STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0011953	A. BUILDING: _____ B. WING _____	R-C 03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PARTNERS STEVENS POINT 1	3349 BUILDING A WHITING AVENUE STEVENS POINT, WI 54481

(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 02/27/2024 and 02/28/2024 Surveyor conducted facility visits at Care Partners Stevens Point 1 to investigate 3 complaints, verify correction of 8 previous deficiencies and review 1 self-report. A fourth complaint was received on 03/01/2024. Information was collected through 03/14/2024. Four (4) of 4 complaints were substantiated. Seven (7) of 8 previous citations were repeat violations. Thirteen (13) new deficiencies were identified. Census: 11 Under statutory provisions of WI Stat. Ch. 50 a $200 revisit fee is being assessed.	{N 000}		
{N 158}	83.12(2)(a) Caregiver: Investigating abuse & neglect Investigating and reporting abuse, neglect, or misappropriation of property. Caregiver. 1. When a CBRF receives a report of an allegation of abuse or neglect of a resident, or misappropriation of property, the CBRF shall take immediate steps to ensure the safety of all residents. 2. The CBRF shall investigate and document any allegation of abuse or neglect of a resident, or misappropriation of property by a caregiver. If the CBRF ' s investigation concludes that the alleged abuse, or neglect of a resident or misappropriation of property meets the definition of abuse or neglect of a resident, or of misappropriation of property, the CBRF shall report the incident to the department on a form provided by the department, within 7 calendar days from the date the CBRF knew or should have known about the abuse, neglect, or	{N 158}		

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

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{N 158}	Continued From page 1 misappropriation of property. The CBRF shall maintain documentation of any investigation. This Rule is not met as evidenced by: Based on interview and record review, after receiving allegations of potential neglect the provider did not take immediate steps to ensure the safety of all residents and did not conduct and document thorough investigations to determine whether misconduct occurred that would require reporting to the office of caregiver quality. Example 1: On 01/18/2024, Administrator A received allegations Resident 1 was observed with dried feces and wearing the same clothes as the day before. Resident 1 had diagnoses to include dementia and relied on caregivers for assistance with dressing and toileting needs. Administrator A did not conduct or document an investigation into the allegations. Example 2: On 02/04/2024, Administrator A was informed Resident 1 was sent to the hospital and diagnosed with a fractured femur and there was no documentation to explain the source of the injury. Administrator A did not take immediate steps to ensure the safety of all residents or promptly conduct or document a thorough investigation into the incident. This is a repeat deficiency being cited for the third time. See Statement of Deficiency (SOD) 5MV212, dated 02/25/2021 and SOD 5MV215, dated 08/16/2023. Findings include: The provider is licensed to serve up to 16 non-ambulatory residents from the following client	{N 158}		

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{N 158}	Continued From page 2 groups; irreversible dementia/Alzheimer's, terminally ill, physically disabled or advanced age. EXAMPLE 1 On 02/27/2024, Surveyor reviewed Resident 1's closed facility record including his/her individual service plan updated 08/15/2023. Resident 1 was elderly and admitted on 08/10/2021. S/he had diagnoses to include dementia. Resident 1 was non-ambulatory and relied on the assistance of 2 staff for transfers. Resident 1 did not use the toilet and needed for incontinence checks/care every 2 hours and assistance with activities of daily living including dressing. Resident 1 was receiving hospice services since at least August of 2023. Surveyor interviewed Hospice Registered Nurse (RN) E on 02/28/2024 at 8:52 AM. RN E described concerns that his/her patients do not receive the incontinence care they need and when s/he tries to address it with caregivers, they just blame other caregivers. Surveyor reviewed documentation from RN E's visits dating back to 01/01/2024 and noted the following: 01/08 - "PATIENT IS SLEEPING IN BED UPON ARRIVAL...WAS WET/SOILED" 01/12 - "PATIENT IS AWAKE IN BED UPON ARRIVAL...VISIBLE SOILED WITH [HIS/HER] BRIEF OFF AND STOOL ON [HIS/HER] HANDS. STAFF CAME IN TO CLEAN AND CHANGE [HIM/HER] AND S/HE BECAME UPSET AND STARTED YELLING. ONCE [S/HE] WAS CHANGED [S/HE] RETURNED TO A PLEASANT MOOD" 01/18 - "PATIENT HAS DRY STOOL ON...CLOTHING AND...SAME CLOTHING ON SINCE [HIS/HER] SHOWER YESTERDAY. UNDERPAD ON BED HAD DRY BROWN	{N 158}		

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{N 158}	Continued From page 3 LIQUID STOOL. [CERTIFIED NURSING ASSISTANT - CNA F] DISCUSSED WITH [ADMINISTRATOR A]" Surveyor interviewed Caregiver M on 02/27/2024 at 5:44 AM. Caregiver M said s/he had concerns with how other shifts cared for Resident 1 and described an incident in mid-February 2024. Caregiver M said s/he worked 3rd shift ending at 6:00 AM and returned 24 hours later for 1st shift with Caregiver G. Caregiver G went to provide morning cares to Resident 1 but brought Resident 1 out of his/her room wearing the same clothes as 24 hours prior and "caked in (urine) and (feces)." Caregiver M was concerned neither night shift nor Caregiver G provided care to Resident 1. Caregiver M said s/he immediately informed Administrator A who "just shook [his/her] head, just sighed." Caregiver M said to his/her knowledge Administrator A did not follow up on the concern. Surveyor reviewed Stevens Police Report C24-01447 on 03/13/2024. Detective R interviewed Caregiver N on 03/01/2024 and wrote, " ...[s/he] has worked a night shift once where an unnamed resident was wearing an outfit. A full 24 hours later, [Caregiver N] came into [his/her] shift with [Caregiver G]. The unnamed resident had not been changed out of [his/her] clothes from 24 hours prior. [Caregiver G] 'pretended' to go get the resident up and changed. [Caregiver G] brought the resident out of [his/her] room with the resident's brief full of 'BM'. [Caregiver N] knew the resident wasn't changed or had [his/her] cares provided. [Caregiver N] immediately went to [Administrator A] to report the staff/resident issue. [Caregiver N] stated that nothing gets done."	{N 158}		

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{N 158}	Continued From page 4 On 02/27/2024 at 6:41 AM, Surveyor interviewed Assistant Administrator K. S/he said, "[Administrator A] knows [Caregiver G] avoids cares, [s/he] is working on that right now. It's a lot all at once [s/he] has to take little steps." Upon request, Administrator A provided Surveyor a binder and said it contained documentation of all investigations s/he has completed since 01/01/2024. On 02/28/2024 at 4:31 PM, Surveyor reviewed the binder and there was no documentation of an investigation into the aforementioned care concerns for Resident 1. EXAMPLE 2 The Department received 2 complaints alleging concerns about a serious injury sustained by a resident and the provider's response to it. The Department also received a self-report authored by Administrator A. Administrator A wrote s/he was informed by caregivers on 02/04/2024 at 8:30 AM via phone call that Resident 1 was injured, sent to the hospital at approximately 5:30 AM and subsequently diagnosed with a fractured femur. S/he was informed there was no documented fall or other incident to explain the cause of the injury. The report read, "I called all staff that was working...from pm on Friday thru Sunday morning...asked them all to fill out statements on everything that they have done for [Resident 1] with cares, mobility, food intake and etc...As of today (02/05/2024), no one has come forward on what has happened to obtain this kind of injury...I'm still trying to figure out what happened to cause this injury, I will keep investigating." [sic-all]	{N 158}		

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{N 158}	Continued From page 5 Surveyor note: The report was vague and did not include dates and times for relevant portions of Administrator A's response. The report did not describe immediate actions taken to ensure residents' health, safety and well-being while the matter was pending. In addition, during the Department's investigation documented below, Administrator A acknowledged s/he did not call, interview or collect statements from all staff that were working during the days preceding the discovery of the injury. Included with the self-report was written documentation from caregivers which detailed neglect. According to the documentation, Resident 1 displayed a change of condition begining at lunch on 02/03/2024. Caregivers L, M and N wrote that between 4:00 PM and 8:30 PM Resident 1 refused incontinence checks, transfers, meals and all cares. At 9:40 PM Caregivers L, M and N observed Resident 1 was covered in feces, his/her left leg was swollen and in an awkward position and s/he "screamed in pain" when staff straightened it. Resident 1 informed staff s/he fell earlier in the day. Caregivers cleaned Resident 1 by rotating him/her side to side, then pivot transferred Resident 1 into the wheelchair. Assistant Administrator (AA) K arrived at 10:00 PM, observed Resident 1 was in pain and the left leg was swollen. AA K did a 1-person pivot transfer to return Resident 1 to bed for the night. At 4:00 AM, AA K rolled Resident 1 side to side to perform fecal incontinence care while Resident 1 "screamed in pain." Resident 1 did not receive pain medication or medical assessment until after 4:30 AM. Surveyor reviewed Hospice RN Q's documentation of a visit for Resident 1 on	{N 158}		

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{N 158}	Continued From page 6 02/04/2024 which read in part, "I was called out for a visit due to staff concerns regarding swelling in patient's left upper leg at about 5am...I moved [Resident 1]'s blanket and attempted to touch [his/her] leg to assess it. Before my hand was even on [his/her] leg [s/he] began screaming in pain telling me not to touch it and that it hurt. I asked [Resident 1] what happened and [s/he] said, '[S/he] threw me on the floor.' I asked who and [Resident 1] repeated that [his/her] leg hurt...While I was working on charting my visit I overheard [AA K] say to an oncoming staff member something along the lines of '[Resident 1] was doing so well, then [s/he] moved to this building and now [s/he]'s hurt, I'm just saying.'..." Surveyor interviewed Guardian P on 03/01/2024 at 8:01 AM. Guardian P said s/he was informed by hospice about Resident 1's undocumented injury and described feeling suspicious of caregiver misconduct. Guardian P said at baseline, Resident 1 was not able to independently transfer or prone to try, but even if s/he had an unwitnessed fall it would have been impossible for him/her to transfer from the floor into bed independently given the severity of the fractures. Guardian P said, "things weren't adding up" and as of 9:17 AM s/he still had not heard from any facility staff. S/he stated, "I was concerned that come Monday, maybe things would change. Maybe documentation would change...I was afraid of some sort of cover up because none of this makes any sense." Guardian P decided to go to the facility in person the morning of 02/04. S/he observed toileting logs were present in Resident 1's room which prompted caregivers to chart 2 hour incontinence checks. Guardian P observed gaps in the charting and scanned copies of the logs. S/he sent them to Surveyor for review on 03/01/2024.	{N 158}		

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{N 158}	Continued From page 7 Surveyor noted the log dated 02/03/2024 captured 1st, 2nd and 3rd shift into the morning of 02/04/2024. The only overnight checks were 9:00 PM and 5:00 AM, in spite of Resident 1 having a known change in condition and needing 2 hour incontinence checks and repositioning at baseline. Surveyor also noted Caregivers M and N documented 2 hour checks at 3:00 PM, 5:00 PM and 7:00 PM and charted Resident 1 was continent each time. Those times contradicted their other written documentation reporting Resident 1's refusals of incontinence checks until 9:40 PM Surveyor interviewed Detective R with the Stevens Point Police Department on 02/28/2024 at approximately 8:00 AM. Detective R and adult protective services (APS) were doing a joint, active investigation into the cause of Resident 1's injury to determine if criminal abuse or neglect occurred. S/he said the initial report did not come from the provider and they were unaware of the injury until 02/08/2024. Detective R said the timeframe of the injury was most likely 02/03 - 02/04 and during the investigation, Administrator A had not been forthcoming about the fact that Caregiver O worked a portion of 2nd shift on 02/03/2024. In addition, Administrator A was not forthcoming about future scheduling to assist Detective R in knowing when s/he could interview staff. Eventually, Detective R determined the following 8 caregivers worked on 02/03: 1st shift - Caregivers G and H 2nd shift - Caregivers L, M, N and O Caregiver O left abruptly approximately 2 hours into 2nd shift due to an anxiety attack and Caregiver M arrived between 4-5:00 PM 3rd shift - Caregivers J and Assistant Administrator K	{N 158}		

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{N 158}	Continued From page 8 Upon request on 02/27/2024, Administrator A provided Surveyor with all documentation of his/her investigation since the self-report was authored on 02/05/2024. Surveyor noted the documentation did not indicate toileting logs were reviewed and it did not include documentation of interviews with 5 of 8 caregivers who worked 02/03-02/04 (Caregivers G, H, M, N or O.) Upon request on 03/06/2024, Administrator A provided a copy of Resident 1's toileting logs for 02/03-02/04. Surveyor noted it was the same document scanned by Guardian P the morning of 02/04, however Administrator A's copy was altered. AA K added checks at 10:30 PM, 12:30 AM and 3:00 AM. The date "2/4" was written over the original date of "2/3". This date was not accurate because Resident 1 was sent to the hospital approximately 5:30 AM on 02/04. Surveyor interviewed Administrator A (02/27/2024 at 7:44 AM and 11:15 AM and 03/13/2024 at 8:30 AM) and s/he stated the following: On 02/04 after learning of the injury, neither Administrator A nor other management reported to the facility to ensure the safety of residents or begin an investigation. This did not happen until 24 hours later on 02/05. On 02/04, all 8 aforementioned staff worked 1st, 2nd and 3rd shift without additional management supervision. While working together, they wrote statements about cares provided to Resident 1 during their previous shift. The statements of cares were not part of an active interview process. Administrator A subsequently learned Caregivers L and N copied each other's statements. S/he did not have follow up communication with Caregiver N about this. Caregiver O did not provide a written statement and Administrator A did not make attempts to obtain a statement or interview him/her. Surveyor	{N 158}		

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{N 158}	Continued From page 9 note: Caregivers O was 1 of 2 staff that matched the gender Resident 1 used when s/he told Hospice RN Q s/he was thrown to the ground. Administrator A did not review the toileting logs to compare with the written staff statements or consider them as a source of evidence. After Surveyor showed Administrator A the logs obtained by Guardian P, Administrator A acknowledged the copy s/he provided Surveyor was different and apparently altered. Four days after the injury on 02/08, some of the involved caregivers were issued 3 day disciplinary suspensions. Administrator A said, "I can't fire all my staff. I did suspend 5 of them because they were driving me nuts." Three more times during interviews with Administrator A, s/he reiterated staff were suspended because they kept trying to talk with him/her about what may have caused Resident 1's injury and s/he needed to be left alone to investigate. Surveyor noted these were missed opportunities for interviews. According to the DHS "WISCONSIN BACKGROUND CHECK AND MISCONDUCT INVESTIGATION PROGRAM MANUAL" revised 01/2024, "All entities regulated by DQA must conduct a thorough internal investigation and document the findings for all allegations or incidents at the entity. A thorough internal investigation may include: Collecting and preserving any physical and documentary evidence...; Interviewing alleged victims and witnesses; Collecting other corroborating/disproving evidence; Involving other regulatory authorities who can assist (e.g., local law enforcement, elder abuse agency, Adult Protective Service agency, DQA, Board on Aging Ombudsmen, Client Right's Specialist, etc.); and Documenting each step taken during the internal investigation. These steps should be taken as	{N 158}		

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{N 158}	Continued From page 10	{N 158}		

part of the entity's initial attempt to determine what, if anything, happened and to determine the complete factual circumstances surrounding the alleged incident." https://www.dhs.wisconsin.gov/publications/p0/p00038.pdf

On 03/13/2024, Surveyor received and reviewed Stevens Point Police Department report C24-01447 authored by Detective R. Surveyor noted the following interview, "I asked [Caregiver O] if [Administrator A] followed up with [Caregiver O] at all on why [s/he] did not stay for [his/her] full shift on the 3rd. [Caregiver O] said no...I asked [Caregiver O] if [Administrator A] talked to [him/her] about anything, why [s/he] left, where [his/her] statement was, why [s/he] didn't write a statement, what [s/he] saw or heard on the 3rd. [Caregiver O] said no." The police report concluded, "Through my investigation and interviews, I found numerous inconsistencies...staff members admitting to copying statements... The investigation that [Administrator A] had completed...I could not find credible...due to the misinformation and inconsistencies [s/he] provided me throughout my investigation. With this information, I am unable to request any criminal charges."

Surveyor interviewed Regional RN C on 02/27/2024 at 8:07 AM and 02/28/2024 at 11:15 AM. RN C stated whether the injury was intentional or not, s/he considered the caregivers' response to it a form of misconduct. Specifically, s/he said the failure on 02/03/2024 to immediately report the injury and/or subsequent change in condition to hospice and the administrator is a "bigger issue, it could be abuse." S/he said caregivers "failed to take care of the resident" and while "accidents happen, if it happened and you

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{N 158}	Continued From page 11 hid it, then it's abuse." RN C acknowledged Administrator A did not report to the facility for 24 hours after being informed of the unexplained injury and there was no immediate response by other management to ensure the safety of residents and begin an investigation. RN C expressed disappointment Administrator A didn't inform the corporate office until the afternoon of 02/05/2024. RN C also acknowledged the ineffectiveness of having involved staff write statements while they were together and that were not part of an interview process. S/he confirmed some staff copied each other's statements and others wrote information that was "off track" and irrelevant to the incident. Cross Reference: N0161 DHS 83.12(3) Investigate Injuries of Unknown Source N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies with Laws N0214 DHS 83.15(3) Administrator Shall Supervise Daily Operations N0348 DHS 83.12(2) Rights Of Residents: Free From Mistreatment N0399 DHS 83.36(2) Maintain Current Written Staffing Schedule Y3244 CH 50.09(1)(L) Care	{N 158}		
{N 161}	83.12(3)(a) Investigate injuries of unknown source. Investigating injuries of unknown source. A CBRF shall investigate any of the following: 1. An injury that was not observed by any person. 2. The source of an injury to a resident that cannot be adequately explained by the resident. 3. An injury to a resident that appears suspicious because of	{N 161}		

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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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the extent of the injury or the location of the injury on the resident.

This Rule is not met as evidenced by:
Based on observation, record review and interview, the provider did not conduct investigations to determine the source of bruising for Resident 1, Resident 4 and Resident 8.

This is a repeat, uncorrected deficiency. See Statement of Deficiency 5MV215, dated 08/16/2023.

Findings include:

The provider is licensed to serve up to 16 non-ambulatory residents from the following client groups; irreversible dementia/Alzheimer's, terminally ill, physically disabled or advanced age.

EXAMPLE 1 - Resident 1

Prior to conducting the onsite visit, Surveyor reviewed the facility's compliance history. During the previous survey on 08/16/2023, the provider was issued a citation for not investigating bruises of unknown origin on Resident 1's legs. On 02/28/2024, Administrator A provided Surveyor with the plan of correction (POC) for the deficiency which read, "No further harm or abuse to [Resident 1]...Bruise healed w/out complications, pain or other concerns...was not r/t abuse...Regional nurse reviewed Reportable incidents & all parts needed with Admin...All staff had re-education 10/10/23 job duties; including body audits...correct documentation...incident reports..." Correction date 10/27/2023. [sic-all]

On 02/27/2024, Surveyor reviewed Resident 1's closed facility record. Resident 1 was elderly,

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{N 161}	Continued From page 13	{N 161}		

non-ambulatory, had diagnoses to include dementia and was receiving hospice services. Resident 8's medication list did not include blood thinners. On 02/04/2024 Resident 1 was diagnosed with a fractured femur and the cause of the injury was unknown.

On 02/28/2024 at 8:52 AM, Surveyor interviewed hospice registered nurse (RN) E and certified nursing assistant (CNA) F. CNA F said 2 weeks before Resident 1 was diagnosed with a fractured femur (diagnosis date 02/04/2024), s/he observed Resident 1 had "a bunch of little bruises on [his/her] lower leg. They didn't make sense." RN E said s/he also observed the bruises and said they were the shape of "polka dots...like finger spots all over." Both CNA F and RN E said they did not know of a logical cause for the bruising and described Resident 1 as being unable to explain the source due to his/her diagnoses of dementia. CNA F said, "I brought [Administrator A] in there to look at them."

Upon request on 02/28/2024, Administrator A provided Surveyor a binder and said it contained documentation of all investigations s/he has completed since 01/01/2024. Surveyor reviewed the binder and noted there was no documentation of an investigation into the bruising.

On 03/13/2024 at 8:30 AM, Surveyor conducted an interview with Administrator A. S/he confirmed CNA F informed him/her of the bruising and said s/he "likely" did not document it. Administrator A said s/he assumed the bruising occurred during a staff assisted transfer but did not describe any investigative steps taken to reach that conclusion.

EXAMPLE 2 - Resident 8

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{N 161}	Continued From page 14 During the aforementioned review of the investigation binder, Surveyor noted incident reports which documented injuries of unknown origin, but did not include evidence of investigations to determine the causes of the injuries. For example, there was an incident report dated 01/17/2024, authored by a caregiver and signed by Administrator A that documented bruises on both of Resident 8's buttocks. The form prompted for "Action Taken immediately" and the handwritten response was "see care notes." Surveyor reviewed the care notes which only described the discovery of the bruises by caregivers. The incident report also prompted for "Immediate Director follow up and comments" which read, "will monitor and let physician know." Neither the form nor the care notes included information to show Resident 8 was asked about how the bruising was sustained, or any other investigative steps taken to determine the source of the injury. Surveyor reviewed portions of Resident 8's record on 03/06/2024 and noted s/he had diagnoses to include Alzheimer's dementia and relied of staff for toileting and transfer needs. Resident 8's medication list did not include blood thinners. During an interview with Administrator A on 02/28/2024 at 4:41 PM, s/he confirmed there was no additional documentation of investigations for the incident reports and his/her process was to document the injury and make notifications. EXAMPLE 3 - Resident 4 On 02/27/2024 at 5:36 AM, Surveyor observed Caregiver M and Assistant Administrator K perform incontinence care for Resident 4. While	{N 161}		

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performing cares, both staff pointed out bruising on Resident 4's buttock and upper right thigh. Neither staff knew the source of the bruising but both speculated the bruise on the thigh was from unwitnessed attempts to self-transfer into the wheelchair.

During the aforementioned review of the investigation binder on 02/28/2024, there was no documentation of an investigation into the bruising.

On 02/28/2024 Surveyor reviewed portions of Resident 4's record. His/her diagnoses were major neurocognitive disorder with behavioral disturbances and Parkinson's disease. The ISP section for the medication list was blank; Surveyor noted Resident 4 did not have diagnoses that would indicate the need for blood thinners. Resident 4 used a wheelchair for ambulation and relied on staff assistance with bathing, toileting, dressing and other activities of daily living. The individual service plan was silent to Resident 4's transfer needs or interventions to ensure Resident 4's safety if s/he was prone to self-transfer. Resident 4's record did not document the bruising. Surveyor reviewed documentation of showers during February 2024 found in caregiver notes and on forms titled "Shower Day Worksheet/Body Audit" and noted the following:

February 2024:
02/02 - no bruising charted (body audit)
02/06 - "old bruise still on butt" (body audit)
02/13 - no bruising charted (body audit completed by Administrator A)
02/23 - "no concerns and nothing new found" (body audit)
02/27 - shower given by Caregiver G, no bruising

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{N 161}	Continued From page 16 noted (charted in notes - no worksheet/body audit completed) On 02/28/2024 between 12:49 PM and 1:30 PM Surveyor conducted interviews Caregiver G and Caregiver H. Administrator A and RN C were present and particpated. Caregiver G said s/he was unaware of current bruising because s/he did not give the shower s/he charted on 02/27, Caregiver H did. Caregiver H said s/he gave the shower the previous day, but did not recall bruising on Resident 4's buttocks or thigh At the conclusion of the interviews, Administrator A offered toileting assistance to Resident 4 and assessed him/her for bruising. After the assessment, Administrator A informed Surveyor there was bruising on Resident 4's buttocks near his/her tailbone. Administrator A and RN C acknowledged no investigation into the source of the bruising was completed because caregivers did not follow procedure to document or report the bruising to Administrator A. Cross Reference: N0158 DHS 83.12(2)(a) Caregiver: Investigating Abuse & Neglect N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies with Laws N0214 DHS 83.15(3) Administrator Shall Supervise Daily Operations N0348 DHS 83.12(2) Rights Of Residents: Free From Mistreatment N0389 DHS 83.35(3)(d) Service Plans Updated Annually Or On Changes Y3244 CH 50.09(1)(L) Care	{N 161}		

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N 196	Continued From page 17	N 196		
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, interview and record review, the licensee did not ensure the CBRF and its operation comply with all laws governing the CBRF. The is a repeat deficiency being cited for the 3rd time. See Statement of Deficiency (SOD) 5MV214, dated 09/01/2022 and SOD 5MV213, dated 06/30/2021. Findings include: During the past 4 years and over the course of 6 consecutive surveys, the provider displayed a pattern of ongoing non-compliance with regulations. The current survey SOD5MV216 ending on 03/13/2024, identified 13 new deficiencies resulting from 4 of 4 substantiated complaints and 7 of 8 uncorrected deficiencies. The 13 new deficiencies included the following recites: Caregiver: Investigating Abuse & Neglect- 3rd recite and uncorrected from 5MV215 Investigate Injuries of Unknown Source - 2nd recite and uncorrected from 5MV215 Licensee Ensures Facility Complies with Laws - 2nd recite Continuing Education recite - 2nd recite and uncorrected from 5MV215	N 196		

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Rights Of Residents: Free From Mistreatment recite - 2nd recite and uncorrected from 5MV215
Service Plans Updated Annually Or On Changes - 2nd recite
Leisure Time Activities recite - 2nd recite and uncorrected from 5MV215
Rooms Clean and Free From Odors - 2nd recite and uncorrected from 5MV215
Interior Floors, Walls and Ceilings - 4th recite and uncorrected from 5MV215
Care - 2nd recite

On 02/27/2024, Surveyor interviewed Administrator A and Regional Registered Nurse (RN) C. Administrator A said Licensee B had not been onsite at the facility since the last survey ending 08/16/2023. RN C said regional staff share information with Licensee B as needed.

On 03/11/2024, Surveyor sent an email to Licensee B which read, "I am hopeful your administrator and/or regional staff have informed you of the Department's survey work at both Stevens Point locations. I just sent an email to [Administrator A] asking to schedule the exit conference Weds 3/13 at 8:30 or 9:00am. I will need about an hour to ask some follow up questions and then will review the preliminary findings, which are significant. I will be sending a Microsoft Teams invite for this meeting...I would like to include you...Does this date/time work for you? Thank you" Licensee B responded, "Yes this will work with my schedule please send me an invite also." Surveyor scheduled the exit conference via Microsoft Teams on 03/13/2024 at 8:30 AM and sent Licensee B a meeting invite.

On 03/13/2024 at 8:30 AM, only Administrator A and Regional RN H joined the meeting. Surveyor asked if Licensee B would be joining and RN H

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replied, "No, it would be unprecedented." and was surprised Surveyor thought otherwise. RN H asked if Licensee B has ever joined an exit conferences with Surveyor in the past. Surveyor explained Licensee B had not attended past exit conferences but Licensee B was informed the findings of the current survey were significant and agreed to attend. Licensee B did not join the meeting any time prior to the conclusion at 11:37 AM and did not subsequently contact the Department to review the findings or provide additional information.

The current survey is the 6th consecutive survey with substantiated complaints, uncorrected deficiencies and/or repeat deficiencies. This survey event history is as follows:

SOD 5MV211, dated 06/25/2000 - 1 of 5 complaints substantiated and 2 deficiencies:
Supervision related to the elopement of a resident who left the facility twice within four days.
Health Monitoring related to a resident who suffered a change of condition, which was not assessed or reported. The resident went to the hospital the next day and later died of urinary sepsis.

SOD 5MV212, dated 02/25/2021 - 2 of 2 complaints substantiated, 1 of 2 deficiencies uncorrected and 9 new deficiencies.
Caregiver: Investigating Abuse & Neglect related to an allegation of caregiver abuse and an incident of caregiver neglect. Neither incident prompted the provider to take immediate steps to protect residents, or complete a thorough investigation of the incidents.
Orientation
All Employee Tyrannizing
Rights Of Residents: Receive Medication related

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to the administration of medications to a diabetic resident.
Service Plans Updated Annually Or On Changes
Qualified Staff In Charge, On Duty and Awake
Health Monitoring
Infection Control Program
Care
Special order: "the Department of Health Services HEREBY ORDERS that Care Partners Stevens Point 1 NOT ADMIT ANY NEW OR ADDITIONAL RESIDENTS until all violations in Statement of Deficiency (SOD) #5MV212 are corrected..."
Special order: "Pursuant to Wis. Stat. § 50.03(5g)(b)6....the licensee shall ensure the administrator supervises the daily operation and ensures the provision of services to meet residents' physical and mental health needs. In consultation with a Registered Nurse (RN), the licensee will develop (or review/revise) procedures to address...Health Monitoring...Caregiver Misconduct..."

SOD 5MV213, dated 06/30/2021 - 1 of 9 deficiencies uncorrected, 3 new deficiencies with 2 of 3 being repeat deficiencies.
Licensee Ensures Facility Complies with Laws
Infection Control Program
Interior Floors, Walls and Ceilings

SOD 5MV214, dated 09/01/2022 - 1 of 3 complaints substantiated, 2 of 3 deficiencies uncorrected, 4 new deficiencies with 2 of 4 being repeat deficiencies.
Licensee Ensures Facility Complies with Laws
Rights Of Residents: Confidentiality
Medication Storage: Locked Cabinet
Infection Control Program

SOD 5MV215, dated 08/16/2023 - 1 of 1 complaint substantiated, 8 new deficiencies with

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N 196	Continued From page 21 3 of 8 being repeat deficiencies. Caregiver: Investigating Abuse & Neglect Investigate Injuries of Unknown Source Orientation Continuing Education Rights Of Residents: Free From Mistreatment Leisure Time Activities Rooms Clean and Free From Odors Interior Floors, Walls and Ceilings Special order: "Pursuant to Wis. Stat. § 50.03(5g)(b)6., the licensee shall develop and implement corrective measures to ensure the provision of a daily activity program to meet the interests and capabilities of the residents. Employees shall encourage and promote resident participation in the activity program. The CBRF shall develop and post the activity schedule in an area available to residents." During the surveys conducted between 2020-2023; Residents experienced elopements and preventable falls with injuries. Residents did not receive medications or health monitoring, developed pressure injuries and were subjected to verbal abuse. Caregivers did not receive required training and the administrator did not investigate allegations of abuse or injuries of unknown origin for vulnerable residents. The facility was not well maintained to provide a homelike environment and leisure time activities were not provided. Cross Reference: N0158 DHS 83.12(2)(a) Caregiver: Investigating Abuse & Neglect N0161 DHS 83.12(3) Investigate Injuries of Unknown Source N0214 DHS 83.15(3) Administrator Shall Supervise Daily Operations N0230 DHS 83.19 Orientation	N 196		

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N 196	Continued From page 22 N0277 DHS 83.25 Continuing Education N0348 DHS 83.12(2) Rights Of Residents: Free From Mistreatment N0389 DHS 83.35(3)(d) Service Plans Updated Annually Or On Changes N0399 DHS 83.36(2) Maintain Current Written Staffing Schedule N0416 DHS 83.37(2)(e) Other Administration Given or Delegated by RN N0427 DHS 83.38(1)(c) Leisure Time Activities N0432 DHS 83.38(1)(h) Medication Administration N0489 DHS 83.44(2)(a) Rooms Clean and Free From Odors N0491 DHS 83.44(2)(c) Interior Floors, Walls and Ceilings Y3244 CH 50.09(1)(L) Care	N 196		
N 214	83.15(3)(a) Administrator shall supervise daily operation The administrator shall supervise the daily operation of the CBRF, including but not limited to, resident care and services, personnel, finances, and physical plant. The administrator shall provide the supervision necessary to ensure that the residents receive proper care and treatment, that their health and safety are protected and promoted and that their rights are respected. This Rule is not met as evidenced by: Based on observation, interview and record review, Administrator A did not supervise the daily operations of the CBRF to ensure residents	N 214		

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received necessary care and services, their rights were protected and they lived in a safe environment.

Administrator A did not ensure 7 of 8 previous citations were corrected and a total of 13 new deficiencies were identified during the current survey.

In addition, Administrator A did not ensure Resident 6 and Resident 2's rights to self-determination and dignity were respected; did not routinely review documentation to ensure medications were administered or charting was accurate; did not address concerns that staff were caring for vulnerable residents while under the influence of drugs; did not investigate allegations or provide increased supervision of caregivers to ensure residents were receiving appropriate care.

Findings include:

As a result of the current survey, four of 4 complaints were substantiated, seven of 8 citations from the previous survey were uncorrected and 13 new deficiencies were identified. Administrator A was in his/her role during both the previous and current survey.

Surveyor conducted interviews, observations and record reviews between 02/27 - 03/13/2024 which consistently identified concerns with Administrator A's oversight. The 13 new deficiencies resulted in actual negative outcome for Residents 1, 2, 3, 6 and 7 and the strong potential for negative outcome for Resident 4.

In addition to the 13 new deficiencies, other areas of concern were identified where Administrator A

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did not provide adequate supervision and monitoring to ensure all residents' rights were respected, they received appropriate care and services and they lived in a safe environment. Examples include:

EXAMPLE 1 - RESIDENT RIGHTS CONCERNS

Resident 6:
On 02/27/2024 at 2:09 PM, Surveyor interviewed Resident 6 and Family Member W. Surveyor observed Resident 6 was in a wheelchair. Resident 6 said, "I don't know why we can't get someone to push us somewhere...they say we can't get someone to push us." Resident 6 explained s/he likes to go outside to smoke and "I like to sit out there. I love the pretty sunshine." Resident 6 said earlier in the day, Resident 7 (who also uses a wheelchair) helped him/her exit the building and "I thanked [him/her] wholeheartedly...It's a chore for me...I bang myself on the arm and leg trying to get out...You just get out the best way you can. You push through it." Resident 6 said s/he has weakness in one arm and Family W said, "[S/he] has to get out there with [his/her] one good arm."

On 02/27/2024 at 1:37 PM, Surveyor observed Caregivers G and M completing end of shift charting which included documenting in the "24-hour book." Surveyor reviewed the book and 2 entries read:

01/17/2024: "Per [Administrator A] if the Resident [sic] wants to smoke they are to take themselves outside. We are not to be taking them out (pushing them!) They can take themselves out."
01/18/2024: "If the Resident [sic] wants to smoke they are to take themselves outside. We ARE NOT to be taking them out (pushing them). They

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N 214	Continued From page 25 can take themselves out. Per [Administrator A]" Surveyor noted the forms in the 24-hour book prompted for important, resident specific information to include "Skin Issues", "Medication Changes" and "Illness/Change of Condition." There was also a section titled "Notes from the Director." During an interview on 03/13/2024 at 8:30 AM, Administrator A denied directing staff not to help residents go outside. Surveyor showed Administrator A the 01/17 and 01/18 notes and asked if s/he reviewed the 24-hour book regularly. S/he replied, "not often" and [s/he] is "more interested in the med books." Administrator A said after the last survey s/he tried to review caregiver charting weekly, but 3 months ago the previous assistant administrator left and s/he didn't have time to review anything other than medication administration records (MARs). (Surveyor note: See Resident 7 example below.) Resident 2: On 02/27/2024 at 8:34 AM, Surveyor interviewed Resident 2. S/he said s/he does not like living at the facility, in part because of Administrator A. On 02/27/2024 at 10:16 AM, Surveyor conducted a joint interview with Resident 2 and Spouse Y. Spouse Y confirmed Resident 2 doesn't like Administrator A and said it may be because Administrator A "brushes it off" when Resident 2 tries to tell him/her things. Spouse Y said s/he also brought a concern to Administrator A and it has not been resolved. Spouse Y explained, "they don't get [Resident 7] up to do a BM (bowel movement)" staff say it's "too hard" to transfer him/her to the bathroom "so just go in your brief." Resident 7 interjected and	N 214		

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N 214	Continued From page 26 told Surveyor it happens "all the time" and Caregiver Z says, "Do it in your pants." Spouse Y said it is safe for 2 staff to transfer Resident 7 most days but acknowledged sometimes s/he has a bad day. Surveyor did not observe a mechanical lift in the room and Spouse Y said, "they lift [under] his/her armpits...then shuffle with [him/her]" Spouse Y stated Resident 7 has skin integrity concerns and a catheter. S/he was worried Resident 7 would lose motivation to be independent if s/he wasn't allowed to use the toilet anymore and was concerned if Resident 7 was left "sitting in BM" s/he would be at higher risk for urinary tract infections (UTIs) due the catheter. Spouse Y said s/he and Registered Nurse (RN) X (funding source care manager) informed Administrator A of the concern at the recent individual service plan (ISP) meeting and Administrator A said staff can't handle transferring Resident 7 and the best approach is for [him/her] to go in [his/her] brief. On 02/28/2024 at 3:14 PM, Surveyor interviewed Administrator A and Facility RN C. Administrator A confirmed the concern was brought to his/her attention at the 02/01/2024 ISP meeting. Administrator A said s/he did not do an investigation to determine if caregivers were refusing to take Resident 7 to the toilet but said, "I believe my staff would have said that." RN C responded, "If you believe they would say that, that is a dignity issue." Surveyor asked Administrator A if s/he agreed it was best for Resident 7 to BM in his/her brief. Administrator A did not answer the question but replied, "We need to get a lift order. I feel it's not safe for [him/her] to sit on the toilet." Administrator A said since the ISP meeting s/he had not done any follow up with the care team to obtain a lift for transfers. Later in	N 214		

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the interview Administrator A said, "Yes I told them (caregivers) to toilet [him/her]. They're not listening to me." Surveyor asked how the information was relayed to caregivers and s/he said, "Probably in a staff memo, I posted it probably. I had a meeting on the 8th, I talked about a lot of things on the 8th." Administrator A did not provide Surveyor with a memo. S/he did provide the meeting agenda for 02/08/2024 and it did not identify Resident 7's toileting needs or review his/her rights to self-determination and dignity. RN C said s/he was present for most of the meeting on 02/08/2024 but did not recall the topic.

Surveyor reviewed Resident 7's ISP on 03/06/2024. It was signed and dated by Administrator A on 02/01/2024. The ISP was silent to the aforementioned needs and possible interventions reviewed at the ISP meeting.

On 02/28/2024 at 4:08 PM, Surveyor interviewed RN X. RN X confirmed the concern about Resident 7 not using the toilet was addressed at a 02/01/2024 ISP meeting and the plan was to put a commode at bedside to make it easier to transfer. (Surveyor did not observe a commode in Resident 7's room on 02/27/2024.) RN X also confirmed Resident 7 is at high risk for UTIs.

On 02/28/2024 at 4:47 PM, Surveyor conducted a follow up interview with Administrator A and RN C and relayed the information from RN X about the commode intervention. During the exit conference on 03/13/2024 at 8:30 AM, Administrator A said s/he followed up with the funding source and Resident 7 was now using a bedside commode for toileting needs.

EXAMPLE 2: OVERSIGHT AND SUPERVISION

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N 214	Continued From page 28 OF CAREGIVERS The Department received a complaint alleging concerns with 3rd shift staff. On 02/27/2024 at 5:10 AM, Surveyor joined Caregiver M who was in the process of completing rounds to check residents for incontinence. Caregiver M initially identified the remaining residents that needed to be checked as Resident 2, Resident 3, Resident 4 and Resident 6. In spite of Caregiver M stating Resident 2 needed to be checked, s/he did not check [Resident 2]. S/he told Surveyor Resident 2 would just call if s/he needed help. Surveyor reviewed Resident 2's record on 02/28/2024 which documented the need for 2 hour incontinence checks and a worsening pressure injury on his/her bottom. Caregiver M also changed his/her statements about Resident 3 and 4 and told Surveyor s/he didn't need to do their checks. Surveyor prompted Caregiver M to complete the checks and both Residents 3 and 4 were soaked in urine. Surveyor conducted an interview with Detective R on 02/28/2024 at approximately 8:00 AM and reviewed Stevens Point Police Department reports C24-01447 and C24-00256 on 03/13/2024. On 02/23/2024 at 5:00 AM while investigating potential abuse of Resident 1, Detective R made an unannounced facility visit. S/he observed 1 of 2 caregivers sitting in the front common area with his/her bare feet up on a table, slippers nearby and wearing a sleeping cap on his/her head. The caregiver was on his/her cell phone, did not get up to assist Detective R and risked waking	N 214		

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residents by yelling loudly for the other caregiver. During this same investigation, Administrator A providing misleading and inconsistent information to Detective R which hampered the investigation. During January 2024, Detective R also conducted an abuse investigation in building 2 (sister facility). The investigation focused on Caregiver H. While abuse could not be proven to a criminal level, concerns about Caregiver H's treatment of residents were identified and shared with Administrator A. Administrator A initially said s/he was going to terminate Caregiver H based on the concerns, but instead transferred him/her to building 1 (this facility).

Surveyor interviewed hospice RN Q on 03/07/2024 at 12:58 PM. S/he described an onsite visit on 02/04/2022 at 5:22 AM after caregivers reported Resident 1 had extreme pain in his/her left leg. RN Q said upon arrival, s/he found both 3rd shift caregivers, Assistant Administrator (AA) K and Caregiver J, sitting in the dining room "on their phones" and not tending to Resident 1. When s/he assessed Resident 1 s/he found him/her to be in extreme pain and obviously injured. Resident 1 was subsequently diagnosed with a fractured femur.

On 02/27/2024 at 9:11 AM, Surveyor interviewed Resident 3 who said caregivers are "Always on their cell phones. Nothing gets done around here." Resident 3 named multiple caregivers that are routinely on their phones, including Caregiver J and Caregiver H. S/he then volunteered, "[Caregiver H] is a little snot....[S/he]'s got an attitude problem." Resident 3 said s/he's reported the concern to Administrator A but s/he has not resolved the problem.

On 02/27/2024 at 9:49 AM, Surveyor interviewed

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Resident 7. Surveyor asked generally about caregivers and s/he replied, "Night shift is terrible" and said AA K is one of the worst. Resident 7 explained, "[S/he] didn't give my...night medications for over a week. Last night I pressed this (call button) at 4:30 AM (and asked) 'Can I have my meds?' [S/he] said, 'I don't have to give them to you until 5:00 AM.' I said, 'I'm in pain now.'" Resident 7 told Surveyor, "I'm supposed to get [Tylenol] every night at midnight and 4:00 AM. [AA K] says I'm asleep. I'm not asleep. [S/he] doesn't come in. I think [s/he] says [s/he] gives them to me (but s/he doesn't)...I'm awake at 4:00 AM, I'm definitely awake...when you (Surveyor) came in I was awake." (NOTE: Surveyor observed Resident 7 was awake and interacting with staff on 02/27 at 5:30 AM.) Resident 7 said if staff are truly unable to wake him/her, that is not his/her baseline and they should be calling 911. Surveyor asked Resident 7 if s/he reported the medication concerns to Administrator A and s/he replied, "Yes. In the last week. Nothing happened." Resident 7 said, "[Caregiver H] is not that great either though. [S/he] has the most snotty attitude...gives looks of being annoyed...has a bad attitude." Resident 7 also said night shift staff are "all are on their phones a lot ...They sit out there in that room and watch TV...I tell [Administrator A] (but) it doesn't do no good [sic] so why bother."

Surveyor reviewed Resident 7's February 2024 medication administration record (MAR) and ISP on 03/06/2024:
9 times the 12:00 AM dose of Tylenol was not administered; reasons were documented 3 of 9 times. AA K charted twice, "refused & wouldn't wake up" and "couldn't wake up" and Caregiver M charted, "refused, tired."
4 times the 4:00 AM dose of Tylenol was not

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administered. No reasons were documented.
The MAR listed other scheduled pain medications to include tramadol, gabapentin and lidocaine patches and cream.
In spite of 5 scheduled pain medications, the ISP dated 02/20/2024 and signed by Administrator A was silent to Resident 7's needs for pain management.

On 02/28/2024 at 3:56 PM, Surveyor interviewed Administrator A and RN C and on 03/13/2024 at 8:30 AM, interviewed Administrator A.

Administrator A stated:
There are ongoing concerns with the work performance of caregivers and acknowledged s/he has not been effective in correcting it.
S/he was aware of Resident 7's complaints about medications and said, "There was one shift [s/he] did not get [his/her] med at midnight. I knew because I saw it in the med cart but [s/he] did get it at 4:00 AM." Administrator A did not describe an investigation or ongoing monitoring of the MAR in an effort to ensure Resident 7 was receiving the medication.
S/he has received complaints from 1st shift that 3rd shift was not performing incontinence care but s/he put part of the blame on 1st shift for not doing their checks right away. Administrator A said s/he did not conduct or document an investigation into the concerns and did not increase supervision of staff during 3rd shift.
Staff are lazy and s/he has provided re-education, written reminders on a whiteboard and worked the floor with caregivers. The plan moving forward is to issue written warnings and fire staff after the 3rd warning.
Caregiver H was moved to building 1 after an abuse investigation in building 2. S/he did not conduct or document an investigation specific to

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concerns against Caregiver H before or since making the decision to move him/her to this building.

RN C stated:
Surveyor's observations during 3rd shift on 02/27 were "not acceptable."
"I've never seen a team go backwards."

EXAMPLE 3 - ALLEGATIONS OF CAREGIVER DRUG USE

The Department received a complaint about caregivers working while under the influence of drugs.

Surveyor reviewed Stevens Point Police Department report #C24-01447 on 03/13/2024. The report detailed Detective R's abuse investigation into a fractured femur sustained by Resident 1 on or about 02/03/2024. During the abuse investigation the following information was reported to Detective R:

Caregiver G said Caregiver J sells marijuana at work. While in work status, Caregiver J asked Caregiver G if s/he wanted cocaine. Caregiver G said Caregiver I also uses drugs at work.
AA K stated s/he informed Administrator A about concerns of staff using drugs like meth and suggested s/he do drug testing. AA K also said on 02/03/2024, s/he observed Caregiver M and N were "higher than a kite" acting "really chippery" and with "glossy eyes."
Caregiver M said Caregiver I uses drugs while at work and has reported this to Administrator A.
Caregiver N said Caregiver I uses drugs like meth in a vacant room at the facility and s/he has reported this to Administrator A.

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N 214	Continued From page 33 On 02/27/2024 at 10:45 AM, Surveyor interviewed Caregiver G. Caregiver G said s/he's had concerns that Caregivers I, M and N are under the influence of drugs while they are working and s/he has reported the information to Administrator A. Caregiver G recalled recently Caregiver I was suspected to be under the influence while working and "[Administrator A] asked [Caregiver I]...in front of hospice if [s/he] was high and [Caregiver I] said no." Caregiver G was unaware of any other follow up by Administrator A and said the situation persists. On 02/27/2024 at 6:41 AM, Surveyor interviewed AA K who said s/he routinely drives Caregiver J to and from work and "[Caregiver J] comes in baked out of [his/her] mind all the time... You can see it in [his/her] eyes." S/he also said, "I know [Caregivers M and N] were high that night (02/03/2024) on marijuana...their eyes were glossy...I told [Administrator A] numerous times to drug test people. I have given [him/her] names of people actively using and coming to work but [s/he] has not drug tested anyone...[s/he] says [s/he] has to catch them before [s/he] can do anything about it." On 02/28/2024 Administrator A provided Surveyor with a binder which s/he said included documentation of all misconduct investigations s/he's completed since 01/10/2024. The binder did not include documentation of any investigations into allegations about caregivers working while under the influence of drugs. On 02/28/2024 at 4:41 PM, Surveyor conducted an interview with Administrator A and Regional RN C. Surveyor asked Administrator A if anyone has reported that staff are using drugs while working or coming into work impaired. S/he	N 214		

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replied, "They vape and I don't know what it is." Surveyor repeated the question and Administrator A replied, "I've smelled it." Surveyor asked again if s/he received allegations and Administrator A replied, "I've had a suspicion." RN C interjected and asked Administrator A, "Did anyone tell you, yes or no?" Administrator A replied, "Um yes, they told me yes. They thought [Caregiver J] was smoking...a joint...outside...about a month and a half ago." RN C asked Administrator A if s/he looked into the allegations and Administrator A replied, "I just told staff I don't care what you do outside of work but don't do it here. I have not seen anyone doing drugs at work. I have not...I've smelled it but I couldn't prove it." RN C directed a response to Administrator A, "Proper protocol would be...you come in and send them for a drug test. (They) have the right to refuse (but) are self-terminated if (they) refuse. Or they get the drug test and if positive we terminate them."

Surveyor informed Administrator A and RN C that multiple interviews alleged caregivers are working under the influence of illegal drugs, including Caregivers I, J, M and N. RN C volunteered concerns that the most of same caregivers alleged to be under the influence while working were also working when Resident 1 sustained an injury on 02/03/2024. RN C stated if the allegations had been investigated by Administrator A when they were first received, it's possible there could have been a different outcome for Resident 1. RN C said they would investigate the allegations.

During an interview with Administrator A and Regional RN H on 03/13/2023 at 8:30 AM, Surveyor asked about Administrator A's response to the allegations presented by Surveyor on 02/28/2024 about Caregivers I, J, M and N.

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N 214	Continued From page 35 RN H stated: It was not feasible to investigate allegations against Caregiver J and N because they no longer work at the facility. "Are we at a place where a state surveyor needs to know the personal lives of staff? That is all outside of work, and we have no control over what staff do outside of work." Surveyor reiterated the allegations were that caregivers are reporting to work under the influence of illegal drugs or using them while in work status, and then providing care to residents. Administrator A stated: Caregivers J and N separated employment so s/he did not investigate the allegations against them. S/he told Caregivers I and M, 'You can do what you want in your personal life but if you bring it to work, I have a problem." There was a time both before and after Surveyor's facility visits when s/he suspected Caregiver I was under the influence of drugs, including once when s/he appeared "jittery." S/he confronted Caregiver I about it in the presence of hospice and recalled, "I asked if [s/he] would be willing to go to a drug test and [s/he] stated no because [s/he] smokes weed outside of work." Administrator A did not describe: Any steps taken to ensure the safety of residents. Any investigative steps other than talking to the alleged caregivers. Documentation of his/her response. Cross Reference: N0158 DHS 83.12(2)(a) Caregiver: Investigating Abuse & Neglect	N 214		

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N 214	Continued From page 36 N0161 DHS 83.12(3) Investigate Injuries of Unknown Source N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies with Laws N0230 DHS 83.19 Orientation N0277 DHS 83.25 Continuing Education N0348 DHS 83.12(2) Rights Of Residents: Free From Mistreatment N0389 DHS 83.35(3)(d) Service Plans Updated Annually Or On Changes N0399 DHS 83.36(2) Maintain Current Written Staffing Schedule N0416 DHS 83.37(2)(e) Other Administration Given or Delegated by RN N0427 DHS 83.38(1)(c) Leisure Time Activities N0432 DHS 83.38(1)(h) Medication Administration N0489 DHS 83.44(2)(a) Rooms Clean and Free From Odors N0491 DHS 83.44(2)(c) Interior Floors, Walls and Ceilings Y3244 CH 50.09(1)(L) Care	N 214		
{N 277}	83.25 Continuing education The administrator and resident care staff shall receive at least 15 hours per calendar year of continuing education beginning with the first full calendar year of employment. Continuing education shall be relevant to the job responsibilities and shall include, at a minimum, all of the following: (1) Standard precautions; (2) Client group related training; (3) Medications; (4) Resident rights; (5) Prevention and reporting of abuse, neglect and misappropriation; (6) Fire safety and emergency procedures, including first aid.	{N 277}		

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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 277}	Continued From page 37 This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Caregiver G and Caregiver S received continuing eduction training in standard precautions, first aid or client group during 2023. This is a repeat deficiency. See Statement of Deficiency 5MV215, dated 08/16/2023. Findings include: On 02/29/2024, Surveyor reviewed training records for Caregiver G hired 08/12/2021 and Caregiver S hied 01/04/2022 for compliance with continuing education training requirements during 2023. Neither Caregiver G nor Caregiver S's records included evidence of training in standard precautions, first aid or client group during 2023. On 03/04/2024, Surveyor sent an email to Administrator A and Registered Nurse (RN) C and offered the opportunity to send any additional evidence the training was completed. RN C emailed Surveyor the company wide training calendar for 2024 for all facilities to show they intended plan for continuing education training. However, the email did not include evidence Caregiver G and Caregiver S received training in the 3 topics during 2023.	{N 277}		
{N 348}	83.32(3)(d) Rights of Residents: Free from mistreatment	{N 348}		

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{N 348}	Continued From page 38 In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Freedom from mistreatment. Be free from physical, sexual and mental abuse and neglect, and from financial exploitation and misappropriation of property. This Rule is not met as evidenced by: Based on interviews and record review, the provider did not ensure Resident 1 was free from neglect. Resident 1 had dementia and was unable to effectively comminate his/her needs. On 02/03/2024 beginning at lunch, Resident 1 exhibited changes in condition to include nausea, refusal of meals and refusal of all cares. At 9:40 PM, 3 caregivers observed Resident 1's left leg was swollen hip to foot and s/he screamed in pain when it was touched. Resident 1 also stated s/he fell. Caregivers proceeded to roll Resident 1 side to side to perform incontinence care while s/he yelled out it pain and then transferred him/her to and from a wheelchair using a pivot transfer on the injured leg. Caregivers did not notify Resident 1's guardian or hospice of the change in condition and did not administer available pain medication. On 02/04/2024 at 4:00 AM, Resident 1 was again screaming in pain while Assistant Administrator K rolled him/her side to side to perform incontinence care. At approximately 4:30 AM hospice was notified, s/he was sent to the hospital and diagnosed with multiple fractures of the femur. 83.02(31) "Neglect" has the meaning as given in	{N 348}		

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{N 348}	Continued From page 39 s. 46.90 (1) (f), Stats: The failure of a caregiver, as evidenced by an act, omission, or course of conduct, to endeavor to secure or maintain adequate care, services, or supervision for an individual, including food, clothing, shelter, or physical or mental health care, and creating significant risk or danger to the individual's physical or mental health. This is a repeat deficiency. See SOD 5MV215 dated 08/26/2023. Findings include: The provider is licensed to serve up to 16 non-ambulatory residents from the following client groups; irreversible dementia/Alzheimer's, terminally ill, physically disabled or advanced age The Department received 2 complaints alleging concerns about a serious injury sustained by a resident and the provider's response to it. The Department also received a self-report authored by Administrator A regarding an injury sustained by Resident 1. The reported noted s/he was elderly with diagnoses to include cognitive impairment. S/he had a legal guardian and was protectively placed at the facility. According to the report, Resident 1 experienced a change of condition beginning 02/03/2024 at the lunch meal, and potentially sooner. Between 4:00 PM and 8:30 PM, Resident 1 refused incontinence checks, transfers, dinner, all cares and was noted to be yelling at staff. At 9:40 PM, 3 caregivers discovered Resident 1 was covered in feces and had a swollen left leg which was in an awkward position. The caregivers straightened the leg and rotated him/her to perform incontinence care and Resident 1 "screamed in pain." The caregivers	{N 348}		

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{N 348}	Continued From page 40	{N 348}		

then transferred Resident 1 out of bed using a pivot transfer which required Resident 1 to stand. At 10:00 PM Assistant Administrator (AA) K also observed Resident 1 to have a swollen left leg. AA K transferred Resident 1 back to bed using a pivot transfer. At approximately 4:00 AM, Resident 1 again screamed out in pain during incontinence care. AA K notified hospice at 4:30 AM. Hospice instructed the administration of pain medication and arrived to medically assess at approximately 5:30 AM. Resident 1 was sent to the emergency room, admitted and diagnosed with a fractured femur. The self-report noted there was no documented fall or other incident to explain the cause of the injury. The report concluded, "As of today (02/05/2024), no one has come forward on what has happened to obtain this kind of injury...I'm still trying to figure out what happened..."

Surveyor reviewed hospital records which read in part, "[Resident 1] is (an elderly person) with a history of severe dementia on hospice...had some recent improvement and there was some thought to taking [him/her] off hospice. [S/he] has a court appointed guardian...mostly gets around in a wheelchair at baseline but does assist with transfers...(Sustained) a left periprosthetic proximal femur fracture..." (fracture of the femur around the prostheses from a previous hip replacement) The fracture was "comminuted" (broke in at least 2 places) and "fragments were identified...There is an additional avulsion-type fracture (piece of bone attached to a tendon or ligament which is pulled away from the main part of the bone) of the lesser trochanter (bony projection from the femur) which is displaced...discussed with patient's guardian...the stem (prostheses from the hip replacement in the femur) is likely loose and surgery would involve

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{N 348}	Continued From page 41 revision of [his/her] femoral component...it would be a major surgery with quite high risk for a frail patient with underlying severe dementia...After discussing the options, we made the shared decision not to pursue surgical treatment..." (records received and reviewed 03/13/2024) Surveyor reviewed Stevens Point Police Department report # C24-01447 on 03/13/2024 and Resident 1's complete facility record on 02/28/2024. Resident 1's record included the most recent individual service plan (ISP), daily charting, January & February 2024 medication administration records (MARs) and caregiver statements. Resident 1 was admitted 08/10/2021 and discharged 02/04/2024. S/he was non-ambulatory and required the assistance of 2 staff with all transfer needs. No incidents, falls or attempts to self-transfer were documented preceding the injury. Resident 1 relied on staff for activities of daily living including dressing, eating, medication management and toileting. Resident 1 needed incontinence checks and repositioning every 2 hours. Surveyor also conducted interviews with caregivers, hospice staff and Resident 1's guardian. Surveyor determined the following timeline beginning 02/03/2024 into the morning hours of 02/04/2024: 1ST SHIFT -CAREGIVER G Written statement: "Not feeling well today. Appears to be pale. Given anti-nausea med"	{N 348}		

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{N 348}	Continued From page 42 Interview (02/27/2024 at 10:45 AM): Caregiver G said Resident 1 fine during the shift until lunch hour when s/he was nauseous and only ate "one bite of food" for lunch 1ST SHIFT - MAR Ondansetron was ordered 1/12/2024 PRN for nausea. It was administered once on 02/03/2024 at 11:30 AM and noted as ineffective. 2ND SHIFT - CAREGIVER N Written statement: 2:00 PM - "1st shift told 2nd shift that [Resident 1] refused cares and both meals...insisted PM (shift) gets the PM cares done because resident was still in [his/her] pajamas from the night before." 4:00 PM - "yelling/refusing to be changed" 5:00 PM - "refused dinner" 6:00 PM - "refused cares/changing - yelling at staff" 7:45 PM - "PRN (as needed medication) given for anxiety/aggitation" [sic] 8:30 PM - "refused cares/changing upset with staff" 9:40 PM - "agreed to be changed and clean. When staff pulled the blankets back they saw the resident had smeared poop on [self] and...blanket ...saw [his/her] leg positioned like a backwards 4 ...When staff straightened (the) leg [s/he] screamed in pain ...allowed staff to clean and change [him/her] but [s/he] yelled again in pain when staff pulled [his/her] pants up. Staff asked '[NAME] what happened?? Why does your leg hurt?' Resident said, 'I fell this morning' ...asked for a boost (nutritional drink) so staff transferred [him/her]. Resident was able to bear weight to transfer." Interview (03/07/2024 3:04 PM): Caregiver N said at 2:00 PM when s/he arrived at work, 1st shift told 2nd shift they needed to get	{N 348}		

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{N 348}	Continued From page 43 Resident 1's cares done because s/he refused cares all day including both meals. Caregiver N said the next day 1st shift changed their story and denied they said that, but Caregiver N said they absolutely said it and s/he had the impression Resident 1 hadn't been changed or fed all day. S/he said Caregiver L was the first to check on Resident 1 sometime after 4:00 PM and Caregiver M checked next around 5:00 PM. Both times Resident 1 refused assistance. Caregiver N said s/he first checked around 7:00 PM and Resident 1 "refused again." Caregiver N did not describe any assessment to determine the reason Resident 1 had been refusing assistance and said, "It wasn't typical for [him/her] to be in bed for a whole day ... [s/he]'s normally not like that that's why I was surprised ...looking back now I should have noticed it was a change in condition... [s/he] seemed really anxious and stressed out and cranky ... It was around 7:45 or 8:00 PM when I gave [him/her] clonazepam" and gave the medication "time to work." Surveyor pointed out Resident 1 went at least 7 hours on 2nd shift before receiving incontinence care or food. Caregiver N replied, "I agree I felt it was neglectful to leave [him/her] in that condition" but they were "respecting [his/her] wishes." Caregiver N said around 9:00 PM, s/he and Caregiver L attempted cares. When they entered the room "[Resident 1] asked, 'Is it time to eat?' ...[s/he] was covered in poop [his/her] leg was sitting like a number 4, all wonky. We thought just because [s/he] was in bed all day, [s/he]'s sore, [s/he]'s old...We straightened [his/her] leg out and noticed [s/he] was in pain ... [s/he] told me [s/he] fell...we cleaned [him/her] up got [him/her] taken care of and got [him/her] up to eat ...I know I didn't break [his/her] leg but I feel partially responsible for the condition [s/he] was in ...us transferring [him/her] after the injury probably contributed to	{N 348}		

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{N 348}	Continued From page 44	{N 348}		

severity...and us not recognizing a change in condition."

2ND SHIFT CAREGIVER M
Written statement & charting:
"I arrived at the facility after 5pm ...began to toilet/change residents ...I approached [Resident 1] while [s/he] was laying in bed...attempted to grab residents cover before being able to check resident, resident began to swear at me. I left...continued to serve/plate meals and sent another worker (Caregiver L) into residents room. [Caregiver L] spent around 2 mins ...before being yelled at by resident. Staff could tell resident was in pain...Later in the night resident was given a PRN (as needed medication) so staff could hopefully get residents cares done without causing pain, staff did not realize residents leg was the cause of [his/her] pain until then...Resident has a swollen left leg staff realized that extends into their ankle." [sic-all]"
Interview (02/27/2024 at 5:44 AM):
"It was chaotic...dinner time ...I went into [his/her] room touched [his/her] leg ...[Resident 1] was like, 'Get out.' ...I'm like, 'Fine' ...Asked Caregiver L to go in there. [S/he] got screamed at and immediately came out of the room. I just did my thing after that ...[Caregiver N] gave [him/her] a PRN around 8 or 9...we gave [him/her] some time for PRN to kick in ...and [Caregiver N] and [Caregiver L] went in there to finally try (to provide cares)...[Caregiver N] called me in there ... [Resident 1]'s leg looked wrong. [S/he] asked me if I thought [his/her] leg was broken I said, 'It doesn't look right to me.' Then they started cleaning [him/her]."

2ND SHIFT CAREGIVER L
Written statement:
9:40 PM - "was being aggressive and yelling

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{N 348}	Continued From page 45 while refusing cares and dinner...given a PRN...The PRN kicked in...agreed (too be changed)...was also asking for food...staff pulled [his/her] blanket down...had poop on [his/her] hands and clothes ...(left leg) looked like a backwards four. When staff...straightened it out Resident screamed in pain. [S/he] did let staff get [him/her] cleaned up and put clean clothes on. Staff asked '[Name] What happened to your leg and why does it hurt?' [S/he] had stated [s/he] fell that morning...Staff had pulled [his/her] pants up and [s/he] yelled in pain again. Staff 2 assisted [him/her] into [his/her] wheelchair ...At this time [Assistant Administrator (AA) K] was coming in for (3rd) shift (10:00 PM) ... AA K was informed and said [s/he] would take care of it." [sic - all] Interview (02/27/2024 at 3:22 PM): Caregiver L said when s/he arrived at 2:00 PM, s/he was told by 1st shift that Resident 1 had not been out of bed, changed or had meals all day. Caregiver L said s/he was assigned cleaning tasks and did not attempt any care with Resident 1 until Caregiver M asked told him/her to around dinner time. When s/he entered with the wheelchair Resident 1 immediately said, "Get that thing out of here you can get out too!" Caregiver L said s/he did not return to Resident 1's room until 9:40 PM and at that point Resident 1 "hadn't eaten or been changed all day...[his/her] mouth was very dry. You could barely understand what [s/he] was saying...I pulled [his/her] blanket back and I saw there was poop on [his/her] fingers...we went to pull [his/her] pants down... [s/he] started saying something was hurting...I think [s/he] was screaming actually...[Caregiver N] said we should still pull [his/her] pants down and that's when I saw the swollen leg. [His/her] foot looked awkward. It was bowed out on the outer edge...from [his/her] hip to [his/her] toe the whole thing was swollen....[s/he] was obviously in	{N 348}		

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pain. [S/he] said I fell this morning. [S/he] seemed hungry and kept asking, 'Are we going to eat now?'" Caregiver L said they rolled Resident 1 from side to side to perform incontinence care and s/he seemed "afraid." After cleaning Resident 1, Caregiver N insisted they transfer Resident 1 to the wheelchair and bring him/her out to the dining room. Caregivers M and N said they were going to call hospice to report the change in condition, but Caregiver L later learned they did not. Caregiver L said, "The only thing I would have changed, I would have called hospice myself ...And when we found [him/her] we probably shouldn't have gotten [him/her] up."
Police report:
When describing the 9:40 PM transfer Caregiver L said Resident 1 "looked 'out of it' and could barely lift [his/her] head...Resident 1 stated [s/he] had fallen that morning." When asked about signs of pain during the transfer Caregiver L replied, "because of the PRN, I think [s/he] was just so out of it that I don't think [s/he] was really able to fight."

2ND SHIFT MAR
Clonazepam was ordered 12/19/2023, .5 mg every 6 hours PRN for "anxiety/restlessness" and it was administered 02/03 at 7:45 PM. Surveyor noted this was the only administration of the medication since 01/01/2024.
Acetaminophen was ordered 08/10/2021, 325 mg every 5 hours PRN for pain. Hydromorphone was ordered 12/19/2024, 4 mg every 4 hours PRN for pain. Neither pain medication was administered during 2nd shift on 02/03. Surveyor also noted neither pain medication had been administered since 01/01/2024.

3RD SHIFT ASSISTANT ADMINISTRATOR (AA)
K

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{N 348}	Continued From page 47 Written statement : "At 10pm when I started my night shift (2nd) shift had me look at [Resident 1]'s (left) leg. I notice it was swollen. [Resident 1] asked if [s/he] could go back to sleep. Got [him/her] back into bed ...staff kept an eye on [him/her] all night. then at 4am when staff went into [his/her] room to change [him/her] again [s/he] had BM (bowel movement) so staff had to roll [him/her] side to side [Resident 1] screamed in pain ...call hospice 4:30 AM... (hospice) had staff give [him/her] a pain med ...sent out to hospital at 6am." [sic - all] Interview (02/27/2024 at 6:41 AM): AA K said when s/he arrived on shift, Caregivers M and N had Resident 1 in the common area and asked AA K to look at Resident 1's leg. AA K said it was swollen and all Resident 1 wanted to do was go back to bed. AA K said, "[S/he] didn't want to get out in the first place" and it was out of the ordinary for Resident 1 to be up in the common area at that time of night. AA K said s/he did a 1 person "bear hug" transfer and put Resident 1 back to bed. AA K recalled, "I bumped into something when I picked up [his/her] legs to turn [him/her] into bed [s/he] screamed out. I thought, 'That's not right.' [S/he] wouldn't let me touch[him/her].'" Resident 1 said s/he just wanted to go to sleep so AA K left the room. AA K said s/he did not check Resident 1 until 12:00 AM, and next at 2:00 AM, and during both checks s/he only felt for incontinence. (see interview below with Guardian P) AA K said at the 4:00 AM check, "[S/he] had the BM. I looked at [his/her] leg again (and thought), 'Wait that don't look right.' It had swelled [sic] up more. The minute we touched that side [s/he] starts screaming" and while rolling Resident 1 to provide incontinence cares, "any little touch, [s/he] was screaming." AA K said in hindsight, s/he feels bad about Resident 1's pain and s/he should have informed Administrator A at	{N 348}		

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{N 348}	Continued From page 48 10:00 PM when s/he first observed the leg was swollen. Police report: AA K stated at 10:00 PM, "[Caregivers L, M and N] were wheeling [Resident 1] out of his/her room in the wheelchair. "Resident 1 was saying 'owe'...staff were pushing [Resident 1] forward in the wheelchair, so [his/her] feet would catch the ground and be pulled backwards/dragged...feet were not in the wheelchair foot rests...[AA K] stated that when [s/he] moved [Resident 1]'s legs, [s/he] 'squawked out', and [s/he] asked [Resident 1] what happened. (Resident 1 said) 'I fell a little bit ago.'...[AA K] also reported [s/he] was unsure why the evening shift would have given [Resident 1] clonazepam, since [s/he] had never taken it before...stated [Resident 1] had never taken an anti-nausea medication either..." 3RD SHIFT MAR The only pain medication administered during 3rd shift was hydromorphone, charted at 5:00 AM. HOSPICE REGISTERED NURSE (RN) Q Surveyor interviewed on-call RN Q on 03/07/2023 at 12:58 PM. S/he arrived at approximately at 5:22 AM on 02/04/2024 and observed the only 2 caregivers were in the common area on their phones. RN Q went to assess Resident 1 and said, "As soon as I even pulled the blanket back, [s/he] screamed in pain. Immense pain. I could see [his/her] knee was bent awkward and [his/her] hip was swollen...[Resident 1] said, "[S/he] threw me on the floor!" but was not able to articulate who. RN Q said, "I stepped out to call my supervisor." RN Q added, "[S/he] was in so much pain I don't know how they would have changed [him/her] or cleaned [him/her]. There was a clear deformity, [s/he] was in excruciating pain...If this injury occurred before (3rd) shift, I	{N 348}		

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don't know how they would have done anything with [him/her] that night."

Surveyor interviewed Guardian P on 03/01/2024 at 8:01 AM, Hospice RN E on 02/28/2024 at 8:52 AM and Facility RN C on 02/28/2024 at 8:07 AM:

GUARDIAN P
Guardian P said s/he was "very frustrated" with the entire incident. S/he described concern with how the injury could have been sustained and the subsequent failure to obtain medical assessment or provide pain medication. Guardian P explained Resident 1 did not have recent falls and was not able or prone to self-transfer, making it almost certain staff were present and aware of the injury at the time it occurred. S/he said, "My assumption is at a bare minimum, [s/he] fell (during a transfer) and they picked [him/her] up and put [him/her] back into bed" because Resident 1 would not have been capable of getting back in bed alone. Guardian P said s/he asked the orthopedic surgeon who agreed and stated, "As an able bodied [man/woman] I could not get myself off the ground with these bones broken. There is no way [s/he] put [him/her] self back into bed." Guardian P said, "Things happen, you can drop people. You have to say something. You can't drop them, put them back and pretend it didn't happen...They probably didn't actually check on [him/her] all night. If [s/he] was being changed or rotated all night there would have been additional screaming before 5:00 AM." Guardian P was upset neither s/he nor hospice were promptly notified of the incident/injury or subsequent change in condition. Guardian P was frustrated about 2nd shift's choice to administer a psychotropic medication and believes they did it "to shut [him/her] up because [s/he] was anxious and agitated. But [s/he] was anxious and agitated

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because [s/he] had broken bones." Guardian P said the morning of 02/04/2024 s/he went to the facility to make observations of the room and review the records. S/he noted the only incontinence checks charted during the overnight were at 9:00 PM and 5:00 AM, corroborating his/her belief Resident was not monitored overnight. (Guardian P emailed Surveyor the documents on 03/01/2024 for review.) Guardian P said based on his/her concerns, s/he made the decision to move Resident 1 to a different facility.

HOSPICE RN E
RN E said his/her last visit with Resident 1 was on 02/02/2024. During that visit and in the preceding weeks, Resident 1 was stable, eating well, gaining weight and they were considering potential discharge from hospice. RN E confirmed Resident 1 was not able to ambulate at baseline and did not have a recent history of self-transferring or falls. At first after the injury, Resident 1 would say things like, "That [guy/gal] who threw me on the floor should be in prison." However, in the past week RN E said Resident 1 had become very withdrawn and was declining quickly. RN E said "It breaks my heart. Someone knows something."

FACILITY RN C:
RN C said no staff have come forward to admit knowledge of how Resident 1 was injured and there was no documentation in the file to explain it. S/he said while they could not definitively rule out intentional abuse, they concluded the injury was most likely sustained while staff were assisting with a transfer or repositioning. RN C said even if the injury was an accident, the failure of multiple caregivers to report or provide appropriate care for Resident 1 was a form of abuse.

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{N 348}	Continued From page 51 IN SUMMARY: On 02/03/2024 begining at least by lunch, Resident 1 displayed signs of a change in condition including nausea and refusal of meals. Second shift caregivers state they were told at 2:00 PM, Resident 1 had refused all meals and care during the day. However, 2nd shift caregivers did not check on Resident 1 or attempt to provide food or cares until 3 hours later. Resident 1 continued to refuse and caregivers did not conduct an assessment to determine the reason. At 9:40 PM, Resident 1 was found hungry, incontinent of bowel, his/her left leg was swollen hip to toe and s/he said s/he had a fall. The leg was bowed out in an awkward position and s/he screamed in pain when caregivers tried to perform care. Caregivers did not inform the guardian, did not seek medical attention and did not provide pain medication. While Resident 1 was in obvious pain, caregivers rolled Resident 1 side to side to perform incontinence care and then transferred him/her to and from a wheelchair, causing Resident 1 to stand on the injured leg. On 02/04/2024 at approximately 4:00 AM, Resident 1 was again found incontinent of bowel and in extreme pain. Caregivers again rolled Resident 1 side to side to perform incontinence care before calling hospice for guidance. Resident 1 was then administered pain medication and sent to the hospital where s/he was diagnosed with multiple fractures of the left femur. There was no documentation of an incident that would have caused the injury and the source of the fractures remains unknown. Cross Reference: N0161 DHS 83.12(3) Investigate Injuries of Unknown Source N0196 DHS 83.14(2)(a) Licensee Ensures	{N 348}		

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{N 348}	Continued From page 52 Facility Complies with Laws N0214 DHS 83.15(3) Administrator Shall Supervise Daily Operations	{N 348}		
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, record review and interview, the provider did not ensure all individual service plans (ISPs) were updated when there was a change in residents' needs or ensure all ISPs were signed by the legal representative acknowledging their involvement in and agreement with the plan. Resident 3's ISP was not updated to reflect his/her needs for pressure injury prevention. Resident 3 was admitted on 01/04/2024 without pressure injuries and by 02/27/2024 s/he had developed at least 9. During Surveyor's observations throughout the day on 02/27/2024, caregivers were not meeting Resident 3's needs	N 389		

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for repositioning, incontinence care or the application of heel protectors. In addition, Resident 3's legal representative was not involved in the development of the ISP.

Resident 4's ISP was not updated to reflect his/her needs for oral care after meals or for a mechanical soft diet. Surveyor observed food hanging from Resident 4's mouth after the breakfast meal on 02/27/2024 and for 2 meals on 02/27/2024 and 02/28/2024, caregivers served Resident 4 food that was not mechanical soft texture as ordered by the physician.

This is a repeat deficiency. See SOD 5MV212, dated 02/25/2021.

Findings include:

RESIDENT 3:

The Department received a complaint alleging care concerns specific to repositioning and documentation.

On 02/27/2024, Surveyor made the following observations:

At 5:10 AM, Surveyor accompanied Caregiver M on rounds to check for incontinence on residents who rely on staff assistance in this area. Upon approaching Resident 3's room Caregiver M said, "I just checked [him/her], [s/he] is dry." Surveyor requested Caregiver M verify. Upon entry to the room Surveyor observed Resident 3 had a pillow under his/her right hip and a pillow under both calves. His/her heels were resting partially on the pillow and partially on the mattress. Resident 3 was not wearing heel protection. S/he was not responsive or able to communicate with the

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caregivers.

Caregiver M checked Resident 3 and found s/he was heavily incontinent of urine. Caregiver M also said Resident 3 had multiple wounds on his/her buttocks.

Assistant Administrator (AA) K assisted Caregiver M with care and said Resident 3 had "8 or 9 wounds" mostly on his/her buttocks and 1 on near his/her groin where the incontinence brief rests. S/he said 2 or 3 of the buttock wounds were starting to open. AA K pointed them out to Surveyor. AA K also said Resident 3 has a right heel wound which Surveyor also observed. AA K said the interventions for wounds are to apply barrier cream to his/her backside, reposition every 2 hours and use heel protectors. AA K stated Resident 3 won't keep the heel protectors on. Surveyor did not observe heel protectors in the room.

Caregiver M, AA K and Surveyor reviewed a repositioning log that was located in the room which prompted for repositioning every 2 hours starting at 12:00 AM, 2:00 AM, 4:00 AM, etc. The most recent repositioning was charted at 6:00 AM, initialed by AA K and documented Resident 3 was last positioned on his/her back. Surveyor observed it was not yet 6:00 AM and Resident 3 was positioned on the left side. Both staff acknowledged the charting was not accurate and said it's because they are doing hourly checks instead of 2 hour checks. Surveyor noted this was not a viable explanation because there were no additional checks were charted beyond the pre-filled 2 hour checks and it didn't address the discrepancy in the position.

At 5:23 AM, the caregivers completed the

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incontinence care and repositioning. Neither caregiver applied the heel protectors. They charted and initialed the repositioning task on the log in the 8:00 AM time slot. Surveyor pointed out the time was again inaccurate. AA K then crossed off 8:00 AM and wrote 5:21 AM. When Surveyor exited the room, Resident 3 was propped with a pillow so that s/he was laying on the right side.

At 8:48 AM (nearly 3.5 hours later), Surveyor returned to Resident 3's room. S/he was laying on the right side and was not wearing heel protectors. The log documented a 6:00 AM check by Caregiver H with position "float" and an 8:00 AM check by both Caregivers H and G with position "left." Both caregivers were in the room and Surveyor asked about the logs. They provided conflicting and confusing responses.

" Caregiver H said when s/he charts a position, it is the side the pillow is under not the side the resident is on.
" Caregiver G said that is not the way it is supposed to be done; the position should be the side the resident is laying on.
" Caregiver G said s/he charted both the 6:00 AM and 8:00 AM checks for both staff because they both checked. However, Surveyor noted the 6:00 AM check only had Caregiver H's initials and the 8:00 AM check documented Resident 3 was last laying on the left side but Surveyor observed s/he was laying on the right side.

Surveyor continued to make observations throughout the day and noted inaccurate charting persisted and Resident 3 did not receive repositioning assistance every 2 hour. Surveyor also noted once the heel protectors were applied, Resident 3 did not kick them off.

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N 389	Continued From page 56 " 9:09 AM - positioned on right side, no heel protection " 10:42 AM - positioned on left side but the log documented s/he was on the right side as of 10:00 AM. Resident 3 was not wearing heel protection. " 12:14 PM -Resident 3 was wearing heel protectors. The log documented s/he was on the left side at 12:00 PM, however Surveyor observed s/he was laying flat on his/her back. " 1:46 PM - positioned flat on back. Heel protectors remained on his/her feet. No changes to the log. " 2:06 PM - positioned flat on back. Heel protectors remained on his/her feet. No changes to the log. " 2:45 PM - positioned flat on back. Heel protectors remained on his/her feet. (Surveyor did not observe the log.) " 3:03 PM - Caregiver T exited Resident 3's room. S/he stated s/he just changed Resident 3's brief and s/he was incontinent of urine. Caregiver T said when s/he did the check, Resident 3 was flat on his/her back. Surveyor noted Caregiver T documented the 3:00 PM check in the 2:00 PM section of the log. Caregiver T acknowledged s/he did not document the accurate time. Heel protectors remained on his/her feet. At 2:38 PM, Surveyor observed a dry erase board in the medication room. One note read, "[Resident 3] 2 hour check, change, repositioning while in bed!" and another note read, "[Resident 3] - Beds sores - why?" On 02/28/2024, Surveyor approached Resident 3's room at 8:45 AM. Hospice RN E was present and said the provider called this morning to report Resident 3 had passed away.	N 389		

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N 389	Continued From page 57 At 8:52 AM, Surveyor interviewed RN E. RN E said Resident 3 was admitted to the facility and to hospice on 01/04/2024. Upon admission, s/he did not have pressure injuries, was eating and was able to communicate but after admission s/he started to decline. RN E commented s/he was aware Resident 3 was not doing well 3-4 days ago, but when s/he received the call today from the facility to report Resident 3 passed, it was not expected. RN E said within 10 days of admission, Resident 3 started developing pressure injuries and attributed this to a lack of frequent incontinence care and repositioning assistance. S/he said, "They would put [him/her] in [his/her] Broda chair and there [s/he] would sit." RN E said it is a standard of practice to provide frequent incontinence care and repositioning to prevent new or worsening pressure injuries, but in addition, s/he specifically instructed facility staff of the needs on 1/15/2024 and 02/13/2024. RN E said the provider used repositioning logs but they weren't accurate. S/he said, "Every time I come, [s/he] is on [his/her] back." RN E expressed frustration that the provider does not follow their plan of care. S/he said, "No matter who you talk to they say they always do it and point out who doesn't do it...They don't follow orders no matter what we write or say verbally... As we would pull in [Administrator A] would announce, "Hospice is here!" as if to announce to staff to do cares they should have been doing anyway. Surveyor reviewed Resident 3's facility record on 02/27/2024 at 12:38 PM. Resident 3 was admitted 01/04/2024 with diagnoses to include dementia. S/he was elderly, non-ambulatory and relied on staff assistance with transfers and activities of daily living. The record included the following:	N 389		

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N 389	Continued From page 58 " "Pressure Ulcer Risk Assessment" form signed and dated by Administrator A on 01/08/2024. A score of 8 or more represented high risk. The assessment score was 10. " Hospice note dated 01/12/2024 signed by RN E documenting staff awareness of a "small area of redness to (left) buttock." " "Shower Day Worksheet/Body Audit" forms - as early as 01/20/2024 sores were documented on his/her buttocks and 01/21/2024 on his/her groin. An unsigned form dated 02/14/2024 documented a pressure sore on the left heel. Forms dated 02/15 and 02/17/2024 also documented pressure sores on the buttocks, the heel and redness under his/her breast. Surveyor reviewed the "24-hour" book on 02/28/2024. The book was a communication tool to for staff to report resident information like "Skin Issues" and the following was documented: " 01/21: "breakdown in groin" " 02/11: "has pressure sores on buttcheeks & redness in creases of legs" " 02/13: "has a lot of sores on butt and front ...put pad on heel of foot" " 02/14: "has repo sheet in room" " 02/21: "bedsores needs to be repo (repositioned) every 2 hrs to avoid any more" and "starting to get an open sore - Hospice RN notified" Resident 3's ISP was dated 01/15/2024. The ISP was not signed by Resident 3 or his/her legal representative, it was only signed by Administrator A. The only information about toileting needs and skin integrity read, "incontinent with urine, wears briefs, needs to be toileted as needed. To be clean and free from break down...To have skin intact at all times. Checked weekly on shower days."	N 389		

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N 389	Continued From page 59 Surveyor noted the ISP was silent to Resident 3's high risk of pressure injuries or specific interventions to prevent them to include repositioning. It was not specific about the frequency of incontinence checks. After Resident 3 developed pressure injuries in mid-January 2024 the ISP was not updated to identify the changes, or interventions to prevent new or worsening pressure injuries. Surveyor interviewed Administrator A on 02/28/2024 at 12:28 PM and 03/13/2024 at 8:30 AM. S/he said when residents are on hospice, the provider maintains their own ISP to incorporate the hospice plan of care. Administrator A explained s/he developed Resident 3's ISP independently without input from others and said to date s/he has never met Resident 3's POA. Administrator A confirmed Resident 3 developed pressure injuries needed 2 hour incontinence checks and repositioning and there were concerns staff were not completing them. Administrator A said s/he did not routinely review the repositioning logs as a tool to ensure Resident 3 was receiving the care but s/he did write reminders for staff on the whiteboard as observed by Surveyor. Administrator A acknowledged the ISP did not identify Resident 3's change in condition related to the development of pressure injuries or identify individualized, specific interventions to address them. Administrator A acknowledged the ISP was not signed by Resident 3 or his/her activated power of attorney (POA) for health care. Note: Bedsores (Pressure Injuries)...are wounds that occur from prolonged pressure on your skin. People who are immobile for long periods, such as those who are bedridden or use a wheelchair,	N 389		

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N 389	Continued From page 60 are most at risk for bedsores...Friction, moisture...can also lead to bedsores...These painful wounds, or pressure ulcers, can grow large and lead to infections. In some instances, bedsores can be life-threatening." Source: https://my.clevelandclinic.org/health/diseases/17823-bedsores-pressure-injuries, retrieval date 4/12/2024 RESIDENT 4: Observations: On 02/27/2024 at 9:11 AM, Surveyor interviewed Resident 4. Surveyor observed Resident 4 had poor dentation with missing and discolored teeth. S/he also had a significant amount of drool and what appeared to be a piece of food approximately 1 inch long suspended in the drool and hanging from his/her mouth. The food remained suspended in the drool for the entire 15 minute interview. Resident 4 said s/he had scrambled eggs and sausage for breakfast and Surveyor observed pieces of egg on his/her clothing protector. Resident 4 said, "I drool. I have Parkinson's disease since 2002." [sic] On 02/27/2024 at 12:55 PM, Surveyor observed Resident 4 at a dining room table with Caregiver G who was assisting with feeding him/her macaroni and cheese. Resident 4 said s/he was originally served pizza for lunch but was unable to eat it. Caregiver G interjected and said, "[S/he] ate the (pizza) topping. [S/he] has good days and bad days." Caregiver G looked at Resident 4 and said, "It's a bad day, right [Resident 4]?" On 02/28/2024 at 1:12 PM, Surveyor observed Resident 4 at a dining room table eating pieces of	N 389		

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N 389	Continued From page 61 ham cut into cubes approximately 1/2 inch in size. Interviews: Surveyor interviewed Administrator A at 9:49 AM. S/he said Resident 4 "drools and food drips out...staff should be cleaning out [his/her] mouth or setting [him/her] up to brush [his/her] teeth... [His/her] teeth are not in great shape...I think [s/he] has had teeth pulled." Surveyor asked if Resident 4 has special needs for food preparation. Administrator A said, "[S/he] won't eat it if we puree it...we cut [his/her] meat very small." Surveyor interviewed Caregiver G on 02/27/2024 at 10:45 AM. Caregiver G said Resident 4 will pocket food during meals and then "2 hours later" it comes out of his/her mouth with the drool. Surveyor interviewed Caregiver H on 02/27/2024 at 1:00 PM. S/he said Resident 4 needs his/her food cut up or pureed but "I've never done it pureed yet." Caregiver H said the lunch meal today was pizza and "I served it cut up" and described the pieces 1/2 - 1 inch in size. Surveyor asked if Resident 4 needs assistance with oral care after meals and s/he replied, "Not that I've known. Maybe brush [his/her] teeth but since I've been here nobody's told me that." Caregiver H said s/he started working in the facility in mid-January 2024. Record review: On 02/28/2024 Surveyor reviewed Resident 4's facility file. Resident 1 was admitted on 09/27/2022. The face sheet read, "Diet order: General diet - ground meat." The file contained a "Physician's Plan of Care"	N 389		

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N 389	Continued From page 62	N 389		

signed and dated 02/22/2024. Diagnoses were major cognitive disorder with behavioral disturbance and Parkinson's. The care plan documented Resident 4's needs for food served mechanically soft and/or pureed.

Resident 4's ISP was last updated 11/01/2023. The section titled "Oral Care" read, "needs to brush teeth twice daily with set up, uses mouthwash twice daily to remove foods." The section titled "Eating" read, "Needs food cut into smaller pieces." A supplemental monthly care plan document for February 2024 was contradictory. Under the "Diet" section of the document, the boxes for "mech soft" and "pureed" diet were not checked and the box "general diet" was checked.

Surveyor noted the ISP intervention to cut food into smaller pieces was inconsistent with the physician's order for mechanically soft or pureed texture. The ISP did not identify Resident 4's need to have food removed from his/her mouth after each meal.

According to the International Dysphagia Diet Standardization Initiative, a mechanical soft diet is the equivalent of the new category "minced and moist." This texture is typically recommended due to the risk of choking. Minced and moist food guidelines are:
" food is soft, moist and needs very little chewing
" small bite sized pieces, 4mm x 4mm (4mm = .16 inch)
" meats must be finely minced and served in an extremely thick non pouring sauce
" soft lumps are easy to squash with the tongue
" food is easily mashed with a fork

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N 389	Continued From page 63 " sticky foods like cheese need to be avoided or specially pureed so they are soft to eat Cross Reference: N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies with Laws N0214 DHS 83.15(3) Administrator Shall Supervise Daily Operations Y3244 CH 50.09(1)(L) Care	N 389		
N 399	83.36(2) Maintain current written staffing schedule Staffing schedule. The CBRF shall maintain a current written schedule for staffing the CBRF. The schedule shall include each employee ' s full name, job assignment and time worked. This Rule is not met as evidenced by: Based on interview and record review, the provider did not ensure current, written staffing schedules were maintained to include employees' full names and hours worked. Findings include: The Department received 2 complaints alleging concerns about a serious injury sustained by a resident and the provider's response to it. On 02/27/2024, Surveyor reviewed the provider's staffing schedules for February 2024. According to the schedule the following staff worked on 02/03 - 02/04/2024: 1st shift (6:00 AM - 2:00 PM) - Caregivers G and H 2nd shift (2:00 PM - 10:00 PM) - Caregivers L, M	N 399		

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N 399	Continued From page 64 and N 3rd shift (10:00 PM - 6:00 AM) - Assistant Administrator K On 02/27 and 02/28/2024, Surveyor interviewed Caregivers G, H, L, M and K. During the interviews the caregivers consistently reported the following: Caregiver O also worked 2nd shift on 02/03, but left abruptly approximately 2 hours into the shift. Caregiver M only worked a portion of 2nd shift on 02/03 because s/he arrived late. Caregiver J worked 3rd shift on both 02/03 and 02/04. On 02/28/2024 at 11:15 AM and 03/13/2024, Surveyor interviewed Administrator A. S/he acknowledged the schedule was not accurate for 02/03/2024 or 02/04/2024. She confirmed the following: Caregiver O worked a portion of 2nd shift on 02/03 and all of 2nd shift on 02/04. Caregiver M only worked a portion of 2nd shift on 02/03 because s/he arrived late. Caregiver J worked all of 3rd shift on both 02/03 and 02/04/2024. Administrator A also acknowledged other areas where the schedules (both January and February 2024) did not clearly identify exact times when caregivers worked. For example on 1/19/2024, Caregiver N was scheduled "12/6" and on 1/24/2024 "10/3." The schedule did not indicate if the hours were AM or PM. On 03/13/2024 Surveyor reviewed Stevens Point Police Department report C24-01447. The report detailed inconsistent and misleading statements from Administrator A to Detective R about the staff that worked on 02/03 and 02/04/2024. The	N 399		

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N 399	Continued From page 65 report described the challenges it presented to Detective R who was conducting a criminal investigation into the cause of Resident 1's injuries. Cross reference: N0158 DHS 83.12(2)(a) Caregiver: Investigating Abuse & Neglect N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies with Laws N0214 DHS 83.15(3) Administrator Shall Supervise Daily Operations N0348 DHS 83.12(2) Rights Of Residents: Free From Mistreatment	N 399		
{N 427}	83.38(1)(c) Leisure time activities. 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: Leisure time activities. The CBRF shall provide a daily activity program to meet the interests and capabilities of the residents. Employees shall encourage and promote resident participation in the activity program. The CBRF shall develop and post the activity schedule in an area available to residents. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure a daily activity program to meet the interests and capabilities of residents or encourage/promote participation in activities. The	{N 427}		

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{N 427}	Continued From page 66	{N 427}		

provider had a posted activity calendar but did not implement it.

This is a repeat deficiency. See SOD 5MV215, dated 08/16/2023.

Findings include:

On 02/27/2024 Surveyor observed the posted activity calendar. The listed activities were:

02/27/2024:
bend and stretch
coffee social
Golden Girls show
soft music
hand massages
evening social

02/28/2024:
Sittercises
coffee social
game show network
word search
evening social

Surveyor was onsite 2 full days on 02/27 and 02/28/2024. Surveyor did not observe any activities occurring.

Surveyor conducted the following 6 interviews:

Resident 7 on 02/27/2024 at 9:49 AM - Surveyor asked if there were activities at the facility and s/he replied, "No. We are starting a little bit, we played checkers the other day that was good. That was actually fun. It was last week. It was the first time in a while." Resident 7 said there is an activity calendar posted, "but they never follow it." Caregiver M on 02/27/2024 at 5:44 AM - S/he

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{N 427}	Continued From page 67 stated they "just started" doing activities and Caregiver N recently did a Valentine's Day party. Caregiver G on 02/27/2024 at 10:45 AM - S/he said, "We just did a Valentine's Day party. We were going to do karaoke, but then [Caregiver N] quit. Today we are just getting to the activity. Not too many people like doing activities...It's supposed to be Golden Girls (TV show) but I can't find it. I put Gun Smoke on." Caregiver H on 02/27/2024 at 1:00 PM - S/he said there is an activity person (Staff U) but "I barely see [him/her]. When I see [Staff U], I'm like, "Oh My God, [s/he] is back." Surveyor asked if activities happen when Staff U is not working and s/he replied, "Today I did an activity, bingo...only 2 residents played." Surveyor asked how the residents knew about bingo and s/he replied, "I don't know if it was bingo day. I just asked if they wanted to color or do bingo." Guardian P on 03/01/2024 at 8:01 AM - S/he said caregivers do not approach Resident 1 in an effective or meaningful way to encourage participation in actities. RN Care Manager W on 03/04/2024 at 9:23 AM - S/he stated that during 2 recent visits s/he did not see activities occurring. S/he said, "What I did see is they have this little TV in the main dining area. I'll see them put someone in there watching a show. No bingo games, nothing like that. They have supplies but I've never seen anyone engaging with them." Surveyor interviewed Administrator A on 03/13/2024 at 8:30 AM. Administrator A said Activity Staff U was hired 10/16/2024 and would come in twice a week. However, s/he was off 3 weeks over Christmas and then in the past 2 weeks s/he removed Staff U from the schedule because Staff U had not completed all required training due mid-January. Administrator A said	{N 427}		

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{N 427}	Continued From page 68 Caregiver N wanted to do activities, but that had not been fully implemented and Caregiver N quit on 02/08/2024. Surveyor shared his/her findings about activities and Administrator A did not dispute them. S/he commented caregivers "have time" and should be providing activities. Cross Reference: N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies with Laws N0214 DHS 83.15(3) Administrator Shall Supervise Daily Operations	{N 427}		
N 432	83.38(1)(h) Medication administration. 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: Medication administration. The CBRF shall provide medication administration appropriate to the resident ' s needs. This Rule is not met as evidenced by: Based on observation, interview and record review, the provider did not ensure medications were administered appropriate to resident needs for 3 of 3 residents reviewed. Resident 6 reported his/her pain was 9 out of 10 and requested staff assistance to receive medication. Caregiver L waited 35 minutes before administering pain medication.	N 432		

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N 432	Continued From page 69 Resident 3 had a medication scheduled 3:00 PM. Caregiver L was unaware of the scheduled medication and only administered it after 4:12 PM when Surveyor brought it to his/her attention. Resident 5 was scheduled for blood sugar checks before the supper meal and insulin administration at 4:00 PM. Caregiver L prompted Resident 5 for both at 2:51 PM and then inaccurately charted the time of each task. Findings include: The Department received a complaint alleging concerns about medication errors. Surveyor reviewed the provider's medication administration policy and "Subcutaneous Injection Competency" form (on 03/10/2024). The documents read part: "It is the policy of Care Partners Assisted Living ...that all medications are stored, labeled, administered, and documented correctly per state regulations .... With the increased needs of individuals in assisted living facilities, facilities must have the ability to manage complex medication regimens ...Although medications can improve the functional status and quality of life for residents, improperly managed medications can also cause serious adverse consequences ... The following are guidelines for proper medication management and specific administration procedures. Wash hands before starting, in between residents, before and after treatments ... Do not touch medications with your hands ... Medications are administered within sixty (60)	N 432		

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minutes of scheduled time, except before or after meal orders, which are given precisely as ordered.
Prior to administration, the medication and dosage schedule on the resident's MAR are compared with the medication label. This is done three (3) times.If the label and the MAR are different, the resident's chart is checked for the correct dosage and the Director is notified of the discrepancy.
Six recognized rights: 1. Right drug 2. Right resident 3. Right time 4. Right dose 5. Right route 6. Right dosage form...

"...Insulin injections are generally given 10-15 minutes before eating..."

"...At the end of each medication pass, the person administering the medications reviews the MAR to be certain that all necessary doses were administered and all administered doses were documented."

On 02/27/2024, Surveyor observed Caregiver L complete medication passes beginning at 2:22 PM and 4:12 PM.

RESIDENT 6:
At 2:23 PM, Caregiver T entered the medication room and informed Caregiver L that Resident 6 requested pain medication because s/he'd been "in pain all morning." Caregiver L asked Caregiver T to find out what the pain level was and Caregiver L prepared a different resident's medications. At 2:28 PM, Caregiver T returned and said Resident 6's pain was 9 out of 10. Caregiver L proceeded to prepare and administer medications for Residents 4 and 5. Thirty minutes later at 2:53 PM, Caregiver L began reviewing Resident 6's medication administration record

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N 432	Continued From page 71 (MAR) to see if it was time to administer pain medication. S/he noted Resident 6 last had tramadol (opiod pain medication for severe pain) at 10:00 AM, so s/he couldn't have it again until 4:00 PM. Caregiver L said Resident 6 could have Tylenol, so s/he prepared the medications. Caregiver L did not perform hand hygiene or apply gloves. S/he administered Resident 6 the medication at 2:58 PM, 35 minutes after Resident 6 first requested it and reported his/her pain was 9 out of 10. Surveyor reviewed the "24-hour book" on 02/27/2024 at 1:37 PM. The book served as a shift reporting tool for caregivers and documented Resident 6's need for pain management. An entry on 02/11/2024 read, "has been complaining about pain less today compared to normal..." and on 02/14/2024 read, "[Resident 6] was in a lot of pain crying & saying [s/he] wanted to die." Surveyor interviewed Hospice RN E on 02/28/2024 at 8:52 AM. S/he said Resident 6 is not his/her patient but s/he overhears Resident 6 calling out in pain. RN E said approximately 2 weeks ago, "[S/he] kept screaming out, 'Help me help me...I'm in so much pain I need my medicine!" Surveyor interviewed RN X (funding source care manager) on 02/28/2024 at 4:08 PM. S/he said Resident 6's pain "hadn't been managed very good" at the facility and recently tramadol was added to the medication regime. RESIDENT 4: At 2:23 PM, Caregiver L prepared 3 medications to administer to Resident 4. Caregiver L did not perform hand hygiene or apply gloves and touched the medications with his/her bare hands.	N 432		

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N 432	Continued From page 72 At 4:12 PM Caregiver L told Surveyor it was time for 4:00 PM medications. Administrator A was also in the medication room. While looking through the MAR binder, Surveyor noted Resident 4 had a 3:00 PM medication scheduled. Surveyor asked both staff if any residents had 3:00 PM medications; they both said no. Surveyor prompted them to review Resident 3's MAR and they agreed s/he was scheduled to receive hydrocortisone at 3:00 PM. Administrator A said their process is to schedule medications at a specified time but allow for 1 hour window before or after. Administrator A said it was "close enough" and Caregiver L should administer the medication. Surveyor noted using the 1 hour window described by Administrator A, Resident 4's 3:00 PM medication could have been administered with the others at 2:23 PM. RESIDENT 5: At 2:36 PM, Caregiver L said Resident 5 needed his/her blood sugar checked and showed Surveyor the MAR. Surveyor noted the scheduled time for the blood sugar check was illegible. Caregiver L agreed with Surveyor but said, "I assume it is 2:00 PM, it's highlighted pink" and noted other 2:00 PM medications for other residents were also highlighted pink. Caregiver L collected the supplies from the medication cart, did not perform hand hygiene or apply gloves and then entered Resident 5's room. Once the room Surveyor observed the supply kit also included Resident 5's injectable insulin. Caregiver L told Resident 5 it was time to check blood sugar and handed Resident 5 the testing supplies. After Resident 5 tested the blood sugar and shared the results with Caregiver L, Caregiver L handed	N 432		

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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 432	Continued From page 73	N 432		

him/her the insulin which Resident 5 injected at 2:41 PM. (Note: Based on Surveyor's observations and an interview with Resident 5 earlier in the day at 9:26 AM, Resident 5 appeared to be capable of this level of independence during the administration.)

Surveyor and Caregiver L then returned to the medication room. Caregiver L retrieved Resident 5's "Blood Sugar Record" which was a form that documented blood sugar values and administration of insulin 3 times daily before meals. The form Caregiver L retrieved specifically prompted for the tasks to be done before the "supper meal" and Caregiver L documented the blood sugar value and insulin administration on the form. Caregiver L then retrieved the MAR which instructed 20 units of levemir flex pen/insulin to be administered "every evening" at 4:00 PM. Surveyor noted the 4:00 PM time was typed and legible. Caregiver L documented on the MAR that the insulin was administered at 4:00 PM.

INTERVIEWS:
At approximately 3:10 PM, Surveyor interviewed Caregiver L about the medication passes. S/he confirmed s/he did not perform hand hygiene or wear gloves at any point. Surveyor asked about the timing of the blood sugar check and insulin administration for Resident 5. S/he said, "I forgot to tell [him/her] to wait. [S/he] did it." Surveyor pointed out Caregiver L brought the supplies and medication to Resident 5 and told him/her it was time. S/he acknowledged Surveyor's observation. S/he also acknowledged Surveyor's review of the documentation and agreed the medication was given earlier than scheduled and then inaccurately charted on the MAR as if it was given on time. Surveyor asked Caregiver L what his/her

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N 432	Continued From page 74 next steps would be in light of this information. S/he thought about it for a moment and said s/he had no idea. Surveyor prompted him/her to report the situation to Administrator A. At 3:16 PM, Caregiver L and Surveyor informed Administrator A about the timing and charting of the blood sugar check and insulin administration. Administrator A stated to Caregiver L, "You know you're not supposed to give insulin until 1/2 hour before a meal." Note: during Surveyor's observations on 02/27 and 02/28/2024, the supper meal was served at approximately 5:00 PM. At 4:15 PM, Administrator A told Surveyor s/he had reviewed Resident 5's MAR. S/he agreed the section highlighted pink for the blood sugar check was illegible, but it was supposed to be 11:00 AM. Surveyor pointed out this meant 1st shift either did not complete or did not chart the 11:00 AM check; Administrator A agreed. Administrator A did not offer an explanation as to why Caregiver L administered the 4:00 PM insulin at 2:41 PM when the scheduled time was clearly identified on the MAR. "Certain times of the day are most helpful to check your blood sugar to assess your overall diabetes treatment plan, especially if you take insulin. These times include:...Before meals: Checking your blood sugar before meals can help you plan your meal..." Source: https://my.clevelandclinic.org/health/treatments/17956-blood-sugar-monitoring, retrieval date 04/12/2024	N 432		

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{N 489}	Continued From page 75	{N 489}		
{N 489}	83.44(2)(a) Rooms clean and free from odors. The CBRF shall keep all rooms clean and shall make reasonable attempts to keep all rooms free from odors. This Rule is not met as evidenced by: Based on observation, interview and record review, the provider did not make reasonable attempts to keep all rooms clean and free from odor. This is a repeat, uncorrected deficiency. See Statement of Deficiency 5MV215, dated 08/16/2023. Findings include: The provider is licensed to serve up to 16 non-ambulatory residents from the following client groups; irreversible dementia/Alzheimer's, terminally ill, physically disabled or advanced age On 02/27/2024, Administrator A provided Surveyor with the plan of correction (POC) from the previous survey for this same deficiency. Surveyor reviewed it on 02/28/2024 at 5:47 PM; it read in part, "Administrator started check off job duties with PAs (caregivers) for all shifts. Will monitor and f/u (follow up) directly with PAs when not completed for discipline." [sic] The correction date was identified as 10/10/2023. On 02/27/2024 at 5:33 AM, Surveyor entered Resident 4's room with Caregiver M. Surveyor immediately smelled a strong urine-like odor. Assistant Administrator (AA) K joined moments later. Both staff confirmed the room smelled strongly of urine. Resident 4 was incontinent but Caregiver M said, "I think it's the carpet."	{N 489}		

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{N 489}	Continued From page 76 Surveyor observed Resident 4's carpet was dirty, worn and stained. Surveyor entered Resident 4's bathroom. There was debris on the floor, it felt grimy underfoot and needed mopping. The garbage can did not have a bag in it and the rim had brown matter on it. The metal grab bar next to the toilet was visibly dirty with unknown substances on it. Both Caregiver M and AA K confirmed the bathroom needed cleaning. At 9:23 AM, Surveyor returned to the room to conduct an interview with Resident 4 and found the room and bathroom in the same condition and the odors persisted. At 9:34 AM, Surveyor requested Facility Registered Nurse (RN) C accompany Surveyor to observe Resident 4's room. RN C said the condition of the room/bathroom was "unacceptable" and the bathroom "needs to be bleached." RN C said s/he had a stuffy nose but s/he could still smell the urine-like odor. At 9:40 AM, Surveyor interviewed Administrator A about the cleanliness and odor of Resident 4's room. S/he acknowledged the observations and said it has been a persistent problem. S/he reported having a meeting the day before when s/he warned caregivers about not completing cleaning and other responsibilities. S/he told them, "Write ups will be happening. Three and you're out (fired.) I'm not dealing with laziness anymore." Surveyor reviewed portions of Resident 4's record on 02/28/2024; Resident 4 is wheelchair bound, has diagnoses to include Parkinson's disease and relies on staff assistance with housekeeping tasks.	{N 489}		

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{N 489}	Continued From page 77 On 02/28/2024 at 11:04 AM, Surveyor entered the building and smelled a strong odor-like urine. Surveyor walked approximately 20 feet to enter a hallway of resident rooms, Surveyor determined the odor was coming from the first room in the hall, Resident 9's room. At 12:30 PM, Surveyor continued to smell the urine odor permeating from Resident 9's room towards the common area in the front of the building. At 3:08 PM, Surveyor interviewed Administrator A and RN C about the strong urine odor coming from Resident 9's room. They both acknowledged the odor. RN C said, "That's on us" and said s/he also noticed it during the morning. Administrator A said Resident 9 has a known behavior of spitting on the bathroom floor. Surveyor and RN C requested Resident 9's individual service plan (ISP) and reviewed with Administrator A. The plan did not address urination as part of a behavior and only noted the bathroom should "be cleaned a few times each shift." Cross Reference: N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies with Laws N0214 DHS 83.15(3) Administrator Shall Supervise Daily Operations N0491 DHS 83.44(2)(c) Interior Floors, Walls and Ceilings	{N 489}		
{N 491}	83.44(2)(c) Interior floors, walls and ceilings. Every interior floor, wall and ceiling shall be clean and in good repair. This Rule is not met as evidenced by:	{N 491}		

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{N 491}	Continued From page 78 Based on observation and interview, the provider did not ensure all interior floors and walls were clean and in good repair. Carpeting in the some resident rooms was badly worn and stained. Both exit doors were badly scuffed and the back door had pieces of the wood frame missing allowing for an opening to the outside even when closed. This is a repeat deficiency being cited for the fourth time. See Statements of Deficiency: QZ1512, dated 07/12/2018 QZ1513, dated 006/23/2021 5MV215, dated 08/16/2023 Findings include: The provider is licensed to serve up to 16 non-ambulatory residents from the following client groups; irreversible dementia/Alzheimer's, terminally ill, physically disabled or advanced age. Resident 4's room: On 02/27/2024 at 5:41 AM, Surveyor observed Resident 4's bathroom floor. The floor trim alongside the wall in front of the toilet was discolored and there were gouges in the painted wall. Directly next to the toilet were areas of tile flooring approximately 2 ft x 4 inches had become detached from the subfloor. The loose pieces of tile were stacked up next to the toilet. The toilet paper holder attached to the wall was broken. The metal plate it had been applied to was visible. The toilet paper roll was hanging loose on a portion of the holder that remained. Resident 7's room: On 02/27/2024 at 9:49 AM, Surveyor interviewed Resident 7 in his/her room. Surveyor observed the carpet was old, worn and stained. Resident 7 agreed the carpet was stained and said staff tried	{N 491}		

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{N 491}	Continued From page 79 to clean it with a machine recently "but it didn't clean it real well." Surveyor also observed an upholstered chair in Resident 7's room was dirty and stained. Resident 10's room: On 02/27/2024 at 10:10 AM, Surveyor observed Resident 10's carpet was old, worn and stained. This included a dark, stained area next to Resident 10's bed that was approximately 2 ft x 2 ft. Resident 6's room: On 02/27/2024 at 2:09 PM, Surveyor interviewed Resident 6 and Family W. During the interview Surveyor observed the carpet was old, worn and stained. This included a circular stain approximately 1 ft in diameter. Within the circle was a thicker, matted substance approximately 3 inches long. Resident 6 and Family W agreed the carpet was stained and Resident 6 said s/he spills sometimes. Surveyor observed Resident 6 used a wheelchair for mobility and Resident 7 during the interview explained s/he has limited use of one arm. Resident 6 also pointed out s/he didn't like the debris on the floor by his/her chair and said some it was toenail clippings. S/he explained, "They clipped my toenails at 5 or 6:00 PM yesterday...They said they vacuumed today, but they didn't." Other areas: On 02/27/2024 at 10:14 AM, Surveyor observed the back exit door. From the floor extending up for approximately 16 inches, the interior door frame was damaged. The white door frame had gouges, black streaks and exposed raw wood. The interior of the frame had missing and peeling pieces of weather stripping which exposed 2 gaps approximately 10 inches and 6 inches to the	{N 491}		

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{N 491}	Continued From page 80 outside even when the door was shut. The interior of the door was white but the bottom of it had black streaks that spanned the entire length. Surveyor noted this door was in the same condition as the last survey in August 2023, except more weather stripping was missing making the exposed sections even larger. On 02/28/2024 at 12:52 PM, Surveyor observed the front exit door. Approximately 24 inches of the interior door frame was damaged. The white frame had gouges, black streaks and exposed raw wood. The interior of the door was white but the bottom of it had black streaks that spanned the entire length. Surveyor also observed piece of floor trim approximately 8 inches long was missing in the meeting area just outside of Administrator A's office. Surveyor interviewed Administrator A and Regional Registered Nurse (RN) C on 02/28/2024 at 3:14 PM. Administrator A acknowledged the condition of the exit doors and said there had been no repairs made to the back exit door since the last survey. Administrator A said since the last survey, the old and worn carpeting was replaced in the common areas and in his/her office. S/he acknowledged the same old carpet remained in some resident rooms including Residents 4, 7, 10 and 6. She acknowledged the carpeting is so old and worn, carpet cleaning has limited effectiveness. Administrator A said there were plans to replace carpeting in 2 vacant rooms, but no plans to replace the carpeting in the four aforementioned resident rooms. Regional RN C said the plan of correction (POC) from the previous survey will document all plans for carpet replacement.	{N 491}		

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{N 491}	Continued From page 81 On 02/28/2024 at 5:47 PM, Surveyor reviewed the plan of correction from the previous survey for this same deficiency. The POC included email correspondence with the flooring contractor dated 10/17/2023. The correspondence only identified plans for the common areas of the facility and Administrator A's office. It did not document a plan to replace any carpeting in resident rooms. Cross Reference: N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies with Laws N0214 DHS 83.15(3) Administrator Shall Supervise Daily Operations N0489 DHS 83.44(2)(a) Rooms Clean and Free From Odors	{N 491}		
Y3244	50.09(1)(L) Care (1) RESIDENTS' RIGHTS. Every resident in a nursing home or community based residential facility shall, except as provided in sub. (5), have the right to (l) Receive adequate and appropriate care within the capacity of the facility. This Rule is not met as evidenced by:	Y3244		

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Y3244	Continued From page 82	Y3244		

Based on observation and interview, the provider did not ensure Resident 2 and Resident 4 received adequate and appropriate care. Resident 2 and Resident 4 did not receive 2 hour toileting checks for incontinence. Both residents were at increased risk for pressure injuries to due lack of mobility and incontinence.

This is a repeat deficiency. See SOD 5MV212, dated 02/25/2021

Findings include:

The Department received a complaint alleging concerns with 3rd shift staff.

RESIDENT 2:
On 02/27/2024 beginning at 5:10 AM, Surveyor accompanied Caregiver M to complete incontinence checks for residents who rely on assistance with that care need. Caregiver M initially said Resident 2 needed incontinence checks, but then corrected him/herself and said Resident 2 did not actually need to be checked because s/he would call for toileting assistance if s/he needed it. Caregiver M did not check on Resident 2 and moved on to other residents.

Surveyor interviewed Assistant Administrator (AA) K on 02/27/2024 at 6:41 AM. S/he said some caregivers don't do their jobs and are on their phones too much. S/he volunteered an example that the day before when s/he reported for work at 10:00 PM, Resident 2 had dried fecal matter on him/her. It was "in [his/her] groin and had leaked through [his/her] pants....[Resident 2] will tell you nobody ever comes in [his/her] room" to check on him/her.

Surveyor interviewed Caregiver G on 02/27/2024

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Y3244	Continued From page 83	Y3244		

at 10:45 AM, and asked him/her to describe Resident 2's toileting needs. S/he stated Resident 2 needs his/her catheter emptied of urine at the end of each shift and when Resident 2 needs to have a bowel movement, Resident 2 notifies staff for assistance and they transfer him/her to the toilet. Caregiver G did not describe a need for incontinence checks or to proactively offer toileting assistance every 2 hours.

Surveyor interviewed Resident 2 on 02/27/2024 at 8:34 AM. S/he said things could be better at the facility and s/he doesn't like it there. Resident 2 said sometimes caregivers check on [him/her] during the night and other times they don't.

On 02/28/2024 at 1:35 PM, Surveyor reviewed Resident 2's facility record. Resident 2 was admitted on 05/09/2016 with a history of stroke and right side weakness. The current individual service plan (ISP) dated 02/01/2024 and related care plan documentation indicated Resident 2 had a catheter, was non-ambulatory, needed the assistance of 2 staff for transfers and showers twice weekly. Contrary to caregiver statements, the ISP noted s/he needed staff to assist with repositioning and bowel incontinence checks every 2 hours. The ISP also documented Resident 2's need for daily skin assessments due to risk of pressure injuries and that s/he had an active wound on his/her buttocks that was being managed by home health.

Daily charting of bowel activity documented Resident 2 was incontinent of bowel at least 15 times 02/01-02/27/2024.

The record contained worksheets to document showers and body audits. During the month of February 2024 only 2 showers were documented

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Y3244	Continued From page 84 on the worksheets: 02/01 - "Gave bed bath due to dry poop" 02/07 - "[groin is] red. really red. cream put on them." The only documentation of a shower after 02/07 was an observation noted dated 02/27/2024 and the condition of Resident 2's skin was not noted. The record contained a physician's order for wound care 3 times weekly by home health beginning 01/17/2024 for a pressure ulcer. A caregiver note dated 02/23/2024 read, "wound care came...discharged from wound care this AM." Surveyor interviewed Registered Nurse (RN) Care Manager X on 02/28/2024 at 4:07 PM. S/he said Resident 2 needs staff assistance to be repositioned every 2 hours and assistance with all toileting needs. RN X said Resident 2 had a recent history of pressure injuries. S/he explained home health was providing services to manage a wound. There had been improvement and they were going to discharge him/her, however within the past week the wound on his/her bottom opened up again. RESIDENT 4: On 02/27/2024 at 5:30 AM, Caregiver M initially told Surveyor Resident 4 needed 2 hour incontinence checks but then explained Resident 4 didn't need to be checked because s/he was last checked and changed at 3:30 PM. Caregiver M commented, "[S/he] wants more help than s/he really needs" and volunteered "[his/her] butt is red." Surveyor noted 2 hours had passed since 3:30 AM and prompted Caregiver M to verify Resident 4 was dry. Caregiver M agreed and said, "[S/he] is probably wet, just so you know."	Y3244		

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Y3244	Continued From page 85 Upon entering the room, Caregiver M confirmed Resident 4 was incontinent and commented, "[S/he] is really wet, [s/he] normally is." Surveyor asked Caregiver M if Resident 4 had pressure wounds and Caregiver M said s/he couldn't recall from the last time s/he worked, even though s/he stated s/he provided cares at 3:30 AM. While providing incontinence care Caregiver M told Surveyor that Resident 4 did not have pressure wounds, "just some redness." On 02/28/2024 at 1:25 PM, Surveyor reviewed Resident 4's record. Resident 4 was admitted on 09/27/2022 with diagnoses to include major neurocognitive disorder and Parkinson's disease. Resident 4 was non-ambulatory and relied on staff for assistance with transfers. "Pressure Ulcer Risk Assessment Forms" dated 11/22/2023 and 01/30/2024 signed by Administrator A, documented Resident 4 was at high risk for the development of pressure injuries. Resident 4's assessment score was elevated in part due to mobility limitations and incontinence. The record contained monthly charting of bladder and bowel action. Resident was incontinent at least 45 times between 02/01 and 02/27/2024. The most recent ISP dated 11/01/2023 read in part, "Assist of one and is on two hour toileting scheduled to provide dryness and being clean. Wears pull ups at all times ...Is incontinent of bowel and bladder ...Skin is intact at this time ... [s/he] can be weak and tired at times due to [his/her] Parkinson's ..." [sic - all] Resident 4's record contained supplemental monthly care plan documentation that was contradictory; it identified Resident 4 as being continent of bladder and bowel. Surveyor reviewed Resident 4's February 2024	Y3244		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0011953	A. BUILDING: _____ B. WING _____	R-C 03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PARTNERS STEVENS POINT 1	3349 BUILDING A WHITING AVENUE STEVENS POINT, WI 54481

(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
Y3244	Continued From page 86 observation notes and noted the following documentation of overnight checks: 02/21 - "asleep on checks. Changed at 5am" (AA K) 02/22 - "asleep on checks. Changed at 4am" (AA K) 02/23 - "asleep on checks. Changed at 4:30am" (AA K) 02/24 - "resident was checked on every 2 hours. Resident slept throughout the night." (unidentified 3rd shift staff) 02/26 - "asleep in bed on checks. Up to bathroom at 3:30am changed again at 5:40am" (AA K) 02/27 - "asleep in bed on checks. Changed at 4am." (AA K) Surveyor noted the documentation was not clear if the checks were wellness checks or if Resident 4 was actively checked for incontinence and/or asked if s/he needed to use the toilet. Surveyor interviewed Resident 4 on 02/27/2024 at 9:11 AM. Resident 4 said staff help him/her with toileting "2 or 3 times a day." Surveyor asked if they check during the night and s/he said no, only if s/he uses his/her call button. Resident 4 complained about caregivers and Surveyor asked what they could do better. S/he replied, "They talk too much. They are always on their cell phones. Nothing gets done around here." During the interview, Surveyor observed Resident 4's call pendant was dirty with dried substances on it and the lanyard was stained and also had particles of dried food. At 9:34 AM, Surveyor was in the hallway and heard Resident 4 calling out, "Help! Help!" Surveyor informed RN C Resident 4 needed assistance and pointed out the dirty call pendant. At 2:20 PM, RN C said when they attempted to clean the call pendant they	Y3244		

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Y3244	Continued From page 87	Y3244		

determined it was not working and they were reprogramming it. RN C confirmed the call light was very "grimy" and s/he was hesitant to touch it with bare hands. RN C was unsure how long Resident 4 had been without a functioning call pendant.

On 02/27/2024 at 9:40 AM, Surveyor interviewed Administrator A. S/he said all residents should receive wellness checks overnight, and some residents like Resident 4 also need 2 hour checks specifically "for toileting." Surveyor shared the observations earlier in the morning of Resident 4 being heavily incontinent after reportedly being checked on 2 hours prior and asked Administrator A if s/he thought the 2 hour toileting checks were happening. S/he replied, "NOC (3rd shift) has been reporting to me getting [Resident 4] up at 4:30 or 5:00 AM because [s/he] is pretty wet at that time." Administrator A then described his/her staff as lazy and said s/he warned them all just the day before they will be written up if they aren't providing cares and after 3 times s/he will fire them.

Cross Reference:
N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies with Laws
N0214 DHS 83.15(3) Administrator Shall Supervise Daily Operations
N0389 DHS 83.35(3)(d) Service Plans Updated Annually Or On Changes