STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015012	A. BUILDING: _____ B. WING _____	R-C 09/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCH HAVEN SENIOR LIVING BEARS HOLLO	1019 15TH AVE W ASHLAND, WI 54806

(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, Surveyor conducted 2 complaints, 2 self-report investigations, and 2 verification visits for Statements of Deficiency (SOD) 58BE12, and SOD ZM9J11 at Birch Haven Senior Living Bears Hollow. Data was collected through 09/23/2024. Two of 2 complaints were substantiated. Eight deficiencies were identified. Six of 8 deficiencies were repeat deficiencies identified in the following SODs: SOD ZM9J11, dated 11/09/2023, N0344, N0397, and N0490 were repeat deficiencies. SOD 58BE12, dated 09/18/2023, N0163, N0450, and N0454 were repeat deficiencies. Under statutory provisions of Wis. Stat. ch. 50, a $200 revisit fee is being assessed. Census: 14	{N 000}		
{N 163}	83.12(4)(a) Reporting when resident's whereabouts unknown A CBRF shall send a written report to the department within 3 working days after any of the following occurs: Any time a resident ' s whereabouts are unknown, except those instances when a resident who is competent chooses not to disclose his or her whereabouts or location to the CBRF, the CBRF shall notify the local law enforcement authority immediately upon discovering that a resident is missing. This reporting requirement does not apply to residents under the jurisdiction of government correctional	{N 163}		

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

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{N 163}	Continued From page 1 agencies or persons recovering from substance abuse. This Rule is not met as evidenced by: Based on record review and interview, the provider did not send a written report to the Department after Resident 1's whereabouts were unknown. This is a repeat deficiency. See Statement of Deficiency 58BE12, dated 09/18/2023. Findings include: On 09/18/2024 and 09/19/2024, Surveyor reviewed Resident 1's record. Resident 1 had multiple diagnoses, including dementia and severe cognitive issues. Resident 1's individual service plan (ISP), with a print date of 09/18/2024, indicated Resident 1 was an elopement risk and had a GPS (global positioning system) monitoring device. Surveyor reviewed Resident 1's notes and incident reports for the past 6 months and did not locate any incidents that involved staff being unaware of Resident 1's whereabouts. On 09/19/2024 at approximately 9:00 a.m., Surveyor interviewed Caregiver E. Caregiver E told Surveyor Resident 1 eloped "a couple months ago." On 09/19/2024 at approximately 11:00 a.m., Surveyor interviewed Resident 2. Resident 2 told Surveyor the police came to the facility one time when they could not locate Resident 1.	{N 163}		

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{N 163}	Continued From page 2 On 09/23/2024, Surveyor emailed Licensee A, who is also the administrator, Administrator in Training (AT) B, and Registered Nurse (RN) C. Surveyor asked if the police were called in 2024 to help locate Resident 1. On 09/23/2024, RN C replied, in part: "The police were called one time when [Resident 1] could not be located. I do not have the exact date but it was about 2 months ago. [S/he] had not eloped. [S/he] was sitting in an empty room on the bed when [s/he] was located before the police arrived." On 09/23/2024 at approximately 3:30 p.m., Surveyor interviewed AT B and asked if Resident 1's whereabouts were unknown. AT B told Surveyor, "Correct." AT B said it was his/her understanding since Resident 1 did not elope from the facility it would not need to be reported. Surveyor explained the regulation reads, "A CBRF (community based residential facility) shall send a written report to the department within 3 working days after any of the following occurs: Any time a resident ' s whereabouts are unknown." Surveyor also explained the provider was required to send a written report to the Department when law enforcement are called to the facility. Surveyor asked what date this happened. AT B said, "I can't recall off the top of my head." Surveyor explained the importance of documentation. The provider did not report to the Department when Resident 1's whereabouts were unknown. Cross Reference: N0454 DHS 83.42(1) Resident Record Maintained	{N 163}		

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N 165	Continued From page 3	N 165		
N 165	83.12(4)(c) Reporting incidents with serious injury A CBRF shall send a written report to the department within 3 working days after any of the following occurs: Any incident or accident resulting in serious injury requiring hospital admission or emergency room treatment of a resident. This Rule is not met as evidenced by: Based on record review and interview, the provider did not send a written report to the Department after 2 residents had a fall that resulted in injury requiring emergency room treatment. Resident 1 fell, was bleeding from the head, and received sutures at the emergency room. Resident 3 fell, sustained a fractured finger that was placed in a soft cast in the emergency room. Findings include: On 09/18/2024 and 09/19/2024, Surveyor reviewed Resident 1 and Resident 3's records. RESIDENT 1 An incident report, dated 06/07/2024, read, in part: "0700 (7:00 a.m.) I received a call from [Caregiver E]. [S/he] reports [s/he] 'heard a loud bang and ran down the hall and saw [Resident 1] lying on the floor by [his/her] bed.' [S/he] was conscious but had 'a lot of blood from the back of [his/her] head.' I directed [Caregiver E] to call 911." A progress note, dated 06/07/2024, read, in part:	N 165		

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N 165	Continued From page 4	N 165		

"0900 (9:00 a.m.) [Resident 1] was seen at [Hospital] and has returned. Discharge paperwork indicates closed head injury, scalp laceration and imaging tests of CT cervical spine and head without contrast ..."

A progress note, dated 06/14/2024 indicated Resident 1 received sutures to his/her head laceration. The note read, "Writer called [family member] to let [him/her] know we will take [his/her] sutures out on Monday."

RESIDENT 3
An incident report, dated 06/14/2024, read, in part: "[Resident 3] had another fall in [his/her] bathroom this morning and was sent out to the ER (emergency room) as [s/he] hit [his/her] head and sustained a laceration above [his/her] left eye. It was unwitnessed and [Resident 3] had been washing up at the sink. [S/he] was complaining of left arm pain as well. Staff sent [him/her] to ER. [S/he] returns late afternoon and writer is informed [s/he] had a fracture of [his/her] left ring finger and is in s [sic] soft cast ..."

On 09/23/2024, Surveyor emailed Licensee A, who is also the administrator, Administrator in Training (AT) B, and Registered Nurse (RN) C. Surveyor asked if Resident 1's fall with sutures and Resident 3's fall with a fracture was reported to the Department.

On 09/23/2024, RN C responded, via email, which read in part, "[Resident 3's] fracture of [his/her] finger was not reported. [AT B] was fairly new in [his/her] position and this was an oversight on [his/her] part ... Regarding [Resident 1's] fall with sutures. No, that was not reported. [His/her] scans were negative ... Because [his/her] neurology work up at the hospital was negative,

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N 165	Continued From page 5 we did not consider it a serious injury ..." The provider did not send a written report to the Department after Resident 1 and Resident 3 fell, resulting in injury and requiring emergency room treatment.	N 165		
N 196	83.14(2)(a) Licensee ensures facility complies with laws The licensee shall ensure the CBRF and its operation comply with all laws governing the CBRF. This Rule is not met as evidenced by: Based on observation, record review, and interview, the licensee did not ensure that the provider and its operation were compliant with all laws governing a community based residential facility (CBRF). Since September 2018, the Department has issued enforcement for 10 surveys and substantiated 9 complaints, including this survey. Findings include: On 08/01/2024, the Department received a complaint that alleged the administrator was not overseeing the operations of the facility. This provider is licensed as a class CNA (non-ambulatory) facility to serve up to 17 residents in the client groups of: physically disabled, traumatic brain injury, irreversible dementia/Alzheimer's disease, advanced age, and emotionally disturbed/mental illness. On 09/18/2024 - 09/23/2024, Surveyor conducted	N 196		

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N 196	Continued From page 6 2 verification visits, 2 complaint investigations, 2 self-report investigations. As a result, 8 deficiencies were identified. Six of the 8 deficiencies were repeat deficiencies. Two of the 2 complaints were substantiated. There were substantiated findings related to the 2 self-report investigations. The following deficiencies were identified (* - denotes a repeat deficiency): 83.12(4)(a) Reporting When Resident's Whereabouts Unknown * 83.12(4)(c) Reporting Incident With Serious Injury 83.14(2)(a) Licensee Ensures Facility Complies With Laws 83.32(2)(b) Post Resident Rights, Grievance Procedure * 83.36(1)(b) Qualified Staff In Charge, On Duty And Awake* 83.41(2)(c) Nutrition: Menus * 83.42(1) Resident Record Maintained* 83.44(2)(b) Toilet And Bathing Area* During this survey, Licensee A was also the administrator. Administrator in Training (AT) B was present during the survey but did not complete the course to become the administrator as of 09/23/2024. Licensee A, as the administrator, was responsible for supervising the daily operations of the CBRF, including resident care and services, personnel, and the physical plant. Since September 2018, the provider has shown a pattern of non-compliance. The Department has issued enforcement for 10 surveys and substantiated 9 complaints, including this survey, as indicated in the following Statements of Deficiency (SOD): SOD 0RD611, dated 09/19/2018 - Enforcement	N 196		

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N 196	Continued From page 7 and 2 complaints substantiated. SOD 3F9T11, dated 12/05/2018 - Enforcement and 1 complaint substantiated. SOD 0RD612, dated 03/06/2019 - Enforcement and 1 complaint substantiated. SOD XKI811, dated 05/23/2019 - Enforcement and 1 complaint substantiated. SOD CMWZ11, dated 10/07/2021 - Enforcement. SOD CMWZ12, dated 08/02/2022 - Enforcement. SOD 58BE11, dated 04/10/2023 - Enforcement and 1 complaint substantiated. SOD 58BE12, dated 09/18/2023 - Enforcement. SOD ZM9J11, dated 11/09/2023 - Enforcement and 1 complaint substantiated. SOD 58BE13, dated 09/23/2024 - Enforcement and 2 complaints substantiated. This is the current survey. Licensee A did not ensure the provider and its operation maintained compliance with all laws governing a CBRF.	N 196		
N 344	83.32(2)(b) Post resident rights, grievance procedure Explanation of resident rights, grievance procedure, and house rules. The CBRF shall post copies of resident rights, grievance procedure and house rules in a prominent public place available to residents, employees and guests. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure a copy of the house rules was posted in a prominent place for residents, employees, and guests to view. This is a repeat deficiency. See Statement of	N 344		

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N 344	Continued From page 8 Deficiency ZM9J11, dated 11/09/2023. Findings include: On 09/18/2024 at 3:15 p.m., Surveyor observed a guest come into the facility with a dog on a leash. Administrator in Training (AT) B approached the guest and told them dogs were not allowed at the facility. The guest questioned AT B and said animals were therapeutic for the residents. AT B continued to tell the guest the dog was not allowed. On 09/19/2024 at 9:00 a.m., Surveyor observed the bulletin board by the front entrance and the bulletin board by the office. Surveyor could not locate the house rules on either bulletin board. On 09/19/2024 at approximately 12:00 p.m., Surveyor interviewed Registered Nurse (RN) C and requested additional information to be emailed, including a copy of the house rules. On 09/23/2024, Surveyor reviewed the house rules. The house rules did not contain a rule indicating dogs were not allowed in the facility. Surveyor emailed Licensee A, who was also the administrator, AT B, and RN C, and asked when it became a rule that dogs were not allowed to visit. On 09/23/2024, Licensee A emailed Surveyor, which read, in part: "This has been a 'soft' policy for some time - dependent on various factors. Pets brought in for individual visits in a Residents [sic] room - we have allowed - with the caveat that it be leashed, under control of the owner and only to interact with the visited Resident. So, they are allowed but under certain conditions. This was based on advice my insurance carrier gave us ..."	N 344		

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N 344	Continued From page 9 On 09/23/2024, Surveyor responded, via email, and explained the guest's dog was on a leash. Surveyor also explained the house rules were not posted in the facility. On 09/23/2024, Licensee A replied: "I will check on and post the house rules if they are not posted currently. I understand on the posting. They may have been removed by Residents, Staff or Families." The provider did not ensure a copy of the house rules was posted and remained posted in the facility.	N 344		
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 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	N 397		

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N 397	Continued From page 10 one resident is 4 minutes or more. This Rule is not met as evidenced by: Based on record review and interview, the provider did ensure at least one qualified resident care staff was present and awake in the facility at all times. Caregiver I overdosed on drugs while working alone in the facility. Caregiver J was found sleeping while working alone in the facility. This is a repeat deficiency. See Statement of Deficiency ZM9J11, dated 11/09/2023. Findings include: On 08/07/2024, the Department received a complaint that alleged the provider did not care who was working in the facility as long as there was a body present. The provider is licensed as a class C non-ambulatory (CNA) facility. A class CNA facility serves residents who are ambulatory, semi-ambulatory, or non-ambulatory, but one or more of whom are not physically or mentally capable of responding to a fire alarm by exiting the facility without help or verbal or physical prompting. The provider is licensed to care for up to 17 residents in the client groups physically disabled, traumatic brain injury, irreversible dementia/Alzheimer's disease, advanced age, and emotionally disturbed/mental illness.	N 397		

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N 397	Continued From page 11 CAREGIVER I On 12/31/2023, Former Administrator (FA) H emailed Surveyor, which read, in part: "[FA H] was notified that employee on site was being arrested for an unknown active warrant. Administrator came to Bears Hollow and employee was transported out." On 01/01/2024, the provider faxed a self-report to the Department. The report read, in part: "Staff member [Caregiver I]. Employee overdose [sic] on drugs in the medication room and passed out. 911 was called. EMTs (emergency medical technicians) revive [sic] employee. Employee had a [sic] active warrant unknown to employer. Employee was arrested and transported off premises ..." The report included a list of the residents at the time. The resident census was 14. On 09/18/2024, Surveyor reviewed Caregiver I's employee file. On 05/17/2023, Caregiver I had a suspension, dated 05/17/2023. The documented discipline read, in part: "[Caregiver I] worked a Noc (overnight) shift 10:00pm - 6:45am at Bears Hollow on Saturday May 13-14, 2023. Timbers Sunday May 14, 2023, to fill in per supervisor request 6:00 am - 11:00am. Investigation: The incident report was made as an employee was acting like [s/he] was under the influence of some unknown substance. The employee didn't appear to be [him/herself] as [s/he] was trying to pick things on the floor that weren't there, [s/he] has rash movements, taking things off the bulletin board and wasn't making sense when [she] was talking. *Resident reported to staff member and to Administrator that employee was seen coming in and out at 3:00am and appeared to be under	N 397		

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the influence of some substance while working. Resident stated that employee smelt [sic] of strong order [sic] of something ... Investigation completed and has included [sic] that employee may have been under the influence on May 13-14, 2023. An employee was seen stealing property from Birch Haven activities department located at Bears ... Employee, will be suspended without pay, until employee can submit a drug screen test at [clinic], which Birch Haven pays for and will set up with the facility. If employee refuses drug screen testing, employee will be volunteering to resign employment with Birch Haven Senior Living." This was signed by FA H and Caregiver I on 05/18/2023.

An employee change of status notice, dated 07/17/2023, indicated Caregiver I resigned. The explanation was "no call no show."

A Misconduct Incident Report (MIR) was submitted by FA H on 01/16/2024. The report read, in part, "Employee [Caregiver I] went unconscious and 911 was called. EMTs revived employee, stating employee had appeared to have a drug overdose. Needle found. Police took needle. Employee had a [sic] unknown warrant that employer Birch haven did not know about, and employee was arrested and removed from premises ... Residents were present and saw EMTs and Police. They were confused and concerned."

On 09/18/2024 at approximately 2:30 p.m., Surveyor interviewed Resident 8. Surveyor asked if Resident 8 recalled the night Caregiver I was working and the EMTs and police came. Resident 8 said s/he did remember. S/he told Surveyor Caregiver I had a known drug dealer that would come and visit Caregiver I and s/he was at the

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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
N 397	Continued From page 13	N 397		

facility the night Caregiver I overdosed. Resident 8 said Caregiver I would come in "high and stoned." S/he said Caregiver I would trip over his/her mechanical lift. Resident 8 said s/he reported that to FA H. Resident 8 said s/he received a witness letter that stated Caregiver I was being charged with multiple counts of neglect.

On 09/19/2024, Surveyor emailed Licensee A and requested additional information.

On 09/19/2024, Licensee A replied via email. The email read, in part: "[Caregiver I] would have been working alone... It is my remembrance that when the police arrived, there was an unknown [fe/male] present (non-employee) and that [s/he] was the one that had called 911. We never did find out who [s/he] was as we were not able to obtain the police report... We are not aware of how long [s/he] was unconscious... The case is still being processed- so I am not able to get the report."

CAREGIVER J
On 01/19/2024, the Department received a self-report from the provider. The report description read: "Employee found sleeping on shift from [sic] [Resident 8] as [s/he] had [his/her] pendant on requesting for assistance to go to bed. Employee [Caregiver J] didn't respond. Resident then went to wake employee and [Caregiver J] didn't wake up. Resident called Timbers Edge (the CBRF located next door) and spoke to [Caregiver K] who then came over and woke [Caregiver J]. [FA H] was contacted." This incident occurred 01/19/2024 at 1:30 a.m.

On 09/18/2024 at approximately 2:30 p.m., Surveyor interviewed Resident 8 and asked if

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N 397	Continued From page 14 s/he recalled the night s/he found Caregiver J sleeping. Resident 8 did remember. Resident 8 told Surveyor that s/he went out to the dining room around 11:25 p.m. to fill her mug with water. S/he said s/he observed Caregiver J sleeping. Resident 8 said s/he went back to his/her room and used his/her pendant to call for assistance to get into bed. Resident 8 said Caregiver J did not come to his/her room. Resident 8 said that at 12:15 a.m., s/he then went out to the living area and "shook [him/her] and touched [his/her] face." Resident 8 said his/her pendant was still going off and s/he could not wake Caregiver J. Resident 8 said s/he went back to his/her room and waited until 1:15 a.m. S/he said that at 1:15 a.m., s/he went and tried to wake Caregiver J again. S/he still could not wake him/her. Resident 8 said s/he went to the kitchen and used the phone to call Caregiver K, who was working at Timbers. Resident 8 said Caregiver K came over to Bears and woke Caregiver J. Caregiver J then assisted Resident 8 to bed. Resident 8 told Surveyor they hired Caregiver J back about a month after this incident. Resident 8 said Caregiver J often slept at night, but Resident 8 could usually wake him/her up. On 09/18/2024, Surveyor reviewed Caregiver J's employee file. Caregiver J was hired, terminated and rehired multiple times. On 09/19/2024, Surveyor emailed Licensee A and requested additional information, including dates of Caregiver J's hire and termination. On 09/19/2024, Licensee A emailed Surveyor Caregiver J's chronological order of dates and terminations. Caregiver J's initial hire was 04/19/2022. S/He was terminated 5 times and rehired 4 times. Caregiver J's last termination was identified as: "Terminated for likely diversion of narcotic medication."	N 397		

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N 397	Continued From page 15 The provider did ensure at least one qualified resident care staff was present and awake in the facility at all times.	N 397		
{N 450}	83.41(2)(c) Nutrition: menus. Menus. 1. The CBRF shall make reasonable adjustments to the menu for individual resident ' s food likes, habits, customs, conditions and appetites. 2. The CBRF shall prepare weekly written menus and shall make menus available to residents. Deviations from the planned menu shall be documented on the menu. This Rule is not met as evidenced by: Based on observation, interview, and record review, the provider did not ensure deviations from the planned menu were documented and maintained for 60 days. This is a repeat deficiency. See Statement of Deficiency 58BE12, dated 09/18/2023. Findings include: On 08/07/2024, the Department received a complaint with allegations there was not enough food to make what is planned on the menu. The complaint alleged staff were not documenting what was actually being served. On 09/18/2024 at approximately 11:15 a.m., Surveyor conducted an interview with Administrator in Training (AT) B. Surveyor requested documentation, including the last 60 days of menus. AT B said staff have been good	{N 450}		

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{N 450}	Continued From page 16 with sticking to the menu. S/he said previously staff were changing the menu and they would run out of ingredients on other dates. On 09/18/2024 at approximately 12:15 p.m., Surveyor observed lunch. The menu indicated the vegetable was coleslaw but the residents were served cooked mixed vegetables. On 09/18/2024 at approximately 3:00 p.m., Surveyor reviewed the menus provided by AT B. Surveyor received a rotating 6 week menu. The menus were not dated and there were no deviations documented on the menus. On 09/19/2024 at approximately 8:20 a.m., Surveyor observed and interviewed residents in the dining room eating breakfast. Resident 4 and Resident 5 both told Surveyor they have run out of bread. Resident 6 said, "Just last week, we ran out of toast." Resident 5 said, they have run out of butter a few times. Resident 7 said, "I'd like to get a beef roast. Something cooked in the oven." On 09/23/2024 at approximately 3:30 p.m., Surveyor interviewed AT B on the phone. AT B told Surveyor that at times, staff will call Driver F to go and pick up something from the store if they run out of something. AT B said staff were documenting deviations from the menu on a separate paper. Surveyor asked if s/he had the last 60 days. AT B said s/he did not. Surveyor explained concerns from the residents regarding food and Surveyor should be able to review the last 60 days of menus to know what the residents ate each day.	{N 450}		
{N 454}	83.42(1) Resident record maintained.	{N 454}		

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{N 454}	Continued From page 17 The CBRF shall maintain a record for each resident at the CBRF. Each record shall include all of the following: (a) Resident ' s full name, sex, date of birth, admission date and last known address; (b) Name, address and telephone number of designated contact person, and legal representative, if any; (c) Medical, social, and, if any, psychiatric history; (d) Current personal physician, if any; (e) Results of the initial health screening under s. DHS 83.28(4) and subsequent health examinations under s. DHS 83.38(1)(g); (f)Admission agreement; (g) Documentation of significant incidents and illnesses, including the dates, times and circumstances; (h) Assessments completed as required under s. DHS 83.35(1); (i) Individual service plan and resident satisfaction evaluation; (j) Documentation to accurately describe the resident's condition, significant changes in condition, changes in treatment and response to treatment; (k) Results of the annual resident evacuation evaluation; (l) Documentation of sensory impairment of the resident as required under s. DHS 83.48(7)(b); (m) Summary of discharge information as required under s.DHS 83.31(7); (n) Any department-approved resident-specific waiver, variance or approval; (o) Physician ' s orders or other authorized practitioner ' s written orders for nursing care, medications, rehabilitation services and therapeutic diets; (p) Current list of the type and dosage of medications or supplements; (q) Results of the quarterly psychotropic medication assessments as required in s. DHS 83.37(1)(h)1; (r) Documentation of administration of all medications, supplements, the person administering the medications or supplements, any side effects observed by the employee or	{N 454}		

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{N 454}	Continued From page 18 symptoms reported by the resident, the need for PRN medications and the resident ' s response, refusal to take medication, omissions of medications, errors in the administration of medications and drug reactions; (s) Photocopy of any court order or other document authorizing another person to speak or act on behalf of the resident, or other legal documents as required which affect the care and treatment of a resident; (t) Documentation of all other services including rehabilitation services, treatments and therapeutic diets; (u) Completed notice of pre-admission assessment requirement under s. DHS 83.30; (v) Nursing care procedures and the amount of time spent each week by a registered nurse or licensed practical nurse in performing the nursing care procedures. Only time actually spent by the nurse with the resident may be included in the calculation of nursing care time; (w) Plans of care for terminally ill residents; (x) Date, time and circumstances of the resident's death, including the name of the person to whom the body is released. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Resident 1 and Resident 8's records contained all documentation to accurately describe Resident 1 and Resident 8's condition and all documentation of significant incidents, including the dates, times, and circumstances. This is a repeat deficiency. See Statement of Deficiency 58BE12, dated 09/18/2023. Findings include: On 09/18/2024 at approximately 11:30 a.m.,	{N 454}		

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{N 454}	Continued From page 19 Surveyor requested documentation from Administrator in Training (AT) B and Registered Nurse (RN) C. Surveyor requested the last 6 months of notes and incident reports for Resident 1. Surveyor also requested the incident report and notes surrounding Resident 8's incident, when s/he fell in the shower. RESIDENT 1 On 09/18/2024 and 09/19/2024, Surveyor reviewed Resident 1's notes and incident reports for the last 6 months. On 09/18/2024 at approximately 4:00 p.m., Surveyor interviewed Caregiver D. Caregiver D told Surveyor Resident 1 had been making attempts to elope from the facility. S/he said the past weekend Resident 1 was trying to elope and became physically aggressive with staff and another resident. This was not documented in Resident 1's record. On 09/19/2024, Surveyor reviewed the staff communication notebook located in the medication room and reviewed the following notes: Communication note, dated 09/13/2024 read, in part: "Had insident [sic] with [Resident 1] around 3pm. Tried to elope [s/he] hit staff and resident in the head, hit staff with walker multiple times trying to leave building. [Driver F] was outside so I got help to get [him/her] to [his/her] room to relax ..." Communication note, dated 09/14/2024 read, in part: " ...redirected [Resident 1] and [Resident 9] several times from going outside ..." Communication note, dated 09/15/2024 read, in part: "[Resident 1] hid from me this morning,	{N 454}		

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{N 454}	Continued From page 20	{N 454}		

looked everywhere, got help from Timbers (CBRF located next door). [S/he] was hidding [sic] in the kitchen pantry under the shelves on [his/her] knees ..."

The above incidents were not documented in Resident 1's record.

On 09/19/2024 at approximately 9:00 a.m., Surveyor interviewed Caregiver E. Caregiver E told Surveyor Resident 1 eloped "a couple months ago." Caregiver E said that this past summer, Resident 1 left the facility. S/he said s/he walked with Resident 1 as s/he was not aware of safety. Caregiver E said AT B picked Caregiver E and Resident 1 up with his/her vehicle and brought them back to the facility. Surveyor could not locate documentation of these incidents in Resident 1's record.

On 09/19/2024, at approximately 12:00 p.m., Surveyor interviewed RN C and requested additional documentation to be emailed to Surveyor, including the incidents of Resident 1 attempting to leave and being aggressive with staff.

On 09/23/2024, Surveyor reviewed a fax from RN C which included late entries, dated 09/20/2024, documented by AT B.

On 09/23/2024, Surveyor emailed Licensee A, who is also the administrator, AT B, and RN C. Surveyor asked if the police were called in 2024 to help locate Resident 1.

On 09/23/2024, RN C replied, which read, in part: "The police were called one time when [Resident 1] could not be located. I do not have the exact date but it was about 2 months ago ..."

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{N 454}	Continued From page 21 On 09/23/2024 at approximately 3:30 p.m., Surveyor interviewed AT B and asked what date the police were called when they could not locate Resident 1. AT B said, "I can't recall off the top of my head." Surveyor explained the importance of documentation. Surveyor asked if the caregivers were allowed to document in the residents' records. AT B told Surveyor the caregivers did not have access to document in the residents' records. S/he said they complete handwritten reports in their communication book. The management staff reviews this information and documents it into the resident's electronic record. RESIDENT 8 On 09/18/2024 at approximately 2:30 p.m., Surveyor interviewed Resident 8. Resident 8 told Surveyor that in March 2024, Caregiver G was giving her/him a shower. S/he said Caregiver G was pulling the shower chair backwards and s/he went forward. S/he said his/her legs were pinned under the shower chair. Resident 8 said s/he thought s/he sprained his/her knee. Resident 8 said s/he iced his/her knee and his/her leg remained swollen. Resident 8 said that when RN C returned to work, s/he assessed Resident 8's leg. RN C advised Resident 8 to be seen at the doctor's office. Resident 8 said s/he fractured his/her femur. Resident 8 said s/he had surgery and remained at a skilled nursing facility until August 2024. On 09/18/2024 at approximately 3:05 p.m., RN C told Surveyor s/he could not locate any documentation of the incident in Resident 8's record until RN C assessed Resident 8 on 03/25/2024. RN C said s/he told Former Administrator (FA) H to document an incident report as FA H was working the evening Resident	{N 454}		

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{N 454}	Continued From page 22 8 fell. FA H did not document an incident report. The provider did not ensure Resident 1 and Resident 8's records contained all documentation to accurately describe Resident 1 and Resident 8's condition and all documentation of significant incidents, including the dates, times, and circumstances.	{N 454}		
N 490	83.44(2)(b) Toilet and bathing area. All toilet and bathing areas, facilities and fixtures shall be clean and in good working order. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure all toilet areas remained clean. This is a repeat deficiency. See Statement of Deficiency ZM9J11, dated 11/09/2023. Findings include: On 9/18/2024 at approximately 11:54 a.m., Surveyor observed Resident 10's bathroom. Resident 10's toilet outlet was dirty, the base of the toilet and the floor around the toilet was also visibly dirty. The garbage in the bathroom was full. At 11:55 a.m., Surveyor observed Resident 11's bathroom. His/her toilet had dark yellow urine in it with a foul smelling odor. There was a sign above the toilet that read, "PLEASE FLUSH TOILET." At 12:10 p.m., Surveyor observed Resident 3's bathroom. S/he had a toilet seat riser. The back of the toilet and the toilet riser had brown marks that appeared to be feces on it. The floor	N 490		

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N 490	Continued From page 23 surrounding the toilet was visibly dirty. The garbage can was overflowing with a plastic glove on the floor next to the garbage. On 09/18/2024 at approximately 2:45 p.m., Surveyor interviewed Resident 4. Resident 4 said s/he was trying to get his/her bathroom cleaned for 2 days. S/he said staff just put cleaner in there. S/he said they will clean the bathroom if you ask them to. S/he said the caregivers are busy handing out pills and doing supper dishes. On 09/18/2024 at approximately 4:30 p.m., Surveyor interviewed Caregiver D. Caregiver D said s/he did not have time to clean bathrooms. S/he said s/he will ensure their bedding gets changed and empty their garbage. On 09/19/2024 at approximately 10:22 a.m., Surveyor observed Resident 3's bathroom. It was in the same condition as 09/18/2024, with brown marks splattered on the back of the toilet seat riser and back of toilet. Resident 3 was in his/her room. Resident 3 told Surveyor, "They don't clean like they used to." S/he told Surveyor it made him/her feel unhappy. On 09/19/2024 at 11:32 a.m., Surveyor observed Resident 11's bathroom. Resident 8's toilet water was a dark brown and appeared to have feces in it. The bathroom had a very strong odor. On 09/19/2024 at approximately 11:40 a.m., Surveyor observed Resident 10's bathroom. Resident 10's toilet bowl outlet remained dirty, along with the base of the toilet and the floor surrounding the toilet. The provider did not ensure all toilet areas remained clean.	N 490		

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