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	0017751	A. BUILDING: _____ B. WING _____	C 11/01/2023

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N 000	Initial Comments On 10/19/2023, Surveyor conducted an abbreviated survey and investigated 2 complaints at SV North Oconto 2. Additional information was collected through 11/01/2023. Two (2) of 2 complaints were substantiated and 4 deficiencies were identified. Census: 10	N 000		
N 164	83.12(4)(b) Reporting when law enforcement is called. A CBRF shall send a written report to the department within 3 working days after any of the following occurs: Any time law enforcement personnel are called to the CBRF as a result of an incident that jeopardizes the health, safety, or welfare of residents or employees. The CBRF ' s report to the department shall provide a description of the circumstances requiring the law enforcement intervention. This reporting requirement does not apply to residents under the jurisdiction of government correctional agencies. This Rule is not met as evidenced by: Based on interview and record review, between July and September 2023, the provider did not ensure reports were submitted to the Department when law enforcement responded to the facility for 4 incidents that jeopardized the health, safety or welfare of residents. Findings include: Prior to conducting the onsite facility visit, Surveyor reviewed Department records and determined the provider had not submitted any self-reports since 2021.	N 164		

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

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During the entrance conference with Manager A on 10/19/2023, Manager A did not recall submitting any self-reports to the Department since s/he assumed the management role approximately 3 months ago.

On 10/23/2023 at 3:50 PM, Surveyor interviewed Oconto Police Department Captain D. S/he recalled personally responding to the facility during July 2023 to provide assistance to staff who were unable to manage a resident with behaviors. Captain D said their Department had responded a "handful" of other times as well. Upon request on 10/24/2023, Captain D emailed the following 3 police reports to Surveyor.

07/03/2023 at 5:49 PM, Captain D and Officer G were dispatched to the facility for a "disturbance...combative person...Dispatch advised there was a resident causing a disturbance and throwing things around." Caregiver B told the officers, "[Resident 1] has tantrums and refuses to do what [s/he] is asked... [s/he] threw a spatula at a resident...Officers spoke with [Resident 1] for awhile [sic] until [s/he] calmed down and agreed to take [his/her] meds."

07/09/2023 at 1:13 PM, facility staff called police for assistance due to Resident 1 "causing a disturbance." Upon arrival, the caregiver reported Resident 1 was upset and throwing items around the lunch areas and the officer wrote, "I could hear [Resident 1] screaming from [his/her] room." Officers were able to calm Resident 1 and get him/her to agree to take his/her medication.

09/18/2023 at 6:19 PM, a citizen called police requesting assistance for Caregiver C who was on foot with Resident 2 near a bar at 1200 Main St., Oconto. (Surveyor note: this location is 6

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miles from the facility.) Upon arrival Caregiver C told the officer s/he watched Resident 1 "walk out of the facility and wander down the road." Caregiver C followed Resident 1 but was unable to redirect him/her back to the facility. Caregiver B did not have his/her phone so s/he flagged down a patron of the bar to "call law enforcement for assistance." The officer was able to get Resident 2 into the squad care and transport him/her back to the facility.

On 10/30/2023 at 10:00 AM, Surveyor interviewed the management team, including Manager A and Director E. Manager A verified the submission of self-reports is his/her responsibility. Surveyor reviewed the 3 incidents with the management team and asked Manager A if s/he was aware of the 2 July incidents with Resident 1. Manager A said she was aware of a July incident with Resident 1 where police responded to the facility. S/he reviewed his/her records and determined it was an incident that occurred on 07/11/2023 and s/he submitted the self-report via fax on 07/12/2023. Surveyor asked if s/he had the fax confirmation and s/he replied, "I probably do" and agreed to send it to Surveyor. In response, Licensed Practical Nurse E sent Surveyor an email that read in part, "please see the self report for [Resident 1]. [Manager A] is currently tied up and cannot get an actual fax confirmation." The email contained a report titled, "WI - Assisted Living Facility Self-Report Behavioral." The report detailed an incident that occurred on 07/11/2023 at 4:20 PM, when Resident 2 was "aggressive with staff throwing items and hitting them with objects. The Oconto Police department was called to de-escalate the situation after [Resident 1] became Physical [sic] abusive with Staff [sic]." Surveyor noted this incident was a different date and time then the previously known July incidents

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N 164	Continued From page 3 and was a 4th example of police response to the building. The document did not include any information to indicate the it was submitted to the Department. During the 10/30/2023 interview, Surveyor also asked about the 09/18/2023 incident with Resident 2. Both Manager A and Director E described general knowledge that Resident 2 left the building on that date, but were unaware staff were unable to redirect him/her back to the facility or that the caregiver was unable to summon help until s/he was .6 miles from the facility. Manager A said the information was "new to me" and attributed it to caregivers "not letting us know what happens and what goes on."	N 164		
N 386	83.35(3)(a) Comprehensive Individualized Service Plan Comprehensive individual service plan. Scope. Within 30 days after admission and based on the assessment under sub. (1), the CBRF shall develop a comprehensive individual service plan for each resident. The individual service plan shall include all of the following: 1. Identify the resident ' s needs and desired outcomes. 2. Identify the program services, frequency and approaches under s. HFS 83.38(1) the CBRF will provide. 3. Establish measurable goals with specific time limits for attainment. 4. Specify methods for delivering needed care and who is responsible for delivering the care. This Rule is not met as evidenced by: Based on observation, record review and	N 386		

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interview, the provider did not ensure a comprehensive individual service plan (ISP) was developed for Resident 2 within 30 days of admission to identify needs and individualized services in the areas of behavior management and fall prevention.

Findings include:

The Department received a complaint alleging care concerns for Resident 2.

The provider is licensed to serve up to 16 residents from the following client groups: advanced aged, terminally ill, irreversible dementia/Alzheimer's and physically disabled.

On 10/19/2023, Surveyor reviewed portions of Resident 2's record. Resident 2 was admitted on 09/12/2023, was elderly and had diagnoses to include Alzheimer's diseases. S/he had an activated power of attorney for health care (legal decision maker) and was admitted to hospice on 10/10/2023.

Resident 2's observation notes detailed persistent episodes of confusion, agitation, night waking, disrobing in common areas, incontinence and an inability to communicate needs. Examples included:

09/13 3:00 AM- disrobed in the living room in front of another resident and crawled under the Christmas tree.
09/20 2:00 PM - "disrobing in the hallways...had a BM (bowel movement) on the floor in the middle of the hallway...tried to redirect...was agitated...turned around and bent over and smeared it around the floor..."
09/20 4:45 AM - "touching other residents, going

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in their rooms and taking off all of [his/her] clothes...said [s/he] didn't need to use the bathroom then proceeded to sit down on a chair refuse to get up and started peeing...on one of the checks staff walked in and [s/he] was on all fours with [his/her] pants pulled down peeing and poopingon the floor..." [sic-all]
09/21 4:00 AM - at approximately 5:00 PM the previous day, was in the common area "completely naked...fought with writer to return to [his/her] room...become violent...when [s/he] is awake you can not take yuoor eyes off of [him/her]...has now begun to flush items down the toilet...power naps for 20 tp 30 minutes and then can go for hours...does not sleep...is incoherent, [s/he] does not follow basic directions." [sic-all]
09/26 11:30 PM - "has again been putting items down [his/her] toilet...as always confused, incoherent, mumbling, [his/her] balances if off and [s/he] CAN NOT SEE...has been trying to crawl on top of [his/her] night stand tonight...cognitive abilities at night are very very impaired...did have [his/her] room tore up a bit...resident and [his/her] blankets and [his/her] room were covered in both feces and urine..."
10/01 12:15 AM - "writer has spent most of the night chasing resident. [s/he] will not...keep clothing on...it has been a struggle tonight. in the process of running around naked resident has defecated x2 on the floor in the hallway..." [sic - all]
10/11 9:15 AM - "is urinating on [his/her] carpet again and its [sic] starting to smell..."
10/16 4:45 PM - "...fell in [his/her] room."
10/18 12:01 PM - incident report - unwitnessed fall 11:51 PM 10/17/2023. "went in to check on [Resident 2]...was laying on the floor beside [his/her] bed...stated [s/he] fell on [his/her] butt...seemed to be in a little pain for [his/her] legs and butt..."

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N 386	Continued From page 6 The record contained a temporary ISP dated the day of admission that did not identify interventions to meet Resident 2's needs in the areas of behavior management, toileting or fall prevention. The temporary ISP read, "[Resident 2] is a polite...re-directable if [s/he] is doing something that [s/he] is not suppose [sic] to be doing." The record included an update on 09/13/2023 identifying risk for elopement and the need for frequent supervision to prevent it. The record did not contain a comprehensive ISP developed within 30 days of admission (10/12/2023.) A document titled "Active Cares" contained updates on 10/17/2023 and 10/19/2023. During an interview with Licensed Practical Nurse (LPN) F at 1:49 PM, s/he confirmed a comprehensive ISP was not developed by 10/12/2023. S/he explained the updates to the "Active Cares" reflected his/her efforts to begin development of an ISP. LPN F verified the 10/19/2023 entries were made after Surveyor entered the building. In addition, LPN F confirmed the provider uses their own comprehensive ISP to incorporate the hospice plan of care. Surveyor reviewed the active cares and the partially completed ISP current as of 10/19/2023 specific to behavior management, toileting needs and fall prevention and noted the following: 10/17/2023: "Dressing/Undressing/Wake Up and Bed Time...likes to get up between 7am and 9am...likes to go to bed between 8pm and 10pm...needs assistance throughout day to redress due to disrobing/incontinence." 10/17 - "Toileting...requires daily or more often	N 386		

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assistance with the use of incontinence products or related hygiene needs. Resident requires assistance with toileting schedule...is toileted every 2 hours while awake...Chart with any concerns or changes in toileting conditions."

10/19/2023:
"Bed Check...will be checked on every two hours night...will be checked on a minimum of two times nightly or more often as needed. Resident will be checked on ____ night due to [left blank.]"
"Aggressive/Combative...not currently applicable...Attitude...Positive, self-motivated attitude."
"Destructive/Abusive Behaviors...Not currently applicable."
"Communication/Verbal Skills...is difficult to understand and requires staff time to communicate...requires daily assistance to manage communication tools (mail/phone)." [sic - all]."
"Falls Management...rarely falls (6 or less times per year.)...has had two falls recently. No alarms in pace at this time."

Undated:
Behavior Monitoring "resident takes mental health medications. Monitor behaviors accordingly."

Surveyor noted the active cares and ISP did not:
Identify Resident 2's tendencies for night waking and associated needs for close supervision during the overnight to ensure safety.
Document interventions to protect Resident 2's dignity through prevention or prompt response to Resident 2's tendencies to frequently disrobe and urinate/defecate in common areas.
Identify interventions to prevent falls.

On 10/19/2023 at 11:18 AM, Surveyor interviewed

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Caregiver B and asked about Resident 2's needs. Caregiver B said Resident 2 was a newer admission to the facility and s/he had declined quickly since then. Surveyor asked to meet Resident 2 and Caregiver B said Resident 2 was laying down in room 8 which was a vacant room. Caregiver B explained earlier in the day Resident 2 was incontinent in his/her room and a fan was blowing to dry the carpet.

At 11:42 AM, Caregiver B brought Surveyor to the vacant room. Surveyor observed Resident 2 laying on his/her back on the bed, slowly pulling his/her pants down. His/her pants were at mid-thigh and s/he had no undergarments on his/her bottom. Surveyor observed s/he was unsettled and appeared to be in distress. Caregiver B approached Resident 2 and asked if s/he was in pain. Resident 2 was unable to provide a decipherable response. Caregiver B exited the room and told Surveyor s/he was going to call hospice to see if s/he could administer morphine. Caregiver B returned momentarily and said s/he was waiting for a return call from hospice.

At 11:49 AM, Surveyor exited the building and returned at 12:22 PM. Upon entry to the building, Surveyor observed Manager A and Licensed Practical Nurse (LPN) F in the front office with the door shut. Surveyor did not observe any caregivers in the common area. Surveyor went immediately to room #8. The door was partially open and Surveyor observed Resident 2 sitting on the edge of the bed. His/her pants and incontinence brief were completely off. Resident 2 was rocking back and forth and moaning. Resident stood up and then sat down, and then again stood up and sat back down. Surveyor observed s/he was unsteady on his/her feet and

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N 386	Continued From page 9 appeared as if s/he was at risk of falling. Resident 2 then got down on the floor on his/her hands and knees and began to crawl, reaching for something, but nothing was there. Resident 2 stood back up and was again unsteady while doing so. During the 3 minute observation, no caregivers or management staff were present. Surveyor did not observe Resident 2 wearing a call pendant and it did not appear Resident 2 would have had the cognitive ability to use one to call for help. At 12:25 PM, Surveyor went to find staff and at the same time, Caregiver A and Shower Aid J (the 2 staff on duty) walked in the back door from the outside smoking area. Surveyor informed the caregivers Resident 2 needed assistance. Both staff entered the room and tried unsuccessfully to comfort Resident 2. Surveyor asked if Resident 2 was at risk for falls and Shower Aid J confirmed s/he was and had recently experienced falls. Surveyor asked Caregiver B what s/he was doing outside earlier and Caregiver B said s/he was smoking. Surveyor retrieved Manager A and LPN F from the office and asked them to observe Resident 2. After the observation, Surveyor returned to the office with the managers and described the observations between 11:42 AM and 12:25 PM. The managers expressed frustration the care staff did not more closely monitor Resident 2 or inform them of his/her condition.	N 386		
N 397	83.36(1)(b) Qualified staff in charge, on duty and awake. The CBRF shall ensure all of the following: 1. An administrator or other designated qualified resident care staff in charge is on the premises of the CBRF daily to ensure the CBRF is providing	N 397		

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safe and adequate care, treatment and services. 2. At least one qualified resident care staff is present in the CBRF when one or more residents are present in the CBRF. 3. At least one qualified resident care staff is on duty and awake if at least one resident in the CBRF is in need of supervision, intervention or services on a 24-hour basis to prevent, control or improve the resident ' s constant or intermittent mental or physical condition that may occur or may become critical at any time including residents who are at risk of elopement, who have dementia, who are self-abusive, who become agitated or emotionally upset or who have changing or unstable health conditions that require close monitoring. 4. At least one qualified resident care staff is on duty and awake if the evacuation capability of at least one resident is 4 minutes or more.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure at least 1 qualified resident care staff was on the premises when residents were present.

Caregiver N worked a 12 hour shift scheduled to end at 5:00 AM on 04/08/2023. The 5:00 AM relief staff did not report to the facility. At 7:05 AM after being unable to secure coverage, Caregiver N made Manager A aware of the situation asked for help. Caregiver N subsequently sent Manager A 2 text messages saying s/he would remain in the facility until 1:00 PM at which time s/he would leave regardless of whether there was coverage.

At 1:02 PM after working 20 hours, Caregiver N clocked out and no other staff were working. Eight residents were left without qualified care staff in the building. Caregiver M from the

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neighboring facility checked on the residents 1-2 times between 1:30 PM and 02:18 PM. Relief staff did not arrive to the facility until approximately 2:57 PM. Some residents did not receive lunch until after 3:30 PM and some residents did not receive prescribed medications.

Findings include:

The Department received a complaint alleging residents were left alone in the building on 04/08/2023.

The provider is licensed to serve up to 16 residents from the following client groups: advanced aged, terminally ill, irreversible dementia/Alzeheimer's and physically disabled.

Observations:
Upon arrive to the facility on 10/19/2023 at 8:15 AM, Surveyor observed 2 separately licensed buildings on the same property. The north building had an address of 427 Pecor St, and this building was the facility being surveyed. The south building has an address of 425 Pecor St. Upon entry to the north/427 building, Surveyor observed Caregiver B was the only staff on duty for 11 residents. During interviews at 8:28 AM and 11:19 AM Caregiver B said typically the buildings are staffed with 1 caregiver for a 12 hour shift. S/he said there is also a caregiver designated as the shower aid who is a float for both buildings for portions of some shifts on some days. Caregiver B said s/he has experienced times when relief staff does not report and s/he has had to work 20-24 hours. Caregiver B said when s/he tries to contact management in those situations, "Sometimes management answers you, sometimes they don't." Caregiver B said it is difficult to stay awake when s/he works such long

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N 397	Continued From page 12 shifts. Misconduct Incident Report (MIR): Surveyor reviewed Department records which included the MIR submitted by the provider on 04/13/2023. It read in part, "[Caregiver N] was scheduled 5:00 PM-5:00 AM on 04/07/2023, after [his/her] 5:00 AM-5:00 PM relief scheduled for 04/08/2023 didn't show up for their scheduled shift, [Caregiver N] left the building...without a replacement....knowingly [sic] that coverage was being sought after at 1:00 PM...Staff member from next door facility/building monitored both buildings until staff came in at 2:45 PM. [Caregiver N] was upset that [his/her] relief didn't come in...[Caregiver N] left because [s/he] was frustrated. There was a second staff that came in at 7:00 AM but instead of [Caregiver N] leaving at 1 pm [s/he] let the second staff go home and willingly said [s/he] would stay, the (then) left the residents unattended. [S/he] did inform the house in front of [him/her] [s/he] was leaving..." [sic - all] The section of the MIR that prompted the provider to describe or attach their investigation read, "Entity had been working on coverage since 7am...[Caregiver N] left [his/her] building without a replacement...Coverage arrived at 2:45pm." No investigation was attached or described. Police Department Response: Surveyor reviewed Oconto Police Report C23-04215 dated 04/08/2023. The report read in part, "Date: 04-08-2023 Time: 2:18 pm. On the above date and time I [Sergeant L]..was dispatched to Sun Valley Homes: 427 Pecor St for a Welfare Check. Dispatch advised the anonymous complainant stated that there were no workers in the facility. I arrived on scene and walked into the North building. I spoke to several patients there who stated they had not seen a	N 397		

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nurse in hours. I made my way to the South building and made contact with [Caregiver M].... [s/he] appeared exhausted. [Caregiver M] told me...[Caregiver N] ...got upset due to management's lack of effort to fill the shift; so they abandoned the building...I asked [Caregiver M] how many patients [s/he] is managing at the moment, and [s/he] stated 8 in the North building, and 10 in the South building. [Caregiver M] stated the 10 patients in the South building require constant higher level care so [s/he] has only made it to the North building once or twice since 1pm. [Caregiver M] was attempting to call [his/her] supervisors while I was on scene and [s/he] was unable to get a hold of anyone. I took [Caregiver M]'s information and told [him/her] to call rescue if [s/he] had an emergency. I advised [a fire department captain and chief] of the potential hazards...this report will be forwarded to Human Services for review." [sic - all]

Surveyor interviewed Sergeant L on 11/01/2023 at 12:56 PM. S/he recalled responding to the facility on 04/08/2023 and said one of his/her biggest concerns was the safety of the residents if there had been a fire at the facility while no staff were present. S/he said after consulting with his/her management, s/he informed the captain and chief of the fire department of the situation. Sergeant L also recalled Caregiver M said s/he felt "ignored" by management as s/he tried to navigate the situation and stated it was not uncommon to have difficulty reaching management on the weekends.

Adult Protective Services (APS):
Surveyor interviewed APS Case Worker K on 10/23/2023 at 1:43 PM. APS K said on Monday, 04/10/2023 s/he received a referral from law enforcement because residents were left alone

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for approximately 2 hours on Saturday, 04/08/2023. APS K said s/he responded to the building on 04/10/2023 and based on his/her investigation s/he concluded the following:
A 3rd shift caregiver was frustrated his/her relief staff did not report and management did not respond to assist.
After working 20 hours at approximately 1:00 PM, the caregiver left the facility leaving all the residents unattended.
A caregiver from the neighboring building (separately licensed facility) covered both buildings for "a couple hours."
Residents were not fed lunch until mid afternoon and some residents did not receive medications.
Resident 3 was under APS supervision and was protectively placed at the facility, at least 1 resident was an elopement risk, and other residents had diagnoses of dementia with needs for constant staff supervision.

Impacted Residents:
Surveyor reviewed documents received from the provider on 10/30/2023. This included the resident roster from 04/08/2023 which listed 9 residents and face sheets for 6 of the 9 residents. Surveyor noted the records documented diagnoses, risk factors or cognitive limitations that placed the residents at risk for negative outcome when they were without a qualified caregiver:

Resident 3 - fall risk (and per APS interview was protectively placed)
Resident 5 - fall risk and mild cognitive impairment with memory loss
Resident 6 - fall risk, diabetic and end stage renal disease
Resident 7 - diabetic, paranoid schizophrenia and legal guardian
Resident 8 - dementia and legal guardian

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N 397	Continued From page 15 Resident 9 - fall risk, emphysema and chronic obstructive pulmonary disease Management interviews and facility documentation: On 10/19/2023 at 4:05 PM, Surveyor interviewed Manager A. S/he said on 04/08/2023, after working 20 hours, "[Caregiver N] said [s/he] was done and walked out without notifying anybody." Caregiver M was working in the other building and had to cover both buildings until relief staff arrived. Surveyor asked Manager A to describe his/her involvement on the day of the incident. Manager A retrieved his/her cell phone and Surveyor observed him/her reading text messages. Manager A stated the following while reviewing the text messages: 7:05 AM, Caregiver N texted Manager A to report relief staff did show up 5:00 AM. Caregiver N wrote, "I've tried everything" and asked Manager A to help find coverage. 7:27 AM, Manager A sent a text to Caregiver N that s/he was still trying to find coverage. 9:31 AM, Caregiver N texted Manager A and asked for an update. Manager A asked if Caregiver B had showed up and Caregiver N replied s/he had not. 10:15 AM (approximately), Caregiver N texted Manager A and wrote s/he had been at the facility for 17.25 hours and by 1:00 PM s/he would have "20 [expletive] hours and...will be leaving the facility." Manager A replied to the text at 12:36 PM and said s/he assumed the 3rd shift staff was a no show because Caregiver N was a no show for that same staff the week before. Caregiver N replied and expressed frustration that s/he was being punished.	N 397		

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N 397	Continued From page 16 12:50 PM, Caregiver N texted Manager A and wrote, "9 minutes to have someone get here I have to call out and then I'm calling the police because the facility will be unattended." Surveyor asked Manager A if s/he provided an update about coverage to Caregiver N between 09:31 AM and 12:50 PM. Manager A said, "from my end I'm sure I was looking for a replacement." Surveyor asked if management considered responding to the facility and Manager A replied, "I was up in Newberry MI (3 hours away) and [Director E and Assistant Director O] were on their way back from Colorado...we had it planned that [Caregiver P] was going to come in at 5pm...I think that's how it went." Surveyor asked if it was communicated to Caregiver N that s/he would have to work until 5:00 PM (a total of 24 hours) and Manager A said, "Yeah, I don't know. Unless it was assumed [s/he] was going to stay." Manager A did not describe any steps s/he took after receiving the 12:50 PM text from Caregiver N stating s/he would be leaving the building unattended in 9 minutes. Manager A provided Surveyor with a word document titled "Plan of Correction" that consisted of a meeting agenda for caregivers that occurred on 04/26/2023. The agenda items included "call in procedure," "refill self when unable to attend," "manager on call for staffing emergency" and "managers have other responsibility that entails full time work." Surveyor requested all documentation of the provider's investigation into the incident and screen shots of the aforementioned text messages. Manager A agreed to send both. However on 10/23/2023 Manager A indicated s/he got a new phone 2 months ago and couldn't	N 397		

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access text messages prior to that. Surveyor noted this contradicted Surveyor's observation of Manager A reading the 04/08/2023 text messages during the onsite visit.

On 10/23/2023, Manager A emailed Surveyor a 2 page untitled, undated and unsigned document that contained a typed statement from Caregiver M. It read in part,

"Saturday morning dayshift 5am to 5pm worker in 427 had called in sick so [Caregiver N] was still there from nightshift...[Caregiver P] was there 7am-1pm as caregiver/shower person... [Caregiver P] is a float between buildings... [Caregiver P] left at 1pm as scheduled. Around 1:30 i noticed [Caregiver N]'s vehicle was gone. I answered some call lights (in 425) and went next door...There was no staff in the building the residents stated [Caregiver N] had left.

I answered 2 call lights going off (in 427) and one resident stated they did not eat lunch yet. I notified [Manager A] who was out of town and working hard on finding coverage...I was making sure both buildings all residents cares were met...and serve them Lunch. Sometime after 2pm a police officer stopped...all [s/he] could say was sorry to leave you in this position but call 911 if there is a medical emergency....after (the officer) left i was running between buildings and [Director E] stated to get a hold of [Caregiver P] and have [him/her] come back in til we find replacement... [Caregiver P]...arrived at 2:55 and started making sandwiches right away...[Caregiver P] talked to [Director E] regarding...medications punched out in top drawer that were not given. Some signed out and some clicked off in ECP (electronic record system) but not given." [sic-all] Caregiver M wrote at 3:30 PM after s/he was relieved in

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building 425, s/he went back over to building 427 to help Caregiver P finish serving lunch.

The document also included a section titled "Notes" that read,

"1. Who did day shift call into? The house- not manager.
2. One mgr knew a call in had occurred [s/he] filled protocol of finding replacement.
3. [Caregiver P] is a fully certified worker - [s/he] should have released [Caregiver N] from duty under mgr advisement...
4. Once it had been known [Caregiver N] left the building mgr advisement was for the 7a-1p person (Caregiver P) to return immediately.
5. [Caregiver N] had left a dose of Tylenol in the med cart. MD notified of missed dose.
6. Further instruction was for RN or LPN to be notified of any further missed doses...
7. Team meeting held. Policies and procedures were discussed.
8. [Caregiver N] wouldn't return calls for interview. Self term
9. Misconduct filed." [sic - all]

On 10/30/2023 at 10:00 AM Surveyor conducted an interview with the management team including Manager A, Director E, Administrator O and Licensee P.
Manager A said in addition the steps s/he described on 10/19/2023, s/he also placed a call to Caregiver N between 7:30 - 7:45 AM and again at approximately 10:30 AM to tell him/her Caregiver P could relieve him/her, but Caregiver N said s/he would stay until replacement arrived. Manager A said s/he did not directly speak to Caregiver P and direct him/her to stay to cover the shift. Surveyor asked Manager A about his/her response after the 12:50 PM text. S/he

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replied, "I don't remember what the response was...I have nothing to say. [Caregiver N] could have left (when Caregiver P was there)...it happened. It's unfortunate."
Director E said s/he was responsible for conducting the investigation. S/he authored the "Notes" section of the 2 page document and completed the MIR. In addition s/he said s/he reviewed time cards, interviewed the only 2 residents that would be accurate historians, and reviewed parking lot camera still shots. Director E said [Caregiver N] punched out at 1:02 PM but the parking lot cameras showed a "car that looked like [Caregiver N]'s as best as I could tell" leaving between 1:35 PM - 1:45 PM. Director E said s/he would need verify the camera footage times and see if s/he documented this part of the investigation. Director E said the camera "Just takes snap shots...of movement. It's not a video recorder." Surveyor asked if there was any other movement between 1:02 PM and the time s/he thought s/he saw Caregiver N's car. Director E said there was not.
Director E said, "From memory, the only 1 (med missed) was the 2:00 PM Tylenol (for Resident 4)." Surveyor asked if further investigation was conducted to determine if other medications were prepared, documented as administered, but left in the top drawer (as noted in Caregiver M' statement.) Director E said s/he did not investigate further to determine the scope of potential medication omissions that day.
Director E confirmed after the police were onsite and while Caregiver M was responsible for 2 buildings, s/he instructed Caregiver M to find his/her own relief staff by contacting Caregiver P. Director E explained the 2 staff are related and Caregiver P was not always responsive to management.
Licensee P acknowledged the need to improve

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their process for investigations and would ensure the management team developed policies and procedures to ensure "nothing like this happens again."

On 10/31/2023, Director E emailed surveyor and wrote, "I wanted to explain that the reason I cannot provide a screen shot of movement of [Caregiver N]'s car is because our camera is not advanced enough for continuous movement. I do remember looking at the camera 'live' and seeing [him/her] pull out." The email did not specify the time s/he looked at the camera, if that piece of the investigation was documented or information that the camera was monitored live after 1:00 PM when Caregiver N said s/he would be leaving. The email did include screen shots of time cards that confirmed Caregiver N clocked out at 1:02 PM and Caregiver P clocked in at 2:57 PM.

IN SUMMARY ON 04/08/2023:

At 5:00 AM, Caregiver N's 12 hour shift was over and his/her relief staff did not report.

At 7:05 AM, Caregiver N notified Manager A of the situation asked for assistance finding coverage.

At 10:15 AM (approximately), Caregiver N informed Director A s/he intended to leave the facility at 1:00 PM because s/he would have worked 20 hours at that point.

At 12:50 PM, Caregiver N again informed Manager A s/he would be leaving the facility by 1:00 PM and s/he intended to call the police to report the residents would be there alone. Manager A did not take immediate steps to ensure a qualified care staff would be in the

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N 397	Continued From page 21 building at 1:00 PM to ensure the health and safety of the residents. At 1:02 PM, Caregiver N clocked out. Sometime after 1:30 PM, Caregiver M (working in the neighboring building) entered the facility and discovered no staff were present in the building and residents had not had lunch. At 2:18 PM, 1 hour and 16 minutes after Caregiver N clocked out, the police department arrived and discovered no staff were present in the facility. Residents told the police officer they had not seen staff "in hours." While the officer was on the property, Caregiver M tried to contact management staff and could not reach anyone. At 2:57 PM, 1 hour and 55 minutes after Caregiver N clocked out, relief staff [Caregiver P] clocked in. Residents were still being fed lunch after 3:30 PM and Caregiver P reported some medications had not been administered.	N 397		
N 409	83.37(1)(j) Proof-of-use record. Proof-of-use record. The CBRF shall maintain a proof-of-use record for schedule II drugs, subject to 21 USC 812 (c), and Wisconsin ' s uniform controlled substances act, ch. 961, Stats, that contains the date and time administered, the resident ' s name, the practitioner ' s name, dose, signature of the person administering the dose, and the remaining balance of the drug. The administrator or designee shall audit, sign and date the proof-of-use records on a daily basis. This Rule is not met as evidenced by:	N 409		

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N 409	Continued From page 22 Based on observation, record review and interview, the provider did not maintain accurate proof-of-use documentation for a scheduled II medication and did not audit the proof-of-use records daily. On 10/19/2023 there were 10 pills remaining in Resident 3's oxycodone medication card, but the proof-of-use record documented the total should be 16. The proof-of-use record documented discrepancies between the actual number of pills and the recorded number of pills dating back to 09/21/2023. Findings include: Note: According to the Department of Justice/Drug Enforcement Administration, "Drugs and other substances that are considered controlled substances under the Controlled Substances Act (CSA) are divided into five schedules....Substances are placed in their respective schedules based on whether they have a currently accepted medical use in treatment...their relative abuse potential, and likelihood of causing dependence when abused....Schedule II...Substances in this schedule have a high potential for abuse which may lead to severe psychological or physical dependence...Examples of Schedule II narcotics include...oxycodone." Source: https://www.deadiversion.usdoj.gov/schedules, retrieval date 11/01/2023 On 10/19/2023 Licensed Practical Nurse F (LPN) F provided Surveyor a copy of a the facility's medication administration policy dated 01/19/2017. The policy read in part: "It is the policy of Sun Valley Homes LLC that all	N 409		

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Narcotics are to be counted. The quantities must be counted at the beginning/ending of each shift or when another Team Member is assuming responsibilities for the medications. The med Techs are solely responsible for the Narcotics on their shift.....Accuracy is a MUST!! You will be held accountable for any 'missing' medications; resulting in immediate termination and possible criminal charges based on the investigation...Count is Incorrect???...Notify Administrator/Designee that the count was incorrect..." [sic - all]

On 10/19/2023 at 3:41 PM, Surveyor reviewed the provider's medication storage system. In the narcotic drawer was a medication card containing PRN (as needed) oxycodone prescribed for Resident 3. The card contained 10 pills in individually blister packaged compartments. Surveyor requested evidence of a proof-of-use record for this schedule II medication. LPN F accessed the proof-of-use record in ECP (electronic record keeping system.) According to the proof-of-use record, there should have been 16 pills remaining in the card.

LPN F tried to account for the discrepancy and in doing so, s/he explained the proof-of-use record for a scheduled dose of the same medication for Resident 3 was also inaccurate. LPN F stated:

Resident 3 has both scheduled and PRN prescriptions for oxycodone
The previous day, s/he became aware Resident 3 was out of the scheduled medication. However, according to the proof-of-use record record 3 pills should have remained
LPN modified the proof-of-use record to reflect zero because 3 times during October, the medication administration record (MAR) was left

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blank for the scheduled oxycodone. S/he assumed the medications were administered but not recorded on the proof-of-use record. However, LPN F said s/he did not interview staff or otherwise investigate for proof the 3 scheduled doses were actually administered.
LPN F said, "I'm usually not notified when narc count is off." Surveyor asked if s/he considered the count could be off due to staff misappropriation and s/he replied, "That's my concern."

LPN F continued to explain:
Upon learning the scheduled medication was out, s/he informed the prescribing provider a refill was needed and instructed staff to administer from the PRN card
3 scheduled doses were administered from the PRN card since the previous evening

In summary, LPN F confirmed:
16 pills should have been in the PRN card according to the proof-of-use record as of 10/18/2023
3 pills were administered for scheduled doses after the 10/18/2023 count, therefore 13 pills should remain in the PRN card
3 pills were unaccounted for because only 10 pills remained in the PRN card

LPN F could not offer an explanation for the discrepancy but went to the office to try to figure it out

At 3:51 PM, Surveyor interviewed Caregiver B and asked if s/he knew why the narcotic count was off for Resident 3's oxycodone. Caregiver B said some staff forget to document administration of the medication on the proof-of-use record and "management don't [sic] always fix it...We let

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017751	A. BUILDING: _____ B. WING _____	C 11/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SV NORTH OCONTO 2	427 PECOR ST OCONTO, WI 54153

(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 409	Continued From page 25	N 409		

[Manager A] or [LPN F] know. As far as I know they can see all this too." Caregiver B said it is their policy at shift change for both the oncoming and outgoing caregivers to count together to ensure the total number of scheduled II narcotics in the medication cards align with the total in the proof-of-use record. However, Caregiver B said they can skip the count all together, or simply enter a note if count is off. S/he said, "depending on who is working, they won't want to do (count) if the count is off. They know management and [LPN F] know about it and it's not fixed, so they don't want to be responsible." Caregiver B said as recently as today the 3rd shift person from last night refused to count with Caregiver B at shift change this morning because s/he knew the count was off. S/he said the 3rd shift staff said, "I'm not doing it. I'm not responsible for that. They should be fixing this." Caregiver B said the count for Resident 3's oxycodone has been off for several days, "probably longer."

Caregiver B and Surveyor reviewed the proof-of-use record. Surveyor noted between 09/21/2023 and 10/18/2023, there were 18 notes by different caregivers about the inaccurate count. Examples include:

09/21 - "count entered was 18, but the count in the system (proof-of-use record) is 20."
09/22-09/28 - 3 pills administered; bringing the count in the system to 17 and the actual count to 15.
09/28 - pill count 15, but "count in the system is 17...(pill) count is correct, staff counted many times...getting this number (15) every time."
09/29 - 10/01 - there was no documentation of administration, but the following day the count in the card was one less.
10/02 - pill count 14, system is 17 "staff counted

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N 409	Continued From page 26 many times" 10/18 at 5:00 PM - pill count 14, system is 17 "staff counted many times, getting this same number (14) every time." 10/18 at 11:25 PM - administered PRN dose leaving 13 pills and but a system count of 16 At 4:05 PM, Surveyor returned to the office and met with LPN F and Manager A. LPN F was tearful and adamant s/he counted the medications the previous day and there were 17 in the card. Manager A said it was likely LPN F's count was an error and there were only 14 in the card the previous day. Both managers initially blamed Caregiver B for not reporting the count was off but eventually acknowledged the count had been off since 9/21/2023 and many different caregivers made entries in the system regarding the discrepancies. Manager A said staff are supposed to "notify immediately" if the count is off and "they are not supposed to leave" the facility until the count is reconciled. LPN F said s/he does not audit the proof-of-use record daily, but acknowledged, "I should." Manager F responded, "The sooner we know it's off (the count), the sooner we can do our investigation. It's easier for us to narrow down." During the exit interview with LPN F and Manager A on 10/30/2023 at 10:00 AM, Manager A and LPN F said they had not made efforts to reconcile the proof-of-use records for Resident 3's oxycodone since Surveyor was onsite 10/19/2023.	N 409		