective plan with interventions to meet and minimize Resident 1's behaviors. Findings include: On 01/03/2018, Surveyors conducted a self-report review at the facility. Resident 1 is deceased, Surveyor conducted a closed record review. Resident 1 was admitted to the facility on 10/28/2017 from another assisted living facility. Resident 1's diagnosis include Dementia. An Individual Service Plan (ISP) and Evaluation/Assessment, dated 09/28/2017, prior to Resident 1's admission to the facility, includes: Personal Hygiene... Clepto[sic]/Shopper... Specific behaviors: Hoarding/squirreling or hiding items... Exit seeking... Resident 1's ISP, dated October 2017, includes: Supervision - 24-hour supervision; Capacity for Self Care - Needs total assistance... Self-concepts/Orientation - Current status: Resident easily disoriented needing multiple reminders daily as to either date, time or place... Wandering - Redirection In House:	N 433	Individual staff meetings or shift meetings will be scheduled to immediately address changes as well as a review during regular monthly meeting. Notes will be provided in the electronic charting indicating a change as an alert for all staff to sign off on indicating they read the notes. Meetings/trainings to address specific behaviors will be placed as priority and specific interventions will be noted in the aforementioned as well as in the charting. Additional training may include professionals knowledgeable in the specific field in which training is needed. Training of staff regarding the needs of the client group are scheduled to occur with RN Consultant on February 7, 2018. Topics inclusive with training are: sundowning, challenging behaviors, wandering residents and dementia related behaviors and interventions. Completion Date: 2/19/2018	

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N 433	Continued From page 37 Resident wanders in house in others rooms during the daytime, but is easily redirected by staff. Current Status: Has a tendency to wander into other resident rooms during daytime hours...usually doesn't take anything and is easily redirected... Resident 1's updated ISP/Care plan, dated 11/15/2017, includes: Cognitive Status - Self Concepts/Orientation - Redirection/reminders needed multiple times daily. Needs supervision outside of house...Current status: Resident easily disoriented needing multiple reminders daily as to either date, time or place due to dementia diagnosis... Wandering - Wanders/trespasses into other rooms during daytime, easily redirected...Redirection In House - Resident wanders in house in others rooms during the daytime, but is easily redirected by staff. Current status: tendency to wander into other resident rooms throughout the day/daily...would take belongings of other residents, and place them in [her/his] room... Specific behaviors - Resident exhibits signs of the following tendencies requiring a need for staff intervention: Not sleeping at night/up while others are sleeping. At times resident would wander up and down the halls of facility...Exit seeking - this behavior has been previously noted in care plan. Quarterly Nurse Report, dated 10/31/2017, includes: Description - A & O (alert and orientated) x (times) 1-2, pleasant...wanders throughout community enters others rooms...Behavioral Symptoms - Wandering...Does resident participate in or use any other of the following/ Elopement Precautions...	N 433			

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N 433	Continued From page 38 Documentation includes: (times of entry reflect actual time staff documented their observations that occurred sometime during their work shift). * 11/04/2017 - 7:45 PM - Resident been in every other resident room all evening, [s/he] also been at the back door numerous times trying to get out very easy redirect but keeps on with the same things all evening... * 11/05/2017 - 8:00 PM - All evening resident was in and out of other residents room getting them upset...[S/he's] been trying to leave out the back door all evening also... * 11/09/2017 - 9:15 PM - was in and out of all rooms...Communication log entry - PM shift - [Resident 1's room number] was in and out of all rooms [s/he] can get in [s/he] was found in [room number] chair reclined all the way back, resident was restless. * 11/11/2017 - 2:45 PM - In and out of peers room, taking peers belongings...taking table mates napkins wiping nose and placing back on table...taking peers food and drinks...redirected 10 times or more times...entering [room number] going through closet and drawers...attempted to redirect with little to no success... Communication log - AM shift - check on [Resident 1] - doing a lot of wondering [sic].. * 11/12/2017 - 2:15 PM - In and out of other peers rooms and taking their food and drinks... * 11/16/2017 - 8:45 PM - was in and out of other residents rooms taking stuff that didn't belong to [her/him] getting in other residents beds, staff had to remove [her/him] and redirect... * 11/17/2017 - 9:45 PM - A lot of walking around	N 433			

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N 433	Continued From page 39 facility getting into peers things. Resident got into [staff title] purse and removed all items and took to [her/his] room... * 11/22/2017 - 8:45 PM - was in and out of every room [s/he] can go in...in out of different beds, staff constantly finding [her/him] in a lot of beds redirecting [her/him] to room or TV room...wouldn't stop going in and out of rooms picking up other residents things, staff constantly taking things from [her/him] that didn't belong... * 11/27/2017 - 10:15 PM - walked in and out of every room [s/he] could, laying in beds that weren't [her/his] or sitting in chairs in their rooms... * 11/30/2017 - 9:30 PM - walked in and out of every room constantly, staff had to keep redirecting [her/him] to [his/her] room... * 12/07/2017 - 9:15 PM - was in and out of every room, staff had to kept [sic] putting stuff back in the rooms the items belong in... * 12/12/2017 - 8:45 PM - resident walked around the building in and out of residents rooms resident was constantly redirected to common area and [her/his] room... * 12/17/2017 - 8:15 PM - Resident was wandering and getting into everything like other house mates room, trying to leave out the doors etc. PRN (as needed medication) given and didn't help at all...doesn't listen or following [sic] directions at all... * 12/18/2017 - 7:30 PM - trying 4 times to leave the building; resident as redirected back in... * 12/20/2017 - 8:30 PM - was in and out of all room constantly taking things, staff had to redirect [her/him] constantly, resident would not stay in one place... * 12/27/2017 - 7:15 AM - Resident walked around	N 433			

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N 433	Continued From page 40 trying to escape the entire night. On 01/03/2018 at 11:20 AM, during an interview with Resident 2, Resident 2 commented how [s/he] knew [Resident 1] as "[s/he] tried to get into my room a lot but I told [her/him] no, out and than [s/he] would walk away. [S/he] tried to get into other rooms and did take stuff..." On 01/03/2017 at 12:00 PM, Surveyor asked Administrator B if Resident 1 had a specific behavior management plan with interventions (environmental adaptations, specific activity plan, snacks, walks, etc.) to deal with Resident 1's behaviors, including wandering into peers room throughout the day, taking their belongings and hiding the in [her/his] room and taking food and drink items from peers. Adm B stated, "We did hourly checks and staff would redirect [her/him] and remove those items [s/he] did take and return them to residents." Summary Resident 1 displayed behaviors including entering other peers' rooms without their permission and removing their belongings, sleeping in peers' beds, taking peers' food and drinks and exit seeking. The facility did not have a specific plan with individualized interventions that were effective to meet and minimize Resident 1's intrusive behaviors. Cross reference N0214 DHS 83.15(3)(a) Administrator Shall Supervise Daily Operations N0358 DHS 83.32(3)(a) Rights of Residents: Safe Environment N0426 DHS 83.38(1)(b) Supervision	N 433	Regarding Special Orders (1/23/18): 1. With respect to mailings for the individual case manager and funding companies... Confirmations and receipts will be provided by 2/19/18 or before. 2. Ensuring resident rights: a) Behavior Management is noted in this response/Plan of Correction on pages 36 and 37. Summized as such to indicate oversight of daily observations, tasks and cares by measurable means; shift audits (working or shadowing shifts) monthly (see schedule/timetable); Wandering and Behavioral Assessments completed; progress notes and monitoring by staff indicating triggers, interventions and outcomes for a period set forth by Administrator; oversight and evaluation by Administrator and RN Consultant for effectiveness; staff training by RN Consultant and/or Administrator to update of changes; Alerts through EMAR. Review monthly by RN Consultant of incidents will occur starting with the first review in February. Review process will help identify patterns and triggers.		

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			b) Safe Environment is noted in this response/Plan of Correction on pages 2 and 3. Alarm specialist assess properly working alarms; Door Alarm Policy implementation and training; ISP review and resident observation after incident; Staff meeting and review/retraining of policies and procedures related to rounding, behaviors, shift report, alarms, elopement; Elopement drill completed; steps implemented for currently known behaviors; exterior lighting maintenance. c) Client Groups noted on page 37 of response/Plan of Correction. RN Consultant is conducting a training (as RN and also Certified Dementia Specialist Trainer) specific behaviors common in client group, triggers for behaviors, risk factors and interventions on 2/7/18.	