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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUBERGE AT OAK VILLAGE A MEMORY CARE COMM	W128 N6900 NORTHFIELD DR MENOMONEE FALLS, WI 53051

(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 09/18/2024, with information gathered through 09/24/2024, the Bureau of Assisted Living, Southern Regional Office conducted a standard licensing survey and a complaint investigation at Auberge At Oak Village A Memory Care Community, located at W128 N6900 Northfield Drive in Menomonee Falls, WI. Six citations of noncompliance were issued. The complaint was substantiated. Census: 46	N 000		
N 352	83.32(3)(h) Rights of Residents: Receive medication In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Receive medication. Receive all prescribed medications in the dosage and at intervals prescribed by a practitioner. The resident has the right to refuse medication unless the medication is court ordered. This Rule is not met as evidenced by: Based on observation, interview, and record review, the provider did not ensure Resident 1, Resident 2, Resident 3, Resident 4, and Resident 6 received all prescribed medications in the dosage and at intervals prescribed by a practitioner. Resident 1 was not administered several doses of prescribed medications, including allopurinol (gout medication), bumetanide (diuretic medication; prescribed for water retention), pantoprazole (medication to reduce stomach acid), melatonin (prescribed for sleep), and escitalopram (psychotropic, antidepressant	N 352		

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

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medication) during June 2024 and July 2024.

Resident 2, Resident 3, and Resident 4 did not receive polyethylene glycol (prescribed for constipation), as prescribed.

Resident 6 did not receive prescribed medications, including donepezil (dementia medication), escitalopram (psychotropic, antidepressant medication), and vitals were not recorded from July 2024-09/18/2024 (day of survey) in regard to parameters set for Metoprolol (beta blocker medication; prescribed for hypertension).

The findings include:

On 08/05/2024, the department received allegations including resident medications were not being administered as prescribed by a practitioner.

Example 1: Resident 1

On 09/18/2024 at 11:37 A.M., Surveyor conducted an interview with Caregiver/Former Residential Care Coordinator (Caregiver) F regarding Resident 1. Caregiver F told Surveyor Resident 1 required caregiver administration of prescribed medications. Caregiver F told Surveyor Resident 1 was sent to the hospital on 07/31/2024 and did not return to the facility before being officially discharged from the facility. Caregiver F told Surveyor most of Resident 1's prescribed medications were delivered by Resident 1's Primary Medication Provider L via mail to the facility in bottles. Caregiver F said the facility would send them to the facility's primary pharmacy to be packed into unit dose packaging. Caregiver F said sometimes those medications

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received from Resident 1's Primary Medication Provider were re-packaged at the facility into unit dose packaging, bubble packs, if the facility was running low and the rest would be sent to the pharmacy for packaging.

On 09/18/2024, Surveyor received Resident 1's "Face Sheet" including Resident 1's medical history/diagnoses from Administrator A. Resident 1 was admitted to the facility on 03/22/2023 and had diagnoses including congestive heart failure (CHF), peripheral vascular disease (PVD), gastroesophageal reflux disease [GERD], hypertension (HTN), gout, dementia, depression, insomnia, and "Adjustment Disorder with anxious mood."

On 09/19/2024 at 1:30 P.M., Surveyor received an email from Administrator A including Resident 1's individual service plan (ISP) dated 04/03/2024. Resident 1's ISP included, "[Resident 1] does have a diagnosis of depression, and did attempt suicide in 12/21 [December 2021]." Resident 1's ISP included Resident 1 required "full assist" with medication administration and "[Resident 1's] medications are provided by [Resident 1's Primary Medication Provider L] and goes through [Resident 1's Primary Medication Provider L] pharmacy." Resident 1's ISP included, "Escitalopram [Lexapro; antidepressant medication] 20 mg [milligrams] (Repack) once a day for mental health." Resident 1's ISP included, "Does [Resident 1] have a history of fluid retention, of weight fluctuation related to fluid? Yes" and "Is [Resident 1] receiving any diuretic medications? Bumetanide 50 mg BID [twice a day]."

On 09/18/2024, Surveyor received Resident 1's practitioner's orders for medications, Resident 1's

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June 2024 and July 2024 medication administration records [MARs], and Resident 1's caregiver "charting notes." Resident 1's practitioner's orders for medications included:
"Allopurinol 300 mg tab [tablet] (Repack) ** Repack med [medication] ** Take 1/2 [one half] tablet (150 mg) by mouth once a day for elevated uric acid [associated with gout]" dated 02/08/2024;
"Bumetanide 2 mg tab (Repack) ** Repack med ** Take 2 tablets (4 mg) by mouth twice daily for water retention [associated with CHF and/or PVD]" dated 02/08/2024;
"Pantoprazole 40 mg tab ([Resident 1's Primary Medication Provider L] med) Take 1 tablet by mouth once daily for stomach acid [associated with GERD]" dated 02/08/2024;
"Melatonin 3 mg tab (Repack) ([Resident 1's Primary Medication Provider L] med) Take 1 tablet by mouth once daily at bedtime for sleep [associated with insomnia]" dated 05/08/2024; and
"Escitalopram 20 mg tab (Repack) ** Repack Med ** Take 1/2 tablet (10 mg) by mouth once a day for mental health [associated with depression]" dated 02/08/2024.
Resident 1's June 2024 and July 2024 MARs documentation included:
10 consecutive doses of allopurinol 300 mg " for elevated uric acid", as prescribed, were not administered to Resident 1 between 06/24/2024 and 07/03/2024. The documented reason allopurinol was not administered to Resident 1 was "med [medication] unavailable."
5 out of 10 potential doses of bumetanide 2 mg "for water retention," as prescribed, were not administered to Resident 1 between 06/01/2024 and 06/05/2024. The documented reasons bumetanide was not administered to Resident 1 included "med unavailable" and "not on the cart."

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N 352	Continued From page 4 The documentation for the evening dose on 06/05/2024 was blank. 5 out of 46 potential doses of bumetanide 2 mg "for water retention," as prescribed, were not administered to Resident 1 between 07/07/2024 and 07/29/2024. The documented reason for 3 out the 5 doses of bumetanide not administered to Resident 1 included "med unavailable...no nighttime meds on cart," "med unavailable...reordered," and "med unavailable...not here." The documented reason for 2 out of the 5 missed doses of bumetanide not administered to Resident 1 included, "out of facility," despite another medication scheduled for the same time on those dates was documented as administered to Resident 1. Resident 1's "charting notes" included a note documented on 07/15/2024 at 3:30 P.M. The documentation included, "[Resident 1] was seen by [Resident 1's hospice agency] for routine visit...[Resident 1] has + [plus] 2 [to] 3 BLE [bilateral lower extremity] edema [swelling/water retention]." A note documented on 07/22/2024 at 4:18 P.M. included, "Edema noted to BLE." 15 out of 16 potential consecutive doses of pantoprazole 40 mg "for stomach acid," as prescribed, were not administered to Resident 1 between 06/22/2024 and 07/07/2024. The documented reason for 14 of the 15 doses of pantoprazole not administered to Resident 1 included "med unavailable." The documented reason for 1 out of 15 doses of pantoprazole not administered to Resident 1 included, "withheld per DR [doctor]/RN [registered nurse] orders." 1 dose on 07/04/2024 was documented as administered to Resident 1, despite the following doses documented as not administered related to the medication not being available. 19 out of 21 potential consecutive doses of escitalopram 20 mg "for mental health," as	N 352		

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prescribed, were not administered to Resident 1 between 07/06/2024 and 07/26/2024. The documented reason these doses were not administered to Resident 1 included "med unavailable." On 07/12/2024, the documentation included, "Medication no in any drawers on med cart. Writer [Caregiver F] checked spare med cart containing additional cards for [Resident 1's Primary Medication Provider L] medications. [Caregiver F] found no bingo card [unit dose bubble packaging] or pill bottle for this medication. Reorder request needs to be submitted to [Resident 1's Primary Medication Provider L] pharmacy." On 07/16/2024, the documentation included, "Reorder with [Resident 1's Primary Medication Provider L] pharmacy." On 07/19/2024, the documentation included, "Reorder request with [Resident 1's Primary Medication Provider L]." Despite documentation of escitalopram not being available at the facility for administration to Resident 1 during this time frame, 3 doses were documented as administered to Resident 1 and 1 dose was documented as "refused" by Resident 1.
21 out of 22 potential consecutive doses of melatonin 3 mg "for sleep," as prescribed, were not administered to Resident 1 between 07/05/2024 and 07/26/2024. The documented reason for 13 doses of melatonin not administered to Resident 1 included, "med unavailable." The documented reason for 1 dose of melatonin not administered to Resident 1 included, "withheld per DR/RN orders." The documented reason for 7 doses of melatonin not administered to Resident 1 included, "Out of facility." Despite documentation of melatonin not being available at the facility for administration to Resident 1 during this time frame, 1 dose was documented as administered to Resident 1.

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N 352	Continued From page 6 On 09/18/2024 at 5:00 P.M., Surveyor conducted an interview with Administrator A and Regional Facility RN B. Surveyor asked for an explanation of the caregiver documentation of some of Resident 1's medications not administered related to "withheld per DR/RN orders" and/or "out of the facility" when the doses on surrounding dates were documented as not administered related to the medication not being available at the facility to administer to Resident 1. Surveyor noted the facility had not provided evidence from Resident 1's record to support MD/RN orders to withhold the medications, as documented, and Resident 1's absence from the facility. Regional Facility RN B said the caregivers documented "out of the facility," for example, because they did not slowdown in order to properly document the actual reason of the medication not being available at the facility. Both Administrator A and Regional Facility RN B told Surveyor there would be a future plan to re-educate caregivers on proper medication administration, documentation, and re-ordering of medications. On 09/24/2024 at 12:29 P.M., Surveyor conducted an interview with Administrator A. Administrator A told Surveyor s/he should have been made aware of the availability issues of Resident 1's medications in June 2024 and July 2024, but s/he was not. Administrator A said Former Facility Nurse M never mentioned any concerns regarding Resident 1's medication availability prior to his/her termination from employment on 07/12/2024. . Example 2: Resident 2 On 09/18/2024 at 1:35 P.M., Regional Facility RN B and Surveyor observed Resident 2's	N 352		

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polyethylene glycol powder, as prescribed, within a medication cart located in the facility's medication room. Resident 2's polyethylene glycol powder container was affixed with a manufacturer's label including the container originally held 30 once-daily doses of 17 grams. The container included a pharmacy label including Resident 2's practitioner's prescription for polyethylene glycol including, "Mix 17 grams (fill cap to line) in 4-8 oz [ounces] of liquid. Stir well, and drink once daily." The pharmacy label included a delivery date to the facility of "06/18/[2024]." Photos #1 and #2. Surveyor observed approximately one-eighth of the medication remained within the container. Regional Facility RN B verbally confirmed same amount remained and confirmed the facility did not have any additional containers of polyethylene glycol tabled for Resident 2.

On 09/18/2024, Surveyor received Resident 2's record including a "Face Sheet," Resident 2's practitioner's orders, and Resident 2's MARs from Regional Facility RN B. Resident 2 was admitted to the facility on 04/16/2024. Resident 2's practitioner's orders dated 04/16/2024 included, "Polyethylene gly [glycol] pwd [powder] 17 gm [gram] scoop powd [powder] - 17 gram[s] by mouth every day for constipation."
Resident 2's June 2024, July 2024, August 2024, and September 2024 MARs documentation included Resident 2 was administered 93 doses of 93 potential doses between 06/18/2024 and 09/18/2024.

On 09/19/2024 at 12:17 P.M., Surveyor conducted an interview with Pharmacy Staff H about Resident 2's polyethylene glycol order. Pharmacy Staff H told Surveyor one 30 once-daily dose container of Resident 2's

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polyethylene glycol, as prescribed, was delivered to the facility from the pharmacy on 04/16/2024. If administered to Resident 2 as prescribed, the container would have been emptied on approximately 05/16/2024. Pharmacy Staff H told Surveyor one 30 once-daily dose container of Resident 2's polyethylene glycol, as prescribed, was delivered to the facility from the pharmacy on 06/18/2024. If administered to Resident 2 as prescribed, the container would have been emptied on approximately 07/18/2024. Pharmacy Staff H told Surveyor this medication was not delivered on an automatic cycle fill. Pharmacy Staff H said the facility would have to contact the pharmacy to request a refill of this medication.

Example 3: Resident 3

On 09/18/2024 at 1:42 P.M., Regional Facility RN B and Surveyor observed Resident 3's polyethylene glycol powder, as prescribed, within a medication cart located in the facility's medication room. Resident 3's polyethylene glycol powder container was affixed with a manufacturer's label including the container originally held 30 once-daily doses of 17 grams (or 60 once-daily doses of 8.5 grams based on practitioner's order). The container included a pharmacy label including Resident 3's practitioner's prescription for polyethylene glycol including, "Mix 1/2 capful (8.5 grams) in 4 to 8 ounces of liquid until dissolved and drink once a day." The pharmacy label included a delivery date to the facility of "07/06/[2024]." Photos #6 and #7. Surveyor observed approximately three quarters of the medication remained within the container. Regional Facility RN B verbally confirmed same amount remained and confirmed the facility did not have any additional containers of polyethylene glycol tabled for Resident 3.

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N 352	Continued From page 9 On 09/18/2024, Surveyor received Resident 3's record including a "Face Sheet," Resident 3's practitioner's orders, and Resident 3's MARs from Regional Facility RN B. Resident 3 was admitted to the facility on 04/10/2024. Resident 3's practitioner's orders dated 04/16/2024 included, "Polyethylene glycol 3350 (Miralax) 17 gm [gram] scoop powder bottle - take 8.5 g [grams] by mouth daily..." Resident 3's July 2024, August 2024, and September 2024 MARs documentation included Resident 3 was administered 69 doses of 75 potential doses between 07/06/2024 and 09/18/2024 from a 60 dose container, based on Resident 3's practitioner's order, with three quarters of the medication remaining in the container. On 09/19/2024 at 12:17 P.M., Surveyor conducted an interview with Pharmacy Staff H about Resident 3's polyethylene glycol order. Pharmacy Staff H told Surveyor one 30 once-daily dose container (or 60 once-daily dose of 8.5 grams based on practitioner's order) of Resident 3's polyethylene glycol, as prescribed, was delivered to the facility from the pharmacy on 07/06/2024. If administered to Resident 3 as prescribed and documented, the container would have been emptied on approximately 09/13/2024. Pharmacy Staff H told Surveyor this medication was not delivered on an automatic cycle fill. Pharmacy Staff H said the facility would have to contact the pharmacy to request a refill of this medication. Example 4: Resident 4 On 09/18/2024 at approximately 1:37 P.M., Regional Facility RN B and Surveyor observed	N 352		

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Resident 4's polyethylene glycol powder, as prescribed, within a medication cart located in the facility's medication room. Resident 4's polyethylene glycol powder container was affixed with a manufacturer's label including the container originally held 30 once-daily doses of 17 grams. The container included a pharmacy label including Resident 4's practitioner's prescription for polyethylene glycol including, "Take 1 capful (17 grams) by mouth every day. Mix powder with water - for constipation - fill to the line inside the cap." The pharmacy label included a "filled" date of "09/05/2024." Photos #3, #4, and #5. Surveyor observed the container was unopened with the protective seal remaining intact. Regional Facility RN B verbally confirmed the container had been unopened and confirmed the facility did not have any additional containers of polyethylene glycol tabled for Resident 4.

On 09/18/2024, Surveyor received Resident 4's record including a "Face Sheet," Resident 4's practitioner's orders, and Resident 4's MARs from Regional Facility RN B. Resident 4 was admitted to the facility on 04/22/2022. Resident 4's practitioner's orders dated 07/08/2024 included, "Polyethylene glycol 3350 oral powder...take 1 capful (17 grams) by mouth every day..." Resident 4's July 2024, August 2024, and September 2024 MARs documentation included Resident 4 was administered approximately 66 doses of 71 potential doses between approximately 07/10/2024 and 09/18/2024.

On 09/19/2024 at 12:33 P.M., Surveyor conducted an interview with Pharmacy Staff I about Resident 4's polyethylene glycol order. Pharmacy Staff I told Surveyor one 30 once-daily dose container of Resident 4's polyethylene glycol, as prescribed, was previously delivered to

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the facility from the pharmacy on 07/10/2024. If administered to Resident 2 as prescribed, the container would have been emptied on approximately 08/09/2024. Pharmacy Staff I told Surveyor one 30 once-daily dose container of Resident 4's polyethylene glycol, as prescribed, was last filled on 09/05/2024 and last delivered to the facility from the pharmacy on 09/10/2024. Pharmacy Staff I said s/he had photo documentation of the delivery on 09/10/2024. Pharmacy Staff I told Surveyor there were no other/additional polyethylene glycol container's delivered to the facility for Resident 4 between 07/10/2024 and 09/18/2024.

On 09/24/2024 at 12:29 P.M., Surveyor conducted an interview with Administrator A. Administrator A told Surveyor s/he was not aware Resident 2, Resident 3, and Resident 4 had not received their polyethylene glycol, as prescribed, before Surveyor's onsite visit on 09/18/2024. Administrator A told Surveyor Resident Care Coordinator C and/or Caregiver F were to be conducting medication cart audits on a weekly basis to check for expired medications only.

Example 5: Resident 6

Resident 6 was admitted to the facility on 04/19/2021 with diagnosis including dementia with behavioral disturbances, hypertension, anxiety, and tremors. Resident 6 had an activated healthcare power of attorney that made medical decisions on his/her behalf. Resident 6's ISP dated 04/10/2024 documented: "Medications: Resident is not able to self-administer medications. Takes psychotropic medication: Lorazepam 0.5 mg at bedtime and every two hours as needed for anxiety. Other medications:

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(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
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Metoprolol 25 mg ER ½ tab daily. Hold for SBP<110 or HR <55."

Resident 6's physician orders documented:
Escitalopram tab 20 mg with directions to take once daily for anxiety with a start date 04/16/2021 and discontinued date of 07/13/2024. Donepezil 10 g with directions to take once daily with a start date of 03/14/2021 and discontinued date of 07/13/2024. Metoprolol 25 mg with directions to take ½ tablet once daily with a start date of 04/14/2022, and the following parameters noted Hold for SBP<110 or HR <55.

Surveyor reviewed Resident 6's MAR for the months of July through September 2024, which documented:
"July 2024:
Donepezil 10 mg was documented as "med unavailable" or "not in/on cart" on the following dates: 07/04/2024, 07/08/2024, 07/09/2024.
Escitalopram 20 mg was documented as "med unavailable" or "not in/on cart", or "Withheld Per Dr/Rn Orders" on the following dates: 07/03/2024, 07/04/2024-07/07/2024, 07/09/2024, 07/ 11/2024, 07/12/2024."
The provider did not record Resident 6's vitals from July 2024-September 18 (day of survey) in regard to parameters set for Metoprolol.

The record did not include any other evidence to show the provider followed up with the pharmacy or physician to see the status of Resident 6's above medications.

On 09/18/2024 at 4:22 PM, Surveyor interviewed Administrator A and Regional Facility RN B regarding Resident 6's medication concerns. Regional Facility RN B stated staff would not hold Resident 6's psychotropic medication per

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N 352	Continued From page 13 parameters, so staff must be in a hurry and not selecting the correct response. Administrator A confirmed staff had not been recording Resident 6's vitals and s/he was not sure why. Administrator A noted there was not a place on the MAR to record the information, but the provider will work on fixing the issue. Summary: The provider did not ensure Resident 1, Resident 2, Resident 3, Resident 4, and Resident 6 received all prescribed medications in the dosage and at intervals prescribed by a practitioner.	N 352		
N 357	83.32(3)(m) Rights of Residents: Recording and filming In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Recording, filming, photographing. Not be recorded, filmed or photographed without informed, written consent by the resident or resident ' s legal representative. The CBRF may take a photograph for identification purposes. The department may photograph, record or film a resident pursuant to an inspection or investigation under s. 50.03(2), Stats., without his or her written informed consent. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure each resident had the right not to be recorded or filmed when an electronic surveillance camera was placed in a common space in the facility. This had the potential to effect 46 of 46 residents that resided there.	N 357		

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Findings include:

The provider is licensed to serve up to 56 residents in the client groups irreversible dementia/Alzheimer's and advanced aged. The facility is one level and all units are considered as "memory care." The unit has a dining area, common gathering spaces, kitchenette area, and a sunroom.

On 09/18/2024 at approximately 12:35 PM, Surveyor toured the facility. Surveyor observed 1 camera facing a large common space and sunroom towards the back of the building. Throughout the day, Surveyor observed activities being completed in this common area and residents meeting with visitors. No signs were posted about electronic monitoring.

On 09/18/2024 at 12:45 PM, Surveyor interviewed Environment Services Director D regarding cameras in the facility. Environment Services Director D led Surveyor to a small office area behind the receptionist's desk that contained a computer monitor with all camera angles in the facility. Environment Services Director D stated these cameras are live 24/7 and cover mostly non-resident areas. Surveyor asked about 1 camera that angled towards the large common space including the sunroom. Environment Services Director D stated the cameras had been up since s/he started in 2022 and s/he thought this angle was supposed to capture back exits but do see where it shows the large common space and sunroom. Environmental Services Director D stated another company monitors/services the cameras, so to make any changes, we would have to make a call.

On 09/18/2024 at 4:53 PM, Surveyor interviewed

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N 357	Continued From page 15 Administrator A and Regional Facility RN B about the facility's camera surveillance system. Administrator A stated s/he was aware of the camera angle that recorded the large common space and sunroom towards the back of the building. Administrator A reported the cameras had been installed since 2022. Surveyor asked Administrator A if residents had knowledge the cameras were live. Administrator A stated s/he was not sure. Administrator A and Regional Facility RN B stated they would contact the company that services the above camera to get it changed. The Department DQA Memo 16-001, Electronic Video Monitoring and Filming in BAL Regulated Facilities, dated 02/01/2016, read, in part: "Privacy is a resident right. Wis. Stats., § 50.09 and Wis. Admin Code §§ DHS 88.10(3) applicable to AFHs and DHS 83.32(3) applicable to CBRFs, are specifically related to preserving resident privacy in many areas. Those areas include: health care; treatment (both physical and emotional); living arrangements; caring for personal needs including toileting, bathing and dressing; visits by spouse or domestic partner; confidentiality of health and personal information and records; private and unrestricted communications; and the right to not be searched when there is a reasonable expectation of privacy. Due to these privacy protections, BAL has determined that electronic video monitoring and filming in the following locations of AFHs and CBRFs would infringe upon resident privacy rights: Resident bedrooms; Facility or resident bathrooms or shower rooms; Dining rooms; Therapy rooms; Visiting areas, lounges, multipurpose rooms, or	N 357		

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N 357	Continued From page 16 activity rooms; Hallways that lead to resident rooms; or Any other space where a resident may be seen meeting with visitors, engaging in an activity (including eating), sleeping, discussing their current condition, or receiving personal care, medical treatment or therapy. Due to concern about violating resident's right to privacy and right to a living environment that is as homelike as possible and the least restrictive, electronic video monitoring or filming in these locations will be viewed by the Department as a violation of resident privacy rights even with the residents' informed, written consent." The provider did not protect residents' privacy. Residents were filmed in a large common space and sunroom, where activities and resident visits occurred	N 357		
N 388	83.35(3)(c) Implement, follow the individual service plan Implementation. The CBRF shall implement and follow the individual service plan as written. This Rule is not met as evidenced by: Based on observation, interview, and record review, the provider did not ensure the individual service plan (ISP) for 1 of 1 resident (Resident 6) was followed as written. Resident 6 did not receive hands on assistance while eating breakfast on 09/18/2024 as indicated on his/her ISP. Findings include: On 09/18/2024, Surveyor reviewed Resident 6 record and identified the following:	N 388		

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N 388	Continued From page 17 On 09/18/2024 between 8:34 AM-8:55 AM, Surveyor observed breakfast served to residents in the dining room. Surveyor observed Resident 6 served a plate of scrambled eggs, diced watermelon, and 2 sausage links. Staff set the plate in front of Resident 6 and walked away. Resident 6 fed him/herself with their fingers. Resident 6 dropped many of the food items on his/her person and in his/her broda chair. During the observation, staff attended to other residents and did not sit next to Resident 6. Resident 6 was seen reaching over and taking his/her table mates food and juice cups without staff intervention. Resident 6 was admitted to the facility on 04/19/2021 with diagnosis including dementia with behavioral disturbances, anxiety, and tremors. Resident 6 had an activated healthcare power of attorney that made medical decisions on his/her behalf. Resident 6's ISP dated 04/10/2024 documented: "Dining: [Resident 6] will need hands on assistance for meals. Will try to feed [him/herself] but will need assistance. Current Diet order: General diet, regular texture, thin liquids." On 09/18/2024 at 12:32 PM, Surveyor observed lunch and interviewed Caregiver N. Caregiver N was assisting Resident 6 with his/her meal. Caregiver N stated Resident 6 is supposed to get full feeding assistance with each meal. Caregiver N did not know why Resident 6 did not get assistance with breakfast. On 09/18/2024 at 4:53 PM, Surveyor interviewed Administrator A and Regional Facility RN B about the above observations for Resident 6. Administrator A acknowledged Resident 6	N 388		

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N 388	Continued From page 18 required hands-on assistance for all meals and did not know why staff did not provide this service.	N 388		
N 389	83.35(3)(d) Service plans updated annually or on changes Individual service plan review. Annually or when there is a change in a resident ' s needs, abilities or physical or mental condition, the individual service plan shall be reviewed and revised based on the assessment under sub. (1). All reviews of the individual service plan shall include input from the resident or legal representative, case manager, resident care staff, and other service providers as appropriate. The resident or resident ' s legal representative shall sign the individual service plan, acknowledging their involvement in, understanding of and agreement with the individual service plan. This Rule is not met as evidenced by: Based on observation, interview, and record review, the provider did not ensure Resident 5's individual service plan (ISP) was updated when there was a change in Resident 5's mobility and dietary needs. Findings include: On 09/18/2024, Surveyor reviewed Resident 5's record and identified the following: Resident 5 admitted to the facility on 12/30/2020 with diagnoses including Alzheimer's. Resident 5 had an activated healthcare power of attorney that assisted in making decision on Resident 5's	N 389		

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behalf.

Resident 5's progress notes documented:

"09/04/2024 8:03 AM- ...CMH confirmed [Resident 5] has a fractured collar bone on right side ...Writer and 1st shift sup. ambulated with [Resident 5]. At baseline, [Resident 5] often required a two person assist for transfers, as [Resident 5] would resist attempts to rise from seated positions, to move from dining room to activity area, etc ... Utilized two-person assist to lift [Resident 5] from wheelchair, utilized gait belt to stabilize [Resident 5] ... [Resident 5] able to ambulate with hands on assist using gait belt, however, [Resident 5] significantly leaning to R side when standing/ambulating ...ISP regarding hospitalization and injury placed out for staff update and direction ...

09/05/2024 3:15 PM- CHANGE OF CONDITION: Care Plan Meeting held today ... HCPOA has expressed concerns for additional falls given [Resident 5's] increased fatigue and leaning when ambulating. HCPOA has requested [Resident 5] ambulate with gait belt and two person assist to ensure future falls do not occur. HCPOA also mentioned request for [hospice provider] regarding broda chair/high back wheelchair for [Resident 5's] comfort ...

09/06/2024 8:20 AM- ALERT CHARTING: [Resident 5] officially admitted to [hospice provider] Services. ISP placed out for staff to update and awareness ..."

Resident 5's ISP, completed on 11/13/2023, with signatures on 04/25/2024, documented:

"Mobility-

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Does Resident need reminders, cues, or guidance during task or is the staff only involved for part of the time and the Resident is able to initiate or complete independently? Yes- Partial Assist.

Transfers-
Does Resident need reminders, cues, or guidance during task or is the staff only involved for part of the time and the Resident is able to initiate or complete independently? Yes- Partial Assist/Partial Independent.
Does the Resident utilize any specialty devices to assist with transfers such as: Stand-up Lift, Full-body Lift, Slide Board, Gait Belt, Transfer Pole. Other? No.

Postural Support/ Device with Restraining Qualities-
Does the Resident utilize any postural supports / supportive devices that may have restraining qualities? No.

Diet and Nutrition-
What is the Resident's current Diet Order? General diet, regular texture, thin liquids.
Does Resident physician order indicate a need for a modified consistency liquid? No.
Does Resident require the use of specialized or adaptive equipment such as: Weighted utensils; Nosey Cup, Separated Plate, Hand-held cups for all foods, Other. No."

Resident 5's Interim Service Plan updates documented:

"09/04/2024 [Resident 5] is now signed on with Hospice: [Resident 5] is now signed on with hospice provider. Please call hospice provider before contacting 911, for any change in

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condition, with questions or concerns, or for advice. Comfort medications will be coming from hospice provider.

09/04/2024 Hospital: [Resident 5] was diagnosed with fractured collar bone. Must wear sling at all times until further notice. Place [Resident 5] on alert charting for 72 hours. Please check on [Resident 5] three times per shift to offer assistance. Please monitor for the following: shortness of breath: take O2 level, start on 2L oxygen if low (below 88%) if available, changes in assistance needs with ADL;s, provide as necessary, rash, nausea, vomiting, and dizziness if changes in medications, dizziness/ weakness. If any of the above are noted, please alert MT/RCC/LN.

09/10/2024 Diet Change: [Resident 5] has been downgraded to puree texture diet for all meals. [His/her] liquids are still thin. [Resident 5] needs help eating at all meals."

Resident 5's Face Sheet documented:
"Diet: Regular, thin liquids".

On 09/18/2024 at 8:05 AM, Surveyors observed breakfast service. Resident 5 was observed sitting in a broda chair at a dining table. S/he was wearing a sling on his/her right shoulder/arm. Surveyor observed Resident 5 being provided his/her meal on a separated plate and the beverage provided was in a spill proof cup that had handles and a cover with a drinking spout.

On 09/18/2024 at 11:30 AM, Surveyor interviewed Caregiver N regarding Resident 5's injury and transfer status. Caregiver N stated Resident 5 was a two-person assist with gait belt and used a broda chair for mobility.

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N 389	Continued From page 22 Resident 5's ISP, Interim Service Plan updates, and Face Sheet did not indicate accurate mobility or dietary information. On 09/18/2024 at 4:52 PM, Surveyors interviewed Administrator A and Regional Facility RN B. Surveyor asked about the inaccuracies identified for Resident 5. Administrator A agreed that Resident 5's change of condition would have required a full ISP review. Administrator A stated s/he was not aware of Resident 5's diet change to puree texture and said the broda chair was being used for safety and comfort. Administrator A stated s/he and Caregiver/ Former RCC F, would complete a full ISP update to include the concerns discussed; 2-person transfer status and broda chair for mobility, and the modified dining ware Resident 5 utilizes.	N 389		
N 431	83.38(1)(g) Health monitoring. 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. 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: Health monitoring. 1. The CBRF shall monitor the health of residents and make arrangements for physical health, oral health or mental health services unless otherwise arranged for by the resident. Each resident shall have an annual physical health examination completed by a physician or an advanced practice nurse as defined in s. N 8.02(1), unless seen by a physician or an advanced practice nurse as defined in s. N 8.02(1) more frequently. 2. When indicated, a	N 431		

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N 431	Continued From page 23 CBRF shall observe residents ' food and fluid intake and acceptance of diet. The CBRF shall report significant deviations from normal food and fluid intake patterns to the resident ' s physician or dietician. 3. The CBRF shall document communication with the resident ' s physician and other health care providers, and shall record any changes in the resident ' s health or mental health status in the resident ' s record. This Rule is not met as evidenced by: Based on interview and record review, the provider did not ensure Resident 1's health was monitored to meet Resident 1's needs in relation to a change in condition. On the morning of 07/31/2024, Resident 1 was hospitalized with diagnoses including cellulitis [bacterial skin infection, potentially serious] to left forehead, left forehead lesion complicated by maggot [fly larva] infestation, and groin rash described as excoriated [raw, irritated skin] with purulent discharge [containing pus, a sign of infection]. The facility did not observe and document within Resident 1's record symptoms of cellulitis to Resident 1's forehead and/or face after Resident 1's hospice agency applied a protective dressing to a growth on Resident 1's left forehead on the morning of 07/30/2024. The facility did not observe and document within Resident 1's record maggot activity found in Resident 1's clothing	N 431		

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prior to being identified by emergency medical technicians (EMTs) before transport to the hospital, and the facility did not observe and document within Resident 1's record symptoms of Resident 1's infected groin rash prior to it being identified at the hospital.

The findings include:

On 08/05/2024, the department received allegations including a resident's health was not monitored to meet the resident's changing health needs.

On 09/18/2024 at 11:37 A.M., Surveyor conducted an interview with Caregiver/Former Residential Care Coordinator (Caregiver) F regarding Resident 1. Caregiver F told Surveyor Resident 1 was sent to the hospital on 07/31/2024 and did not return to the facility before being officially discharged from the facility. Caregiver F told Surveyor Resident 1 was forgetful, preferred to stay in his/her room most of the time, and required caregiver assistance with grooming, dressing, hygiene, and incontinence care. Caregiver F told Surveyor Resident 1 required assistance of 1 or 2 caregivers with pivot transfers or Resident 1 was assisted with the use of a sit-to-stand mechanical lift to transfer out of and into Resident 1's wheelchair or recliner. Caregiver F told Surveyor Resident 1 no longer utilized his/her bed for sleeping prior to Resident 1's discharge from the facility, preferring to sleep in his/her recliner located in Resident 1's room. Caregiver F said Resident 1 was receiving hospice agency services in the months leading to Resident 1's discharge from the facility. Caregiver F told Surveyor Resident 1's room was "always being cleaned" related to Resident 1's friends bringing soda and other snacks to

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Resident 1 and leaving them in Resident 1's room. Caregiver F said Resident 1 often dripped soda on to his/her room floor and left his/her soda containers on the floor. Caregiver F said s/he would not have been surprised by flies being in Resident 1's room because s/he could be "dirty." Caregiver F told Surveyor Resident 1 had 2 cancerous growths on his/her head, one located on the top of Resident 1's head and the other horn-shaped growth located on Resident 1's left forehead. Caregiver F told Surveyor Resident 1 did not like to leave his/her bedroom without a hat on his/her head because s/he was self conscious of the growths. Caregiver F told Surveyor Resident 1 would pull his/her hat down onto his/her forehead, at times, irritating his/her left forehead growth. Caregiver F said Resident 1 would also pick at his/her left forehead growth with his/her fingers, at times, causing the growth to bleed. Caregiver F said Resident 1's left forehead growth was draining a clear liquid with an odor just prior to Resident 1 being sent to the hospital on 07/31/2024. Caregiver F said Resident 1's hospice agency and facility caregivers tried to keep Resident 1's left forehead growth covered with a dressing to prevent Resident 1 from picking at the growth. Caregiver F told Surveyor if Resident 1's left forehead dressing would fall off or if Resident 1 had picked the dressing off, facility caregivers would reapply a dressing to cover Resident 1's left forehead growth and inform Resident 1's hospice agency during their next in-person visit with Resident 1. Caregiver F told Surveyor the facility caregivers would use the facility's own supply of dressings or unused dressings left behind from Resident 1's hospice agency. Caregiver F told Surveyor facility caregivers did not need to call Resident 1's hospice agency to apply a dressing to Resident 1's left forehead growth, but caregivers may have

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called to update Resident 1's hospice agency of the need for a dressing being applied. Caregiver F told Surveyor facility caregivers were to monitor the growths on Resident 1's head.
Caregiver F told Surveyor s/he worked both the morning shift and the afternoon/evening shift on Tuesday, 07/30/2024, the day before Resident 1 was sent to the hospital. Caregiver F said s/he had Resident 1 on his/her list to provide cares. Caregiver F said s/he was not aware of and did not observe a rash to Resident 1's groin on 07/30/2024, but did observe and apply barrier cream to redness between Resident 1's buttocks. Caregiver F said s/he did not see any bug activity, including maggots, on Resident 1's clothing, wheelchair, head growths, or in Resident 1's room. Caregiver F told Surveyor s/he did not work at the facility on 07/31/2024, but Caregiver G called Caregiver F on 07/31/2024 and told Caregiver F about the emergency medical technicians [EMTs] reported maggots were found on Resident 1.

On 09/18/2024 at 12:00 P.M., Surveyor conducted an interview with Caregiver G regarding Resident 1. Caregiver G told Surveyor Resident 1 required assistance with incontinence cares. Caregiver G said Resident 1 would ask for assistance to be transferred to the toilet for a bowel movement, but not for urination. Caregiver G said caregivers were to check Resident 1 for urinary incontinence about every 2 hours and provide cares if s/he was incontinent. Caregiver G told Surveyor Resident 1 liked to stay in his/her room and preferred to sleep in his/her recliner. Caregiver G told Surveyor Resident 1 utilized a wheelchair for mobility and required the assistance of 2 caregivers with all transfers. Caregiver G told Surveyor a friend of Resident 1 would often bring a fruit basket containing fruit

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and "lunch meats" and leave it in Resident 1's room. Caregiver G said Resident 1 did not eat much from the baskets, and the caregivers would have to keep an eye on the baskets and throw them away when they got old. Caregiver G said s/he observed fruit flies and house flies in Resident 1's room because of the food kept in Resident 1's room and Resident 1's "soda jugs on the floor." Caregiver G said Resident 1's room was cleaned on a daily basis between the facility's housekeeping staff and caregivers. Caregiver G told Surveyor s/he did not recall Resident 1 complaining of itchy skin on his/her arms and/or legs and did not recall Resident 1 scratching his/her arms and/or legs. Caregiver G said Resident 1 was to have Eucerin cream applied to legs and feet every day. Caregiver G said Resident 1 required caregiver assistance with dressing and Resident 1 "didn't like to change his/her clothes." Caregiver G said s/he would have to re-approach and convince Resident 1 needed to change his/her clothes. Caregiver G told Surveyor Resident 1 had a cancerous growth on his/her left forehead that would bleed when s/he would pick at it or pull his/her hat down and aggravate the growth. Caregiver G said Resident 1 would say the growth "itched." Caregiver G said Resident 1's left forehead growth had a bad odor that worsened before Resident 1 left for the hospital because s/he kept picking at it. Caregiver G told Surveyor Resident 1 was picking at the left forehead wound more during the week leading up to 07/31/2024. Caregiver G said facility caregivers would clean and cover the growth when it would bleed and then call hospice with an update. Caregiver G said s/he worked on 07/30/2024, saw Resident 1, and did not think Resident 1's face looked inflamed. Caregiver G said Hospice Agency Licensed Practical Nurse

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(Hospice LPN) K cleaned and applied a dressing to Resident 1's left forehead growth on 07/30/2024.
Caregiver G told Surveyor s/he was in the middle of conducting the morning medication pass in the facility's dining room on the morning of 07/31/2024. Caregiver G said Hospice Agency Registered Nurse (Hospice RN) J asked Caregiver G to call 911 related to Resident 1 not feeling well and having a fever (elevated temperature). Caregiver G said s/he called a local non-emergency ambulance to transport Resident 1 to the hospital. Caregiver G said s/he looked at Resident 1 after calling for the ambulance and observed the left side of Resident 1's face was inflamed. Caregiver G told Surveyor Resident 1 was seated in his/her wheelchair near the front entrance of the facility when the EMTs arrived. Caregiver G said facility caregivers assisted the EMTs transfer Resident 1 from the wheelchair to the EMT's stretcher and observed maggots on Resident 1's face and in Resident 1's clothes. Caregiver G said s/he saw 3 maggots on the seat cushion located in Resident 1's wheelchair after Resident 1 was transferred to the stretcher. Caregiver G said Resident 1's wheelchair was supposed to be cleaned on Resident 1's shower day. Caregiver G said Resident 1's bedroom recliner, including under the recliner, and the floor in Resident 1's bedroom were checked and no maggots were found.
Caregiver G told Surveyor a night shift caregiver got Resident 1 "up for the day" before s/he started his/her shift on 07/31/2024 and s/he did not provide any cares for Resident 1.

On 09/18/2024 at 1:59 P.M., Surveyor conducted an interview with Environmental Services Staff (Housekeeper) E. Housekeeper E told Surveyor

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Environmental Services Director D wanted Resident 1's room cleaned daily because Resident 1 would spill soda and was "messy" with snacks and to check his/her room a second time each day to see if it needed to be cleaned again. Housekeeper E told Surveyor s/he did observe fruit flies and house flies in Resident 1's room, but "not tons of flies." Housekeeper E told Surveyor s/he saw 4 to 5 live maggots on the seat of Resident 1's wheelchair before s/he and Environmental Services Director D took the wheelchair outside on the back patio to "hose" it down. Housekeeper E told Surveyor s/he was shocked to see maggots in Resident 1's wheelchair. Housekeeper E said s/he checked Resident 1's room after Resident 1 left for the hospital and found no maggots in Resident 1's room, including Resident 1's recliner.

On 09/18/2024 at 2:20 P.M., Surveyor conducted an interview with Environmental Services Director D. Environmental Services Director D told Surveyor s/he believed Resident 1 was sleeping in his/her wheelchair and not his/her recliner leading up to the day Resident 1 was sent to the hospital on 07/31/2024. Environmental Services Director D said the door leading from the facility's sunroom to the outdoor patio was often propped open during the day because the door closes too fast for the residents to get through the door. Environmental Services Director D said there were flies in the facility during June 2024 and July 2024 and s/he was constantly cleaning up flies in the facility's sunroom.

On 09/18/2024, Surveyor received Resident 1's "Face Sheet" including Resident 1's medical history/diagnoses from Administrator A. Resident 1 was admitted to the facility on 03/22/2023 and had diagnoses including "Squamous cell

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carcinoma of scalp," dementia, depression, insomnia, and "Adjustment Disorder with anxious mood." Surveyor received Resident 1's practitioner's orders for medications, Resident 1's July 2024 medication administration records [MARs], and Resident 1's caregiver "charting notes." Resident 1's practitioner's orders for medications included:
* Eucerin cream to be applied "topically to [Resident 1's] lower extremities and feet once a day" dated 02/08/2024;
* Baza protect cream (barrier cream) to be applied "topically twice daily as needed to irritated skin" dated 02/08/2024;
* Nystatin cream to be applied "topically once a day as needed for fungal infection to lower abdominal fold" dated 02/08/2024; and
* Sensicare barrier ointment to be applied "topically to peri-area twice daily as needed for breakdown" dated 02/08/2024.
Resident 1's July 2024 included documentation Caregiver G administered Resident 1's 07/30/2024 Eucerin cream, as prescribed.
Resident 1's July 2024 included documentation Caregiver G administered Resident 1's 07/31/2024 morning medications, including Eucerin cream, as prescribed.
Resident 1's July 2024 did not include documentation of administration of Resident 1's prescribed 'as needed' Baza barrier cream, Nystatin cream, or Sensicare barrier ointment between 07/01/2024 and 07/31/2024.
Resident 1's practitioner's orders provided to Surveyor did not include any orders for the facility caregivers related to Resident 1's left forehead growth.
Resident 1's "charting notes" for July 2024 did not include any documentation identifying Resident 1's left forehead growth had a bad odor leading up to Resident 1's admission to the hospital on

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N 431	Continued From page 31 07/31/2024, as told to Surveyor on 09/18/2024 by Caregiver F and Caregiver G. On 09/18/2024 at 9:15 A.M., Surveyor conducted an interview with Administrator A. Administrator A told Surveyor the facility did not have any treatment orders related to Resident 1's left forehead growth. Administrator A said if a bandage was applied to Resident 1's left forehead growth and it fell off, the caregivers would call Resident 1's hospice agency. Administrator A said the facility caregivers were to contact Resident 1's hospice agency with any changes in Resident 1's condition. On 09/18/2024 at 5:23 P.M., conducted an interview with Administrator A and Regional Facility Nurse B. Administrator A told Surveyor Resident 1 was to have received a shower twice weekly by facility caregivers with accompanying documentation of Resident 1's skin condition. Administrator A said the caregivers were to document any refusals by Resident 1 within the shower and skin observation documentation. Regional Facility Nurse B told Surveyor Caregiver F assisted Resident 1 with a shower 4 days before Resident 1 was hospitalized. Surveyor asked Administrator A to provide the facility's documentation of Resident 1's showers, given and/or refused, and skin observations from 06/01/2024 through 07/31/2024. On 09/19/2024 at 1:30 P.M., Surveyor received an email from Administrator A including, "Here are the additional documents that [Surveyor] requested. The email included the facility's June 2024 and July 2024 "Skin Monitoring: PCA [personal care aide] Shower Review" documentation for Resident 1. The documents included the following direction to caregivers,	N 431		

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"Perform a visual inspection of resident's skin when giving the resident a shower. Report an abnormal looking skin (as described below) to the med-tech [medication technician] immediately. Forward any problems to the RCC [residential care coordinator]/HSD [health services director] for review. Use this form to show the exact location and description of the abnormality, using the body chart below describe and graph all abnormalities by number." Resident 1's skin monitoring/shower review documentation included the following consecutive notes:
Documentation dated 06/28/2024 included, "[Resident 1] picking at cancer wound on the side of [his/her] eyebrow causing it to bleed."
Documentation dated 07/03/2024 included, "Refused."
Documentation dated 07/05/2024 included, "Nails cleaned [and] cut, blood w/ [with] nails, barrier cream [applied] to coccyx for redness, lotion applied to BLUE [bilateral lower and upper extremities] for dry/scabs."
A skin monitoring/shower review dated 07/10/2024 did not include a documented note, but did identify "7. Redness" to Resident 1's buttocks as the area was circled on the "body chart."
Documentation dated 07/12/2024 included, "Showered w/[hospice] this A.M. [morning]."
A skin monitoring/shower review dated 07/19/2024 did not include a documented note, but did identify "7. Redness" to Resident 1's buttocks as the area was circled on the "body chart." The following "skin care" were circled on the review: lotion, barrier cream, and nails trimmed.
A skin monitoring/shower review dated 07/24/2024 did not include a documented note, but did identify "7. Redness" to Resident 1's buttocks as the area was circled on the "body

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chart."
A skin monitoring/shower review dated 07/26/2024 did not include a documented note nor were any areas of concern circled on the "body chart." There were no further skin monitoring/shower review documents provided to Surveyor.

On 09/18/2024, Surveyor received Resident 1's facility caregiver "charting notes" and hospice "visit notes" as requested by Surveyor.
A facility charting note dated 06/28/2024 included, "Following the conclusion of the AM [morning] meal, [Caregiver F] noted [Resident 1] to have some dried blood on the side of [Resident 1's] face, dripping down from facial growth." The note included, "Took [Resident 1] to their private bathroom, cleansed area with simple saline wash and gauze pads." The note included, "After cleaning area, [Caregiver F] applied foam bordered bandage with hopes the barrier of a bandage will deter [Resident 1] from continuing to pick at area. [Resident 1's] fingers and finger nails had blood on them, likely from picking at growth as [Resident 1] has no blood/open areas anywhere else at this time." The note included, "No new concerns at this time. Will continue to monitor."
A hospice note dated 07/02/2024 included, "[Hospice LPN K] toileted [Resident 1] and provided peri-cares as [s/he] [was] incontinent of urine at this time...Small reddened area to buttock, barrier cream applied." The documentation included, "L [left] side of forehead growth is appearing smaller, no drainage noted and also left OTA [open to air]."
A facility charting note dated 07/02/2024 included, "Will continue to monitor [Resident 1] and provide [hospice] with updates and concerns as needed. Verbal reminder to staff during team stand up

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[meeting] to ensure barrier cream is applied to [Resident 1's] bottom to prevent redness/skin breakdown."
A facility charting note date 07/05/2024 included, "[Resident 1] was seated near dining/front desk area in their wheelchair and stopped [Caregiver F] when passing, requesting assistance going to the bathroom. Assisted [Resident 1] to personal bathroom." The note included, "Redness noted between [Resident 1's] buttock, barrier cream applied. Removed [Resident 1's] wheelchair cushion and wiped down wheelchair while [Resident 1] used the toilet as wheelchair was full of crumbs/food from meals. Small, dried bits of blood noted to side of [Resident 1's] face, reminded [Resident 1] not to pick at facial/scalp growths, cleaned off dried blood with damp paper towel."
A hospice note dated 07/09/2024 included, "Growth to L [left] side forehead present with no drainage from area. No need for dressing to be placed."
A facility charting note dated 07/09/2024 included, "Will continue to monitor and provide [hospice] with updates as needed."
A facility charting note dated 07/12/2024 included, "[Resident 1] continues to pick at growths on scalp/facial area until areas bleed. [Resident 1] provided reminders by [Hospice RN J] and community [facility] staff to cease picking, however, will quickly return to touching/picking growths. Will continue to provide reminders and redirections to stop picking behaviors as needed. No new concerns at this time."
A facility charting note dated 07/16/2024 included, "No new concerns at this time. Will continue to monitor redness on [Resident 1's] bottom and apply barrier cream as needed. No open areas at this time."
A facility charting note dated 07/18/2024 included,

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"No new concerns. Will continue to monitor resident for changes and provide updates to [hospice] team as needed.

On 09/19/2024 at 1:25 P.M., Surveyor conducted an interview with Hospice RN J including review of Resident 1's hospice notes. Hospice RN J told Surveyor Resident 1 started receiving hospice services on 10/06/2023 while residing at the facility. Hospice RN J told Surveyor Resident 1's hospice plan of care included 1 RN visit per week, 1 LPN visit per week, and a caregiver visit twice weekly with an option for additional "as needed" RN visits based on Resident 1's needs since October 2023. Hospice RN J said his/her and Hospice LPN K's visits included services such as taking Resident 1's vital signs with each visit, incontinence care and/or toileting, if needed, grooming, if needed, and observing and providing treatment for Resident 1's scalp and face growths. Hospice RN J told Surveyor Resident 1's twice weekly caregiver visits included assistance with a shower once a week, a partial bath once a week, if needed, incontinence care, and assistance with any activities of daily living Resident 1 may have needed during these visits. Hospice RN J said there were no reports of Resident 1 refusing to participate in bathing and/or any activities of daily living/cares provided by hospice caregivers during the month of July 2024. Hospice RN J said Resident 1 always wore a baseball cap and s/he was not aware this cap ever aggravated Resident 1's forehead growth. Hospice RN J said Resident 1's left forehead growth was left open to air since Resident 1's radiation treatments in June 2024. Hospice RN J said the only time Resident 1's left forehead growth was ever covered with a dressing since June 2024 was if Resident 1 picked at that growth causing it to bleed or drain fluid. Hospice RN J

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said it was not uncommon to see flies in the facility and had seen the door propped open many times between the facility's sunroom and the outdoor patio.
Hospice RN J and Surveyor discussed Hospice RN J's hospice note dated 07/22/2024 including, "[Hospice RN J] was met at the door by [Resident 1] stating that [s/he] needed to use the restroom and was very apologetic. [Hospice RN J] reassured [Resident 1] that everything was okay and that [Hospice RN J] was there to assist." The documentation included, "Peri and incontinence care provided." The documentation included, "No concerns voiced by facility staff at this time."
Hospice RN J told Surveyor s/he assisted Resident 1 with toileting, incontinence care, as noted, and did not observe a rash to Resident 1's groin during this visit. Hospice RN J said s/he observed no maggot or other bug activity associated with Resident 1 during this visit.
Hospice RN J told Surveyor this was that last time s/he visited Resident 1 at the facility until s/he conducted an "as needed' visit on the morning of 07/31/2024.
Hospice RN J told Surveyor s/he was aware Hospice LPN K applied a dressing to Resident 1's left forehead grown on 07/30/2024 related to Resident 1's picking at the growth. Hospice RN J said this was the first time s/he was aware of a dressing being applied to Resident 1's left forehead growth since June 2024.

On 09/23/2024 at 9:30 A.M., Surveyor conducted an interview with Hospice RN J and Hospice LPN K including review of Resident 1's hospice notes.
Hospice RN J, Hospice LPN K, and Surveyor discussed Hospice LPN K's hospice note dated Friday, 07/26/2024, including, "Upon arrival [Resident 1] is sitting in [his/her] wheelchair in common area eating graham crackers. [Resident

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1] is alert and accepts visit from [Hospice LPN K]. Does not wish to go to [his/her] room for visit today so we went and sat by the window and looked outside." The documentation included, "L [left] forehead growth remains intact, no drainage noted and left OTA [open to air]. [Resident 1] will pick at area at times. Has small scabs on lower arms from scratching at skin." The documentation included, "Activities was going to be making s'mores but [Resident 1] does not want to go outside. Instead decides to sit in the sunroom." The documentation included, "No new concerns voiced at this time." Hospice LPN K told Surveyor there was no evidence during his/her 07/26/2024 visit Resident 1 had been picking at his/her left forehead growth, it remained dry at that time. Hospice LPN K said s/he the scabs on Resident 1's arms appeared recent and s/he had not observed them to Resident 1's arms prior to 07/26/2024. Hospice LPN K said s/he did not go into Resident 1's room nor did s/he assist Resident 1 with toileting or incontinence cares during this visit. Hospice RN J and Hospice LPN K said this was the last visit hospice had with Resident 1 before the weekend and prior to the morning of Tuesday, 07/30/2024.

A facility charting note provided to Surveyor on 09/18/2024 dated 07/26/2024 included, "No new concerns at this time. Will continue to monitor."

On 09/23/2024 at 9:30 A.M., Surveyor conducted an interview with Hospice RN J and Hospice LPN K including review of Resident 1's hospice notes. Hospice RN J, Hospice LPN K, and Surveyor discussed Hospice LPN K's hospice note dated Tuesday, 07/30/2024 at 10:00 A.M. until 10:45 A.M., including, "Upon arrival [Resident 1] was sitting near the front desk asking for help. [Resident 1] has a piece of tissue in [his/her]

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hand with scattered blood spots on the tissue. [Hospice LPN K] assisted [Resident 1] to [his/her] room. [Hospice LPN K] saw that [his/her] L [left] forehead growth now appears larger and has small amounts of blood coming from area. Some very light pink surrounding skin. Not warm to the touch. [Hospice LPN K] cleansed area with wound cleanser and applied xeroform [wound dressing] followed by bordered foam dressing. [Resident 1] tolerated well, with some grimacing when touching area. [Resident 1] has blood under nails, appears [s/he] was picking at area. [Hospice LPN K] washed [his/her] hands well. [Hospice LPN K] also shaved [Resident 1]. When shaving [him/her], [Resident 1] became anxious and started to scratch at [his/her] arms saying, "It's my nerves, it's my nerves, honey." [Resident 1] does have small scabs on lower arms from scratching. [Resident 1] then started touching bandage saying, "Oh honey, I [Resident 1] don't know why this is hurting me." Then would also look in the mirror and say, "Oh, you [Hospice LPN K] did this? It looks good." (Referring to the bandage). [Hospice LPN K] asked [Resident 1] if [s/he] would like some pain medication and something to help [his/her] anxiety. [Resident 1] states, "Oh yes. Thank you so much, honey." [Resident 1] began watching T.V. [television]. Writer obtained morphine [pain medication] and lorazepam [psychotropic medication] from [Caregiver G]. [Hospice LPN K] administered medication to [Resident 1]." The documentation included, "[Hospice RN J] updated and will follow up on next visit." Hospice LPN K told Surveyor Resident 1's left forehead growth did not look like an open wound during this visit on 07/30/2024. Hospice LPN K said Resident 1's growth was moist, not dry like it was on 07/26/2024. Hospice LPN K said s/he observed a circle of light pink skin surrounding Resident 1's left forehead

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growth and Resident 1 complained of tenderness when the area was touched. Hospice LPN K said the area appeared irritated from Resident 1 picking at the growth. Hospice LPN K said s/he did not observe any bug or maggot activity associated with Resident 1's forehead growth. Hospice LPN K said Resident 1 remained in his/her wheelchair and s/he did not assist Resident 1 with toileting and/or incontinence care during this visit. Hospice LPN K said Resident 1 was wearing a shirt and a pair of pants, and s/he did not observe any bugs or anything crawling on Resident 1 or his/her clothing during this visit. Hospice LPN K said Resident 1 complained of itching to his/her arms and said it was his/her nerves, and s/he never mentioned anything to Hospice LPN K about seeing bugs. Hospice LPN K said Resident 1's face was not swollen or red during this visit. Hospice LPN K said s/he updated Hospice RN J about the light pink skin surrounding the growth and that s/he had applied a bandage to Resident 1's forehead. Hospice LPN K said s/he did not see Resident 1 again after this visit.

A facility charting note provided to Surveyor on 09/18/2024 dated 07/30/2024 at 2:14 P.M. included, "[Resident 1] continues to pick at bandaged area, but has not removed bandage since [hospice] nurse applied. Will continue to monitor [Resident 1] to ensure [s/he] does not continue to pick at facial growths."

On 09/19/2024 at 1:25 P.M., Surveyor conducted an interview with Hospice RN J including review of Resident 1's hospice notes.
Hospice RN J and Surveyor discussed Hospice RN J's hospice note dated Wednesday, 07/31/2024 at 8:30 A.M. until 9:00 A.M., including, "While [Hospice RN J] was concluding a visit with

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another hospice patient, [Hospice RN J] could hear [Resident 1] screaming out in pain. [Hospice RN J] noted [Resident 1] to be holding [his/her] head and yelling out, "It hurts! It hurts!" [Resident 1] would only move hand briefly. [Hospice RN J] was able to note red inflamed area mid-forehead receding to left side of face. Area was warm and tender to touch making it painful for [Resident 1] to open left eye. [Hospice RN J] administered morphine 5 mg [milligrams] with 5 mg of lorazepam. [Hospice RN J] notified [Resident 1's Nurse Practitioner P] to update. [Resident 1's Nurse Practitioner P] encouraged to send [Resident 1] out to [hospital] emergency department to be evaluated for appropriate treatment." The documentation included, "Facility RCC [Resident Care Coordinator C] was instructed to send [Resident 1] out via 911." Hospice RN J said s/he was visiting a different resident at the facility on the morning of 07/31/2024 when s/he heard Resident 1 screaming in the dining room. Hospice RN J said s/he observed Resident 1 sitting in his/her wheelchair at a table in the dining room and breakfast was being served. Hospice RN J told Surveyor the facility had not contacted hospice after Hospice LPN K's visit on the morning of 07/30/2024 to report any changes in Resident 1's condition. Hospice RN J said his/her next visit with Resident 1 was scheduled for 08/01/2024, but s/he conducted an "as needed" visit with Resident 1 on 07/31/2024 based on his/her observations of Resident 1 in the dining room. Hospice RN J said s/he observed a dressing to Resident 1's left forehead, and s/he did not know if it was the same dressing Hospice LPN K applied on 07/30/2024. Hospice RN J said s/he did not remove the bandage, s/he did not observe Resident 1's left forehead growth, and immediately asked Resident Care Coordinator C

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to call 911 for Resident 1. Hospice RN J said s/he had no more interaction with Resident 1 after s/he asked Resident Care Coordinator C to call 911 and s/he was not there when the EMTs [emergency medical technicians] arrived at the facility.
Hospice RN J and Surveyor discussed Hospice RN J's hospice note dated Wednesday, 07/31/2024 at 8:30 A.M. until 9:00 A.M., including, "[Hospice RN J] called later to get report from emergency department. [Hospice RN J] spoke with [Hospital Nurse Q] who stated that [Resident 1] was being admitted for severe cellulitis to [his/her] face. [Hospital Nurse Q] also suggested reaching out to PCP [Resident 1's Nurse Practitioner P] and facility regarding a "fungal infection to groin with excoriation." The documentation included, "[Hospice RN J] then received a call from [Resident 1's Nurse Practitioner P] with update on [Resident 1]. [Resident 1's Nurse Practitioner P] stated that emergency provider voiced concerns with "poor outpatient wound care" due to the amount of maggots from site. Writer reported to [Resident 1's Nurse Practitioner P] that there was no wound care. Mass to forehead had been left open to air. It was explained that [Hospice LPN K] there [at facility] the previous day covered mass to reduce "picking" from [Resident 1] that caused bleeding." Hospice RN J told Surveyor s/he initially became aware of Resident 1's groin rash and the maggots associated with Resident 1 when Resident 1's Legal Guardian O called Hospice RN J and Hospice RN J said s/he was surprised. Hospice RN J told Surveyor s/he did not know how the facility caregivers assisted resident 1 on the morning of 07/31/2024 and did not notice any maggot activity, "I [Hospice RN J] can't answer that." Hospice RN J told Surveyor the facility had not contacted hospice to report the development

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of a rashto Resident 1's groin following Resident 1's visit on 07/22/2024 when assistance with Resident 1's incontinence care and/or toileting was last provided by hospice.

On 09/18/2024, Surveyor received Resident 1's facility caregiver "charting notes" as requested by Surveyor.
A facility charting note dated 07/31/2024 at 9:30 A.M. included, "[Resident 1] is being sent out via hospice request for cancer wound on forehead."
A facility charting note dated 07/31/2024 at 11:55 A.M. included, "Upon [Resident 1] being sent out, staff and ambulance team noticed that [Resident 1] had maggots coming out of the cancer wound on [his/her] head. AM [morning] caregiver that got [him/her] dressed did not see any type of maggot on [Resident 1's] body when they got [him/her] up and dressed." This document differs from Caregiver G's interview on 09/18/2024 at 12:00 P.M. when s/he told Surveyor a night shift caregiver got Resident 1 "up for the day" before s/he started his/her shift on 07/31/2024 and s/he did not provide any cares for Resident 1.
Administrator A's charting note dated 08/01/2024 included, "[Resident 1] was admitted to hospital on 07/31/2024 with serve [sic] cellulitis and bad yeast infection."

On 08/07/2024, Surveyor received Resident 1's fire department incident record dated 07/31/2024. The documentation included, "Upon arrival to [the facility] staff had [Resident 1] in a wheelchair in the front lobby." The documentation included, "Staff states that [Resident 1's] hospice nurses told [staff] [Resident 1] needed to go to [hospital] to have the wound on [Resident 1's] forehead checked out and they were concerned about cellulitis. [Resident 1] had received morphine this morning, but staff was unsure what time or how

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much was given. [Resident 1] had a 5 x [by] 5 dressing on [his/her] forehead above [his/her] left eye with some redness and irritation around the dressing and eye. Staff on scene state that the dressing was changed an hour ago." Based on review of Resident 1's facility caregiver "charting notes," received by Surveyor on 09/18/2024, there was no documentation regarding this dressing change. The fire department incident record included, "The dressing had dried blood saturated on the lower part of the bandage. [Resident 1] had no drainage from the eye or vision problems. [Legal Guardian O] was contacted for permission to take [Resident 1] to [hospital]. [Resident 1] was assisted in standing and pivoting to the cot [stretcher]. It was noted that maggots were on [his/her] wheelchair when [s/he] stood up. Staff on scene was unsure where they [maggots] came from because they [staff] stated that [Resident 1] did not have maggots an hour ago when the dressing was changed. The bandage was lifted to assess the severity of the wound and maggots were found in the wound. Staff had little information about [Resident 1] and the wound." The documentation included, "[Resident 1] states that [s/he] kept finding little bugs all over [him/her] since yesterday [07/30/2024] but was unsure where they were coming from. [Resident 1] was secured onto the cot and placed in the ambulance with no issues."

On 08/20/2024, Surveyor received Resident 1's hospital records. The emergency room "progress notes" dated 07/31/2024 included, "Excoriation and purulent discharge to L [left] groin. Opened skin to growth on L [left] head above elbow. + [positive for] redness to L [left] side of head with live maggots noted on arrival. + swelling around eye." The documentation included, "[Resident 1]

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N 431	Continued From page 44 presents to the emergency department with a large wound on the left side of [his/her] head with significant surrounding erythema [redness] and pain." The documentation included, "Of note, on EMS presentation to [Resident 1's facility], [Resident 1] was found to have a large amount of maggots on [his/her] head wound and throughout [his/her] close [sic; clothes]. On exam in ER [emergency room], [physician] did remove many maggots from the wound." The documentation included, "Exam is concerning for significant erythema and swelling to the side of [his/her] face that is making it hard for [him/her] to open [his/her] left eye." Resident 1 was admitted to the hospital from the emergency department with diagnoses including cellulitis to left forehead, left forehead lesion complicated by maggot infestation, and groin rash. On 09/18/2024 at 5:23 P.M., conducted an interview with Administrator A and Regional Facility Nurse B. Surveyor asked how it was possible facility caregivers did not observe and reach out to Resident 1's hospice agency and/or Resident 1's primary care practitioner regarding Resident 1's reddened and swollen face prior to it being identified by Hospice RN J on the morning of 07/31/2024, maggot activity found in Resident 1's clothing identified by the EMTs on the morning of 07/31/2024, and Resident 1's infected groin rash identified at the hospital's emergency department. Administrator A and Regional Facility Nurse B said they were unable to answer that question, and Regional Facility Nurse B said "that is the million dollar question." Summary: The provider did not ensure Resident 1's health was monitored to meet Resident 1's needs in relation to a change in condition.	N 431		

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N 481	Continued From page 45	N 481		
N 481	83.43(1) Environment safe, clean, and comfortable Environment. The CBRF shall provide a living environment that is safe, clean, comfortable, and homelike. All common dining and living areas shall contain furnishings appropriate to the intended use of the room. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure the living environment was clean and homelike. Findings include: On 09/18/2024, Surveyor toured the facility and observed the following: At approximately 8:28 AM, Surveyor observed the refrigerator/freezer unit immediately located outside the provider's kitchen. The freezer had a frozen brownish substance running down the walls and a pooled amount on the floor. In the refrigerator, Surveyor observed an apple on the top shelve with a brownish rotten appearance. At approximately 9:06 AM, Surveyor observed Resident 7's bedroom. Resident 7 had pulled the thermostat off the wall near his/her bed and was hanging by electrical wires. In the bathroom, the shower chair had dried bowel movement (bm) towards the back of the seat. On the floor of the shower, observed used Q-Tip's, wet paper towels, and debris. At approximately 11:56 AM, Surveyor observed Resident 7's room again and observed the concerns in the bathroom	N 481		

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remained.

At approximately 9:10 AM, Surveyor observed Resident 8's bedroom. Surveyor observed food crumbs all over the floor. The shower had debris and dirt scattered across the floor. At approximately 11:57 AM, Surveyor observed Resident 8's room again and observed debris consistent with food crumbs scattered all over the floor.

At approximately 9:11 AM, Surveyor observed Resident 9's bedroom. The shower had debris and dirt scattered across the floor. At approximately 11:58 AM, Surveyor observed Resident 9's room again and observed the concerns in the bathroom remained.

At approximately 9:12 AM, Surveyor observed Resident 10's and Resident 11's bedroom. Surveyor observed food crumbs all over the floor. The bathroom had a strong urine odor. At 11:59 AM, Surveyor observed Resident 10's and Resident 11's room again and observed food crumbs in the same location and odor of urine remained.

At approximately 9:25 AM, Surveyor observed Resident 12's bedroom. Inside the room, Surveyor observed a towel with a 5-gallon bucket set on top with a yellow caution "wet floor" sign next to it. Resident 12 reported after running the ceiling air conditioner, the unit will drip condensation onto the floor. Resident 12 reported the bucket was to catch condensation and had been there for a few days.

At approximately 9:32 AM, Surveyor observed Resident 13's bedroom. Next to the bed, Surveyor observed a fall mat not put away

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N 481	Continued From page 47 causing a fall hazard. At approximately 9:44 AM, Surveyor toured the provider's kitchen. Many of the ceiling tiles upon entrance to the kitchen, were covered in dust. A sprinkler head located on the ceiling near the back patio exit was covered in dust. The wall above the coffee station was covered in dust. On 09/18/2024 at 12:45 PM, Surveyor interviewed Environment Services Director D regarding the cleanliness concerns observed during the tour. Environment Services Director D stated housekeeping staff is responsible for deep cleaning resident rooms and caregivers are to do light housekeeping in-between. Environment Services Director D reported s/he was aware of the bucket collecting condensation in Resident 12's room. Environment Services Director D stated s/he left the bucket for a few days to ensure the air conditioner unit was done leaking and we are looking at getting the pitch of the drain hose replaced if the problem continues. Environment Services Director D stated s/he would fix Resident 7's thermostat right away to ensure any wires are hidden. On 09/18/2024 at 4:53 PM, Surveyor interviewed Administrator A and Regional Facility RN B regarding the cleanliness concerns observed during the tour of the facility. Both staff acknowledged the environment needed to meet the requirement of being homelike. Administrator A took notes of the above concerns and stated s/he would follow up with housekeeping. No further updates provided.	N 481		