Wisconsin Department of Health Services

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER			CONSTRUCTION	(X3) DATE S COMPLE	
				A. BUILDING			
		0010354		B. WING			8/2021
NAME OF P	ROVIDER OR SUPPLIER	\$	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
PRO HEA	LTH CARE REGENCY SE	NIOR COM NEW BE		T NATIONAL A	AVENUE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
U 000	INITIAL COMMENTS			U 000			
		eyor conducted a compla ealth Care Regency Sen in.					
	Two deficiencies were	e identified.					
	The complaint was su	ubstantiated.					
	Census: 37						
U 169	89.26(3)(c)1. PARTIC ASSESSMENT	EIPATION IN THE		U 169			
	A comprehensive ass performed or arrange						
	assessment prior to re	whose bills are resources or by  as evidenced by: ew and interviews the elete a comprehensive eadmission to the provide pation of the tenant and t					
	following a fall at the conduct an assessme	ehabilitative stay for 2 we RCAC. The provider did ent with the active nant and the tenants lega	not				
	Findings include:						
	complaint investigation served a discharge no	epartment conducted a on related to Tenant 1 bei otice from the RCAC. Th gency Senior Community	ie				

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

TITLE (X6) DATE

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		0010354	B. WING			C / <b>08/2021</b>
	ROVIDER OR SUPPLIER	NIOR COM NEW BE	ET ADDRESS, CITY, STA O WEST NATIONAL A BERLIN, WI 53151			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETE DATE
U 169	as they felt the tenant the tenant now requir nursing services.  Surveyor reviewed Tediagnoses included donoted Tenant 1's powen according to the nurse 1 sustained a fall on a lert and oriented to serefusing to be changed the CNA did convinced Tenant 1 was noted to staff assistance to trace to the hospital for evalute the same day.  10/03/2021- Notes included the same day.  10/03/2021- Notes included the same day.  10/11/2021- 7:00 AMalassist to 2 assistance incontinence noted. The administration would family.  10/11/2021- 7:00 AMalassist to 2 assistance incontinence noted. The note stated Tenant Con 11/08/2021, at 8:2 Administrator A regard condition as documer 10/03/2021. Administrator A regard condition as documer 10/03/2021 to discondition as documer 10/12/2021 to discondition	enant from the community is needs could not be met as sed over 28 hours of the enant 1's record. Tenant 1's ementia. The record also er of attorney was activated. In progress notes, Tenant 19/12/2021. Tenant 1 was self. Was incontinent and ed. The note documented a Tenant 1 to be cleaned up. To be weak and required 2 insfer. Tenant 1 was taken alluation. Tenant 1 returned dicated staff talked to Tenant out a change in condition aving. Tenant 1 went from 1 with transfers. Increased The notes indicated that follow up with Tenant 1's  Tenant 1 was found on the sent out for increased pain. In thad a fracture.  So AM, Surveyor interviewed ding Tenant 1's change of the notes indicated they did set than the progress notes trator A stated they did set than the progress notes trator A stated the meeting was was at the hospital due to				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S	
			A. BOILDING.			
		0010354	B. WING		1	<i>)</i> 8/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
PRO HEA	LTH CARE REGENCY SE	ENIOR COM NEW BE	ST NATIONAL	AVENUE		
_		NEW BERL	IN, WI 53151			I
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
U 169	69 Continued From page 2		U 169			
	went to the rehabilitate 1 for readmission to the informed Administrator exceed 28 hours per Administrator A stated verbal notice to Resp 1 exceeded 28 hours  On 11/02/2021, a writtenant 1's legal representation of the result	or A that Tenant 1 would week of nursing services. It at that time, they did give consible Party B that Tenant per week.  Itten notice was provided to esentative which stated "dvanced notice of ident's contract is required. required in the event of an an immediate documented and safety of the resident or quires total lift support and is. [S/he] is incontinent and anose needs. Dementia annot be safely met under a living licensure. Nursing at a return to Regency does areat to [his/her] health and tated Tenant 1 could return if day care, and a service greement in place signed by  101 AM, Surveyor of Health Services D. Tenant 1 was assessed at lity. Director of Health N C went to the or assess and informed fenant 1's needs exceeded services.				
		proximately 10:15 AM,				

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CI IDENTIFICATION NUMBE		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SU COMPLE		
		0010354		B. WING		C 11/08	8/2021	
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE			
PRO HEA	LTH CARE REGENCY SE	NIOR COM NEW BE		EST NATIONAL AVENUE RLIN, WI 53151				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FUL SC IDENTIFYING INFORMATIO		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
U 169	Tenant 1 was ready for Regency community. facility to conduct and the only information progress notes from to [Tenant 1] was not restated no other information facility by discharge summary at the rehabilitation facility by discharge summary at the rehabilitation facility on 10/27/2021 Covid 19 lockdown, I behind a glass windout LPN C stated Tenant Surveyor asked if LPI LPN C stated yes but Regency. LPN C stated yes but Regency. LPN C stated yes but Regency. LPN C stated about Tenant 1 CNA's stated Tenant 1 CNA's stated Tenant stated s/he then docu assessment form con C left the rehabilitatio returned to Regency, Administrator A that T 28 hours of nursing.  Surveyor asked LPN the assessment. LPN identified on the asses 10/12/2021 so did not else. Surveyor asked other staff at the rehall stated they would not asked if the record wasked if	ontacted LPN C to state or discharge to return to LPN C then went to the assessment. LPN C starovided to Regency was herapy which indicated ceiving therapy. LPN C nation was provided by thut that LPN C requested nd did not receive this frity.  Tived at the rehabilitation. Due to the facility bein LPN C observed Tenant w, seated in a wheelchaid of the did not recognize LPN C was wearing a mask that s/he wears a mask that s/he wears a mask that s/he asked the 2 CN CNA's stated Tenant 1 aff for transfers. LPN C 's continence status. But I was incontinent. LPN mented this on the higher than the pleted by LPN C and LFN facility. When LPN C LPN C informed the mant 1's needs exceed the capture of the proof of the proo	the eted ted the	U 169				

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/GIDENTIFICATION NUMB		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		DATE SURVEY COMPLETED	
		0010354		B. WING			C <b>11/08/2021</b>	
NAME OF P	ROVIDER OR SUPPLIER			RESS, CITY, STA		·		
PRO HEA	LTH CARE REGENCY SE	ENIOR COM NEW BE		EST NATIONAL AVENUE RLIN, WI 53151				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
U 169	Tenant 1 to return, LI Administrator A made admit/readmit Tenant comment about Tenant incontinence. LPN C declining prior to the planned to talk to the Surveyor asked if the 1 was notified of the a any information relate C stated they felt the admission/readmissic interest due to needs after the assessment, called by phone and thigher level of care, pcare facility.  Surveyor reviewed th LPN C dated 10/27/2/Admission/Readmissis "Reason for not recornot completed.  On 11/08/2021, at 11: interviewed Responsiassessment and notif B stated s/he was not the 10/12/2021 meeti Tenant 1's needs chastated the rehabilitatic discharge Tenant 1 on had to pay privately to provider since they were provider since they were provider since they were plant to the plant to the provider since they were plant to the p	on was made to not per PN C stated both LPN C the decision not to 1 based on the CNA's nt 1's ability to transfer stated Tenant 1 was 10/11/2021 fall and they family at that time.  responsible party for Teassessment and provided to the assessment. It denial for on was in Tenant 1's beautiful the changing. LPN C states, the responsible party would Tenant 1 required a cossibly a CBRF or mer decided to the complete of the complet	c and and y enant ed LPN st ed was a mory ed by "No was he earty e for out arty B hey e of	U 169				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/O IDENTIFICATION NUMBI		` '	CONSTRUCTION	(X3) DATE S COMPLI	
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		0010354		B. WING		1	8/2021
NAME OF PI	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
PRO HEA	LTH CARE REGENCY SE	NIOR COM NEW BE	13750 WES	T NATIONAL A	AVENUE		
			NEW BERL	IN, WI 53151			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU SC IDENTIFYING INFORMATIO		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
U 169	Continued From page	5		U 169			
	NO232 DHS 89.29(3) Retention of Tenants	(a)5. Admission and					
U 232	89.29(3)(a)5. ADMISS TENANTS	SION & RETENTION O	F	U 232			
	(3) TERMINATION O	F CONTRACT.					
	(a) Reasons. A reside apartment complex m contract with a tenant following conditions a	ay terminate its when any of the					
	provider discharged T Tenant 1's condition p self without providing this threat or significa	hreat to the f or others. ricity or physical v or together, stitute a s. as evidenced by: ew and staff interview, renant 1 emergently sta sosed an immediate thre documented evidence nt change in condition.	iting eat to of				
	the provider was awa needs of Tenant 1's conclude a fall risk, incr need for assistance fr transfers. Prior to 10/	spitalization on 10/11/2 re and able to meet the hange in care needs to eased incontinence and om 2 caregivers for saf 11/2021, Tenant 1's pocare had been activated.	d the e wer				
	facility and assessed 2 assist for transfers a	C went to the rehabilita Tenant 1's needs to inc and incontinence cares eyor that Tenant 1's ne	lude				

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	·	·	CONSTRUCTION	(X3) DATE S COMPLE	
		0010354	В	3. WING		11/0	) 8/2021
						1 11/0	0/2021
NAME OF PI	ROVIDER OR SUPPLIER	ST	REET ADDRES	SS, CITY, STAT	E, ZIP CODE		
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U 232	for assistance with tracare, as well as other prior to the fall on 10/ On 11/02/2021, the present the prior to the fall on 10/ On 11/02/2021, the present the provided the provided to the second that Tenara and two persons for the second that Tenara and the sec	ansfers and incontinence needs remained the same 11/2021.  rovider issued a notice of 1's legal representative dvanced notice of equired due to an immediate the health and safety of the immediate threat was not 1 required total lift supportansfers, incontinence care rebalize those needs. The ler used as evidence of an on were the same care red prior to a temporary ion.  epartment conducted a on related to Tenant 1 being otice from the RCAC. The gency Senior Community enant from the community i's needs could not be met quired over 28 hours of the enant 1's record. Tenant 1	g g	U 232			
	pressure checks one with walking 3 times p with putting in and rer day. Assistance with	time per week. Assistance per day. Staff assistance moving hearing aid once po	er				

0010354 B. WING C 11/08/202	AND PLAN OF CORRECTION
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NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  13750 WEST NATIONAL AVENUE NEW BERLIN, WI 53151	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMED TO THE APPROPRIATE DEFICIENCY)  (X4) ID PROVIDER'S PLAN OF CORRECTION (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMED TO THE APPROPRIATE DEFICIENCY)	PREFIX (EA
in the morning. Assistance making bed one time per day. Laundry service one time per week. Trash removal daily. Meals three times per day. Two hour checks 4 times per day and a shower one time per week.  According to the nursing progress notes:  09/12/2021-Tenant 1 sustained a fall. Tenant 1 was alert and oriented to self. Was incontinent and refused to be changed. The note documented the CNA did convince Tenant 1 to be cleaned up. Tenant 1 was noted to be weak and required 2 staff assistance to transfer. Tenant 1 was taken to the hospital for evaluation and returned with a recommendation to follow up with a physician as Tenant 1 recently had a pacemaker change.  10/03/2021- Staff talked to Tenant 1's family member about a change in condition that the tenant was having. Tenant 1 went from 1 person assist to 2 person assistance with transfers. Increased incontinence noted. The note further indicated that administration would follow up with the family. A review of the individual service plan noted no changes to the plan were made. The risk agreement, dated 2/28/2020, was not updated and did note Tenant 1 was unsteady while ambulating and was a fall risk.  10/11/2021- 7:00 AM- Tenant 1 was found on the floor by first shift and sent out for increased pain. The note stated Tenant 1 had a fracture. Tenant 1 was hospitalized on 10/11/2021 related to the injury.  On 11/08/2021, at 8:25 AM, Surveyor interviewed Administrator A regarding Tenant 1's change of conditions as documented in the progress notes	in the morper day. Trash rem Two hour one time page day. According 09/12/202 was alert and refuse document cleaned us required 2 was taken returned was taken returned was a physicial pacemake. 10/03/202 member at tenant was assist to 2 increased indicated the family noted no risk agree updated a while amb 10/11/202 floor by fir The note 1 was hos injury. On 11/08/Administrations

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	ľ	(X3) DATE SURV COMPLETE	
		0010354		B. WING			C <b>11/08/2</b>	:021
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE			
PRO HEA	LTH CARE REGENCY SE	NIOR COM NEW BE		T NATIONAL A	AVENUE			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FUL SC IDENTIFYING INFORMATIO		ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AI CROSS-REFERENCED TO DEFICIEI	CTION SHOULD B O THE APPROPRIA		(X5) COMPLETE DATE
U 232	needs. Administrator canceled as Tenant 1 the fall on 10/11/2021  Administrator A stated went to the rehabilitat 1 for readmission to the informed Administrator exceed 28 hours per Administrator A stated verbal notice to Respund's care needs exceed 28 hours per Administrator A stated verbal notice to Respund's care needs exceed 29 hours per Administrator A stated verbal notice to Respund's care needs exceed 29 hours per Benerally a 30 day and termination of the resident and the resident and the health are others. [Tenant 1] recommended to the health are others. [Tenant 1] recommended to the Regency assisted staff have concern the pose an immediate the safety." The notice staff had 24 hour per provider contracted, as	sponsible Party B for a Tenant 1's increased A stated the meeting was was at the hospital due.  If that on 10/27/2021, LP ion facility to assess Terme provider. LPN C or A that Tenant 1 would week of nursing services at at that time, they did gionsible Party B that Tenaded 28 hours per week.  Item notice was provided sentative which stated "	e to  PN C nant  s. ive ant  to  ed. an ted or nd nt itia er ng loes and urn if e t and	U 232				
	On 11/08/2021, at 10: interviewed Director of Surveyor asked how the rehabilitation facility.	of Health Services D. Tenant 1 was assessed ity. Director of Health	at					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE  A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		0010354	B. WING		C 11/08/2021
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NAME OF T	NOVIDEN ON 301 1 EIEN		ST NATIONAL	,	
PRO HEA	LTH CARE REGENCY SE	NIOR COM NEW BE	RLIN, WI 53151	AVENUE	
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	TION (X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE
U 232	Continued From page	9	U 232		
	rehabilitation facility to	o assess and informed			
	_	enant 1's needs exceeded			
	28 hours per week of				
		ctor of Health Services D if			
		n the assessment. Director			
		stated a RN was covering			
		of the assessment as rvices D began employment			
	at the provider on 11				
	On 11/08/2021 at app	proximately 10:15 AM,			
	•	LPN C who stated the			
	-	otified them that Tenant 1			
	_	ge back to the Regency			
		nen went to the rehabilitation assessment. LPN C stated			
	•	provided to Regency was the			
		herapy which indicated			
		ceiving therapy. LPN C			
		nation was provided by the			
	rehabilitation facility b	out that LPN C requested the			
	_	and did not receive this from			
	the rehabilitation facil	ity.			
	LPN C stated s/he an	rived at the rehabilitation			
	_	. Due to the facility being on			
	•	LPN C observed Tenant 1			
		w seated in their wheelchair.			
		1 did not recognize them.			
		N C was wearing a mask, that s/he wears a mask at			
		stated s/he asked the 2			
		Both CNA's stated Tenant			
		staff for transfers. LPN C			
	-	's continence status. Both			
	CNA's stated Tenant	1 was incontinent. LPN C			
	stated s/he then docu				
		npleted by LPN C and LPN			
	C left the rehabilitatio	n facility. When LPN C			

NAME OF PROVIDER OR SUPPLIER  TO HEALTH CARE REGENCY SENIOR COM NEW BI  (X4) ID PREFIX TAG  COMPLETE TAGE  REGULATORY OR LSC IDENTIFYING INFORMATION)  U 232  Continued From page 10  returned to Regency, LPN C informed Administrator A that Tenant 1's needs exceeded 28 hours of nursing. Surveyor asked about the other areas on the assessment from the prior fall on 10/11/2021. Surveyor asked if LPN C talked to any other staff at the rehabilitation facility. LPN C stated no. Surveyor asked how the decision was made to not permit Tenant 1 to return, LPN C stated both LPN C and Administrator A made the decision not to admit/readmit Tenant 1's ability to transfer and incontinence. LPN C stafed Tenant 1 was declining prior to the 10/11/2021 fall and they planned to talk to the family at that time.		T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE  A. BUILDING: _	CONSTRUCTION	(X3) DATE COMF	SURVEY
NAME OF PROVIDER OR SUPPLIER  PRO HEALTH CARE REGENCY SENIOR COM NEW BI  (X4) ID PREFIX TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG  COntinued From page 10  returned to Regency, LPN C informed Administrator A that Tenant 1's needs exceeded 28 hours of nursing. Surveyor asked about the other areas on the assessment from the prior fall on 10/11/2021. Surveyor asked if the rehabilitation facility. LPN C stated they would not return calls. Surveyor asked if the record was reviewed at the rehabilitation facility. LPN C stated both LPN C and Administrator A made the decision not to admit/readmit Tenant 1 based on the CNA's comment about Tenant 1 bas			0010354	B. WING			
PRO HEALTH CARE REGENCY SENIOR COM NEW BE    13750 WEST NATIONAL AVENUE   NEW BERLIN, WI 53151							100/2021
NEW BERLIN, WI 53151	NAME OF P	PROVIDER OR SUPPLIER					
PREFIX TAG  (EACH OFFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  PREFIX TAG  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE)  U 232  Continued From page 10  returned to Regency, LPN C informed Administrator A that Tenant 1's needs exceeded 28 hours of nursing. Surveyor asked about the other areas on the assessment from the prior fall on 10/11/2021. Surveyor asked if LPN C talked to any other staff at the rehabilitation facility. LPN C stated they would not return calls. Surveyor asked if the record was reviewed at the rehabilitation facility. LPN C stated no. Surveyor asked how the decision was made to not permit Tenant 1 to return, LPN C stated both LPN C and Administrator A made the decision not to admit/readmit Tenant 1 based on the CNA's comment about Tenant 1's ability to transfer and incontinence. LPN C stated Tenant 1 was declining prior to the 10/11/2021 fall and	PRO HEA	LTH CARE REGENCY SE	INIOR COM NEW BE		AVENUE		
returned to Regency, LPN C informed Administrator A that Tenant 1's needs exceeded 28 hours of nursing. Surveyor asked about the other areas on the assessment. LPN C knew about those areas identified on the assessment from the prior fall on 10/11/2021. Surveyor asked if LPN C talked to any other staff at the rehabilitation facility. LPN C stated they would not return calls. Surveyor asked if the record was reviewed at the rehabilitation facility. LPN C stated no. Surveyor asked how the decision was made to not permit Tenant 1 to return, LPN C stated both LPN C and Administrator A made the decision not to admit/readmit Tenant 1 based on the CNA's comment about Tenant 1's ability to transfer and incontinence. LPN C stated Tenant 1 was declining prior to the 10/11/2021 fall and	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE A CROSS-REFERENCED TO	ACTION SHOULD BE TO THE APPROPRIATE	COMPLETE
Surveyor asked if the responsible party for Tenant  1 was notified of the assessment and provided any information related to the assessment. LPN  C stated they felt the denial for admission/readmission was in Tenant 1's best interest due to needs changing.  Surveyor reviewed the assessment completed by LPN C dated 10/27/2021. The form noted: "No Admission/Readmission recommended - Reason for not recommending admission:" was not completed. Other areas on the assessment were documented as the same as prior to 10/11/2021. LPN C informed Surveyor that [Responsible Party B] was then called and told Tenant 1 required a higher level of care, possibly a CBRF or a memory care facility.  On 11/08/2021, at 11:01 AM, Surveyor interviewed Responsible Party B regarding the assessment and notification. Responsible Party	U 232	returned to Regency, Administrator A that T 28 hours of nursing. other areas on the as about those areas ide from the prior fall on asked if LPN C talked rehabilitation facility. not return calls. Surv reviewed at the rehabstated no. Surveyor a made to not permit Te stated both LPN C andecision not to admit/ the CNA's comment at transfer and incontine 1 was declining prior they planned to talk to Surveyor asked if the 1 was notified of the any information relate C stated they felt the admission/readmission interest due to needs  Surveyor reviewed th LPN C dated 10/27/2 Admission/Readmission for not recommending completed. Other are documented as the sc LPN C informed Surv B] was then called an higher level of care, p memory care facility.  On 11/08/2021, at 11: interviewed Responsi	LPN C informed enant 1's needs exceeded Surveyor asked about the sessment. LPN C knew entified on the assessment 10/11/2021. Surveyor It to any other staff at the LPN C stated they would eyor asked if the record was oblitation facility. LPN C asked how the decision was enant 1 to return, LPN C ad Administrator A made the readmit Tenant 1 based on about Tenant 1's ability to ence. LPN C stated Tenant to the 10/11/2021 fall and to the family at that time.  Tesponsible party for Tenant assessment and provided ad to the assessment. LPN denial for on was in Tenant 1's best changing.  The form noted: "No ion recommended - Reason admission:" was not eas on the assessment were ame as prior to 10/11/2021. The form to 10/11/2021. The formation of the assessment were ame as prior to 10/11/2021. The formation of the assessment were ame as prior to 10/11/2021. The formation of the assessment were ame as prior to 10/11/2021. The formation of the assessment were ame as prior to 10/11/2021. The formation of the assessment were ame as prior to 10/11/2021. The formation of the assessment were ame as prior to 10/11/2021. The formation of the assessment were ame as prior to 10/11/2021. The formation of the assessment were ame as prior to 10/11/2021. The formation of the assessment were ame as prior to 10/11/2021. The formation of the assessment were ame as prior to 10/11/2021. The formation of the assessment were ame as prior to 10/11/2021. The formation of the assessment were ame as prior to 10/11/2021. The formation of the assessment were ame as prior to 10/11/2021. The formation of the assessment were ame as prior to 10/11/2021. The formation of the assessment were ame as prior to 10/11/2021. The formation of the assessment were ame as prior to 10/11/2021. The formation of the assessment were and the assessment were				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	· ,	E SURVEY MPLETED	
		0010354		B. WING		1	C 1/08/2021
	ROVIDER OR SUPPLIER	ENIOR COM NEW BE	3750 WES	RESS, CITY, STA T NATIONAL A IN, WI 53151		·	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
U 232	B stated s/he was not the 10/12/2021 meeti Tenant 1's needs cha stated since the rehal discharge Tenant 1 or would not take Tenan privately to keep Tena They were not given a discharge from the Ristated Administrator A services were arrange Tenant 1 could return On 11/08/2021, at 11 interviewed Administrator facility did initially not party that Tenant 1 could return that Tenant 1 could [Responsible Fistated they wanted to 89 codes on the disch notice on 11/02/2021 did not return to Pro Ficommunity New Berl rehabilitation facility viawaiting admission to Cross Reference	told about the purpose for g and had no idea that nged. Responsible Party bilitation facility was ready in 10/28/2021 and the RC to 1 back they had to pay ant 1 at rehabilitation facility any notice of the impending CAC. Responsible Party A informed them that if ed for 24/7 contracted care.  30 AM, Surveyor ator A regarding the verbal notice then writter A stated the rehabilitation if y Tenant 1's responsible build not return. LPN C the Party B]. Administrator A rensure they followed DH marge and sent the written. As of 11/08/2021, Tenant Health Regency Senior in. Tenant 1 remained at with Responsible Party B	y B y to AC lity. ng y B re, n en sen	U 232			