| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| CARE PARTNERS ASSISTED LIVING HORTONVILLE | 112 HARRIS WAY HORTONVILLE, WI 54944 |

| (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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| {N 000} | Initial Comments<br><br>On 09/11/2023, 09/13/2023 and 10/02/2023 Surveyors conducted an on-site standard survey, 5 complaint investigations, 3 self-report reviews, and a verification visit for Statement of Deficiencies (SOD) 8DXE13 and QP2D12, at Care Partners Hortonville. Additional information was gathered through 10/10/2023.<br><br>All deficiencies were verified as corrected for SOD QP2D12.<br><br>Three (3) out of 5 complaints were substantiated.<br><br>As a result of the survey, 20 deficient practices were identified. Of the 20 deficient practices identified, 10 were repeat violations.<br><br>Under statutory provisions, a $200 revisit fee is being assessed for the verification visit.<br><br>Census: 38 | {N 000} | | |
| {N 158} | 83.12(2)(a) Caregiver: Investigating abuse & neglect<br><br>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 | {N 158} | | |

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

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| {N 158} | Continued From page 1<br>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 misappropriation of property. The CBRF shall maintain documentation of any investigation.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the provider did not immediately protect residents and thoroughly investigate and document an allegation of abuse and misappropriation of property for 2 of 2 (Resident 3 and 10) residents reviewed.<br><br>On 06/30/2023 and 07/21/2023, Resident 3's oxycodone tablets were discovered missing by facility staff. Resident 3's oxycodone proof-of-use sheet dated 05/16/2023 had a discrepancy noted. The facility did not thoroughly investigate the missing oxycodone tablets, nor did the facility conduct an investigation into the discrepancy. Furthermore, the facility did not take action immediately upon learning of the misappropriation on 06/30/2023 to protect residents from further misappropriation.<br><br>On 02/28/2023, Resident 10 had 30 pills of lorazepam delivered to the facility. On 09/27/2023, Caregiver S discovered the 30 pills were missing. The facility did not immediately take action to protect from further misappropriation, nor did they conduct an investigation into the missing 30 pills of lorazepam.<br><br>This is a repeat deficiency. See SOD (Statement of Deficiency) 8DXE13, dated 12/19/2022. | {N 158} | | |

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| {N 158} | Continued From page 2<br>Findings Include:<br><br>A facility policy titled, "ABUSE/MISCONDUCT" dated 12/12/12 states, "...Care Partners/Country Terrace believes that all people deserve dignified, loving care with services provided to maximize their potential for living and independence. Our plan shall assure protection of each resident from possible abuse; initial education and on-going education for all staff members on the plan; procedures to ensure appropriate implementation and continuation of this plan; systems for reporting abuse and annual evaluation of the plan.<br>REPORTING INCIDENTS (ACTUAL, SUSPECTED, ALLEGED)<br>1. All employees, volunteers and any other individual involved in resident's care are required to immediately report any known or suspected resident abuse to the Director. A report must also be filed with the Director in the event a resident accuses an individual of abuse. The Director will contact the Corporate Office to assist in the investigation. All reports of actual or alleged misconduct must be reported to the Department of Health Services on Form TS 2247 within seven (7) working days after the initial report....3. Reports should be specific, giving the name of the resident involved, date of incident, other individuals involved, description of the incident, supporting documentation, signed statements, conclusions, individuals notified, actions taken, and any other helpful pertinent information...7. Upon learning of an incident of alleged misconduct, the Director shall take whatever steps are necessary to ensure that resident(s) are protected from subsequent episodes of misconduct while a determination on the matter is pending." | {N 158} | | |

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| {N 158} | Continued From page 3<br><br>Resident 3<br>On 07/10/2023, the Department received a facility self report regarding narcotic misappropriation. The report indicates a supply of 30 oxycodone tablets was delivered for Resident 3 on 06/19/2023. The tablets were signed for and placed in the medication cart. The staff assigned to that medication cart left at 2am and never returned after 06/19/2023. On 06/30/2023, both proof-of-use sheets and empty bubble pack were discovered in common area furniture drawer by Resident 3. Law enforcement was contacted and an internal investigation conducted. Administrator A had provided a typed statement stating, "On Friday June 30th around 9:30am [Officer L] was dispatched to Hortonville facility regarding missing narcotics, the call came from one of our residents [Resident 3]. The night before staff member [Caregiver M] had contacted me stating [Resident 3] was cleaning the back-living room area and stumbled upon a narc [narcotic] count sheet and bubble pack and told me [s/he] had slid it under my door for me to look at when I got in. I reviewed the narcotic sheet which was signed for on June 19th at 3:00pm by two staff members [Assistant Director E and Caregiver N] stating there was 30 oxycodone in the pack. The bubble pack matched the labels but had zero pills in the pack. [Officer L] and [Administrator A] then had met in the training room at the facility to interview staff. 10:30am [Caregiver O] was called into the room. [Caregiver O] had worked back cart since the incident and had worked with [Resident 3] but during [his/her] time working on the carts never gave [Resident 3] an oxycodone as it was PRN [as needed], but [Caregiver O] believes while working on the cart [s/he] had given others PRNs but not oxycodone. 10:53am [Caregiver P] gave [his/her] statement. [Caregiver P] states [s/he] never seen the bubble pack or the narc count | {N 158} | | |

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paperwork. [S/he] has worked back cart but in the month of June never gave out any PRNs to [Resident 3]. [Caregiver P] does not believe anyone working at the building is suspicious of stealing medications. 11:08 [Caregiver S] said [s/he] has been shadowing [Caregiver T and Caregiver P] on the back cart and today June 30th was [his/her] first day alone on the back cart. [Caregiver S] mentioned [s/he] had given [Resident 3] all of [his/her] scheduled 8:00am medications but none of [his/her] PRNs. While counting [Caregiver S] said [s/he] had never seen the 3rd bubble pack card for [Resident 3] nor the narc count sheet. [Caregiver U] came into the room around 11:15am, [s/he] has not been on back cart in months and stated [s/he] does not suspect anyone currently working would steal medications. 11:28am [Caregiver V] came in for [his/her] statement. [Caregiver V] did work 2nd shift before coming onto 1st shift. While working on 2nd shift [Caregiver V] stated [s/he] did give [Resident 3] Oxycodone but hasn't been on back cart since June 16th. 11:33am three staff members had knocked on the door stating after thinking about it the only staff member who recently worked here could be suspected [Caregiver W]. [Caregiver W's] last day worked was June 19th and [s/he] stayed until 2:00am that night. [Officer L] took down [his/her] information to look into that individual and would be following up with myself July 5th. [Caregiver X] came in around 11:51am and stated [s/he] hasn't been on back cart and the only person who seemed to be "sketchy" was staff member [Caregiver W.] In the afternoon I reached out to a few other staff members who work[sic] 2nd shift [Assistant Director E, Caregiver N and Caregiver H]. [Caregiver H] said [s/he] only had seen the card the night [Caregiver M] had slid in under my door. [Assistant Director E] remembers counting the

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card and signing for it, but [s/he] always works front cart normally and that was the last night [s/he] had seen the card. [Caregiver N] stated [s/he] signed for the card that had 30 pills in it, but when counting didn't realize it was missing as both the sheet and card were gone."

The report did not contain written statements from the caregivers, a conclusion to the investigation and what actions the provider was going to take to ensure residents' health, safety and well-being.

On 07/28/2023, the Department received a second facility self report regarding additional oxycodone tablets missing for Resident 3. The report states "awaiting police report" and "meds [medications] replaced." Attached to the report is an email from Regional RN B dated 07/26/2023 and states, "Per [Officer L] of Hortonville PD [police department], [s/he] was told by several staff members of a time when [Administrator A] spoke of trying to get pain medication for [his/her] [family member] who'd recently been diagnosed with cancer. [S/he] told me that this was stated by [Receptionist Y], [Caregiver X], [Assistant Director E], [Caregiver H], [Former Assistant Director Z], and [Former Caregiver AA]. I've followed up with each of these, except [Former Caregiver AA]. [Receptionist Y] denied any knowledge or observation of any staff attempting to get med's from each other, and denied reporting this to the officer. [Assistant Director E] reports that there was a time when [Administrator A] discussed pain med's for [his/her] [family member], but denied reporting this to the officer
[Caregiver X] did not cover [his/her] scheduled shift today and has not responded to my voicemail. [Former Assistant Director Z] reports that [s/he'd] heard of [Administrator A] discussing

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| {N 158} | Continued From page 6 | {N 158} | | |

pain med's for [his/her] [family member], but denied reporting this to the officer. [Caregiver H] denied any knowledge or observation of any staff attempting to get med's from each other, and denied reporting this to the officer. Regarding [Former Caregiver AA], I remember having interviewed [him/her] on unrelated state reports during [his/her] time of employment and [s/he] was not a reliable historian. On Friday of this week 7/28, [Administrator A] is scheduled to be interviewed at the Hortonville Police Station and [s/he] will update [Vice President Resident Services BB].

Another sheet attached to the report is a typed statement from [Administrator A] dated 07/21/2023 and states, "Friday July 21st staff member [Caregiver H] had called me regarding [Resident 3's] pills at 8:55pm. [Caregiver H] stated [Resident 3's] oxycodone's were in the nurses' office and they did not have a key to get in there. I told [Caregiver H] I was running to Dollar General in Larsen and I would be to the facility to open the door. I had arrived to the facility around 9:30pm and [Caregiver H] and [Caregiver CC] had stated [Resident 3] wanted a PRN oxycodone and [his/her] narcotic card was slide[sic] under the nurses' station door the night of July 15th as there was no narc count sheet. When they had contacted the PM Assistant Director E on July 15th about it [s/he] told [Caregiver H] to put in[sic] under the door as there should not be a narc card in the medication cart without a sheet of paper. This was the first time I was hearing about this incident as on July 15th [Caregiver N] has messaged me about not having a narc count sheet for that medication and I had told [him/her] to create a sheet for now until the old one was found. I had opened the nurses' station door and opened up the black medication

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| {N 158} | Continued From page 7 | {N 158} | | |

box, but could not find any oxycodone's for [Resident 3]. Myself, [Caregiver H] and [Caregiver CC] had searched the whole nurses' station and my office as well for this bubble pack but had no luck of finding it. 10:07pm I had contacted [Receptionist Y] to see if [s/he] had seen it at all during the week and [s/he] had no recollection of the medication. Then at 10:11pm I had contacted [Regional RN B] to let [him/her] know about the situation and what was best to do at that time, [s/he] instructed to contact the police department. 10:23pm I had contacted the Hortonville Police Department about missing narcotics. [Officer DD] had come and started a report and I had told [him/her] that a staff member contacted me about needing a medication from the nurses' office and when I had come in there was no medication found. [Caregiver H] was on the phone with [Assistant Director E] at the time, and [Assistant Director E] had said the last time [s/he] had seen it was on [Caregiver X's] business day when it was on top of the black box in the nurses' office. I had contacted [Caregiver X] at 11:29pm Friday night and asked [him/her] of [s/he] could write a statement about [Resident 3's] medication that was slipped under the door over the weekend. [Caregiver X] said [s/he] didn't know about them and hasn't been on back cart. I had then explained to her how they were put under the nurses' station door, but didn't hear anything back about it. Monday July 24th [Officer L] had come in around 2:00pm to talk with staff who had access to the nurses' station door, which was [Assistant Director E, Receptionist Y], myself and talked with [Caregiver N] who was a witness to the meds being slide[sic] under the door July 15th. Tuesday July 25th [Officer L] had come back around 8:00am to talk to [Caregiver X] and [Receptionist Y]. Tuesday July 26th I contacted [Maintenance Director F] to have him install a piece of the door

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which will make it automatically shut, as it was stated that at times the nurses' station door was open and unattended. I also had moved the med destruction box into my office as I am the only one to a key to the office."

The report did not contain written statements from the caregivers, a conclusion to the investigation and what actions the provider was going to take to ensure residents' health, safety and well-being.

On 09/11/2023 and 09/13/2023, Surveyors conducted an onsite visit to the facility. Surveyor requested any additional documentation the facility had regarding the above investigations and the police reports.

On 09/11/2023, Surveyor received 2 additional written statements regarding the 06/30/2023 allegation. Caregiver M's written statement dated 06/30/2023 stated, "While passing out meds, [Resident 3], called me over to a desk by the back patio, and stated that while [s/he] was cleaning out said desk drawers, [s/he] had found an empty sheet of oxycodone that had been [Resident 3's] PRN [as needed] medication. The narc sheet was shoved into the desk drawers along with the pill sheet. On checking the MAR it was noted that the med had not been discontinued, so the narc and pill sheet were passed onto [Administrator A]."

Caregiver P's written statement with no date stated, "On June 30th I [Caregiver P] was on back cart, a resident told the floor runners that on the night of June 29th [s/he] had found a bubble pack of meds that was empty along with the paper that you sign the meds out on. Later that day the resident called the cops to report it. I had

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| {N 158} | Continued From page 9<br>to speak with the officer. I told [him/her] that I have never even seen that bubble pack in the cart, [s/he] also asked if I could think of anyone who would have taken the narcs."<br><br>Additionally, on 09/13/2023, Surveyor received Resident 3's "Proof of Use Sheet" for Oxycodone 5 mg (milligram) tablet to be administered as needed. The sheet indicates Resident 3 had a total of 15 tablets delivered on 05/16/2023. Resident 3 was administered 1 tablet on the following days:<br>" 05/22/2023 leaving 14 remaining<br>" 06/01/2023 leaving 13 remaining<br>" 06/02/2023 leaving 12 remaining<br>" A line that is scribbled out, date is not legible, however, the amount given was "1" by Caregiver H with initials of Administrator A next to name, leaving 11 remaining<br>" A line that is scribbled out, date is not legible, however, the amount given was "1" by Assistant Director E with initials of Administrator A next to name, leaving 10 remaining<br>" 06/15/2023 leaving 8 remaining<br>The sheet does not explain the count discrepancy between 06/02/2023 and 06/15/2023, nor the reason for the scribbled out lines.<br><br>On 09/13/2023 at 2:00 PM, Surveyor interviewed Assistant Director E. Surveyor showed Assistant Director E the above mentioned proof-of-use sheet. Assistant Director E stated Administrator A signed Assistant Director E's name on the proof of use sheet. Assistant Director E stated s/he did not pass oxycodone to Resident 3 and did not sign the proof of use sheet and directed Administrator A to cross out Assistant Director E's name. Assistant Director E did not know what happened to the 4 missing pills. | {N 158} | | |

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| {N 158} | Continued From page 10<br><br>On 09/13/2023 at approximately 3:00 PM, Surveyor interviewed Administrator A. Administrator A verified the facility did not have written statements from the caregivers interviewed during the 06/30/2023 or 07/21/2023 misappropriation allegations. Additionally, Administrator A stated they requested the police report today, verifying the facility did not obtain the police reports until Surveyor requested them. Administrator A stated the 06/30/2023 and 07/21/2023 allegations were inconclusive. Surveyor discussed the proof-of-use sheet with Administrator A. Administrator A acknowledged the discrepancy on the proof-of-use sheet. Administrator A verified s/he scribbled out the 2 lines on the proof-of-use sheet. Administrator A was unable to explain or provide documentation of an investigation into the additional 4 missing oxycodone tablets. Administrator A was unable to explain the action steps the facility took after the 06/30/2023 and 07/21/2023 allegations to prevent further misappropriation and to ensure the health, safety and welfare of the residents.<br><br>On 09/13/2023 at 3:30PM, Surveyor interviewed Regional Registered Nurse (RN) B regarding the misappropriation allegation and additional discrepancy found on the proof-of-use sheet. Regional RN B stated the facility has requested the police reports today verifying the reports were not received until Surveyor requested. Regional RN B verified s/he did not have written statements from the employees s/he interviewed on 07/26/2023. Regional RN B stated based on the information, the 06/30/2023 and 07/21/2023 allegations were inconclusive. Regarding the discrepancy, Regional RN B stated, "I thought we sent in a report to the department about the missing card?" Surveyor explained the report did notify the department of the missing card but did | {N 158} | | |

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| | 0016767 | A. BUILDING: _____ B. WING _____ | R-C 10/10/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| CARE PARTNERS ASSISTED LIVING HORTONVILLE | 112 HARRIS WAY HORTONVILLE, WI 54944 |

| (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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| {N 158} | Continued From page 11 | {N 158} | | |

not contain any information as to how many pills were on the card. Regional RN B was unable to explain or provide documentation of an investigation into the 4 missing oxycodone tablets.Regional RN B verified no formal training on medication pass, policy and procedure on narcotic storage, narcotic counts and what to do if staff recognize a discrepancy was completed with any staff.

In Summary, on 06/30/2023 and 07/21/2023, Resident 3's oxycodone tablets were discovered missing by facility staff. The facility indicates caregiver interviews were conducted but there is no documentation of these interviews, no resident interviews conducted and no copy of the police reports that were filed. Additionally, the facility does not provide a conclusion to the investigation, nor does the facility indicate any action the facility took to immediately protect residents from further misappropriation. While Surveyor was onsite, Surveyor discovered Resident 3's oxycodone proof-of-use sheet dated 05/16/2023 had a discrepancy noted. The facility was unable to provide any investigation into the discrepancy, which should have been discovered by the facility during the investigation into the 06/30/2023 missing oxycodone tablets.

Resident 10
On 09/28/2023, Surveyor received a call from Officer L informing Surveyor that the facility had contacted law enforcement due to another case of missing medications. Officer L indicated the facility had called law enforcement on 09/27/2023 and indicated there was a card of lorazepam missing from the medication cart.

On 10/02/2023, Surveyors conducted an onsite visit to the facility. Resident 10's resident record

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| {N 158} | Continued From page 12<br>was reviewed.<br><br>On 02/28/2023, Resident 10 was prescribed Lorazepam 0.5 mg tablet to be given by mouth every hour as needed for anxiety or restlessness.<br><br>Surveyors requested any documentation into the investigation of the missing medications. Surveyors were provided 3 written statements from the following caregivers:<br><br>On 09/27/2023 Caregiver HH wrote the following: "To whoever [sic] concerns, on the date of Sep 26 I came in for my shift a [sic] 6pm. I did count on the blue cart with [Caregiver II] [s/he] had the other two keys. So after we both finish [sic] 8pm meds. [Caregiver II] and I went to do count on the green cart. That is when I notice [sic] it was only 11 cards in the narc box and it [sic] supposed to be 12 in the cart. [Caregiver II] told me [s/he] was gonna contact [Administrator A] about the meds.<br><br>On 09/27/2023 Caregiver II wrote the following: "On September 26, 2023, around 6:15pm, I went to count memory care green cart with [Medication Passer D], I asked [him/her] where the "controlled substances inventory" sheet was and [Medication Passer D] stated [s/he] didn't see one. It was after I did my 8pm med pass, around 9:20pm, I was counting the cart with [Caregiver HH] and I looked in the pocket of the narc book and found the "controlled substances inventory" sheet hidden behind the "breakdown" sheet. I asked [Caregiver HH] to count the cards to see if the inventory sheet and narc cards matched, but on the inventory sheet it stated, as of 9-24-2023, that there were 12 cards but in the narc drawer there were only 11 cards counted for, meaning one of the cards was either missing or zeroed out and not signed out. I told [Caregiver HH] to call the | {N 158} | | |

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| {N 158} | Continued From page 13<br>[his/her] director [Administrator A] and let [him/her] know. And then I left the building."<br><br>On 09/27/2023 Caregiver S wrote the following: "At 6pm me and [Medication Passer D] went to do narc count on memory care so [s/he] could leave at the end of [his/her] shift. We started with the indiv. [individual] cards that tell us how many bubble packs/bags we should have. The sheet listed 12. I however only counted 11. I then went through each indiv. Mar [Medication Administration Record] to see if a narc was listed in there that was not in the cart. [Resident 10] had a PRN Lorazepam listed that was not in the cart. [Medication Passer D] said count was off for it at 6AM that morning. I contacted [Administrator A] right away to let him/her know count was off. [Administrator A] did come in to check the cart [him/herself] as well as the office and nurses station. [S/he] was also unable to locate anything. Awhile later [s/he] contacted me again with orders from Regional RN B to call and file a police report. At 840PM I called to have an officer sent to the facility. [S/he] came to take a report."<br><br>On 10/02/2023 at approximately 10:45 AM, Surveyor interviewed Administrator A regarding the missing medications. Administrator A stated on 09/27/2023 s/he received a call from Caregiver S that there was a discrepancy of the number of narcotic cards that were on the medication cart. Staff counted only 11 narcotic cards when the sheet indicated there should be 12 cards on the medication cart. Caregiver S had told Administrator A that s/he thought it was Resident 10's Lorazepam card that was missing. Administrator stated s/he came to the facility and looked but could not locate the missing card. Administrator A indicated police responded to the facility. Administrator C (of sister facility) came | {N 158} | | |

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| {N 158} | Continued From page 14<br>the next day and immediately found that the reason there was a discrepancy is because a staff member pulled an empty card from the cart and didn't write it down on the sheet. Administrator A and Administrator C stated the sheet is new for staff since the last time state was in the building so staff just forgot to mark it as empty and off the cart. Administrator C stated they spoke with Resident 10's hospice nurse and hospice didn't think the Lorazepam was ever filled and delivered to the facility. Surveyor requested documentation from the pharmacy regarding delivery of the Lorazepam tablets.<br><br>The pharmacy provided a document that indicated Resident 10's 30 pills of Lorazepam were delivered on 02/28/2023 at 8:00PM and signed by Assistant Director E.<br><br>On 10/02/2023 at 12:15 PM, Surveyor interviewed Administrator A, Regional RN B and Administrator C regarding the pharmacy documentation. All 3 verified the pharmacy did deliver the 30 pills of Lorazepam on 02/28/2023 and the facility could not account for the missing 30 pills. Administrator A verified the caregiver statements above did not address the 30 missing lorazepam pills and there was no further investigation into the missing lorazepam pills. Administrator C stated they had spoke with hospice nurse and figured it was ordered but never filled or delivered. Administrator C did not contact pharmacy to verify if it was delivered until Surveyors requested the documentation today.<br><br>Cross Reference N0348 DHS 83.32(3)(d) Rights of Residents: Free from Mistreatment | {N 158} | | |

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| N 161 | Continued From page 15 | N 161 | | |
| N 161 | 83.12(3)(a) Investigate injuries of unknown source.<br><br>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 the extent of the injury or the location of the injury on the resident.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the provider did not investigate injuries that were not observed by any person or the injury to a resident that appears suspicious because of the extent of the injury or the location of the injury on the resident for 2 of 2 (Resident 1 and 4) residents reviewed.<br><br>On 03/24/2023, Resident 1, who is not ambulatory, was found on his/her bedroom floor with the window open in 20 degree weather and the room in "shambles." Resident 1 was noted to be complaining of pain to shoulder and right leg. Staff noticed scrape and rugburn on Resident 1's right leg. The provider did not conduct an investigation into the injuries, how the window got open or how the room was in "shambles."<br><br>Between 06/24/2023 and 07/12/2023, Resident 4 was noted to have bruising on arms and legs. The provider did not conduct a thorough investigation into the bruises.<br><br>Findings Include:<br><br>Resident 1<br>Resident 1 was admitted to the facility on | N 161 | | |

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| N 161 | Continued From page 16<br><br>03/31/2018 with diagnoses to include the following: Alzheimer's Disease, anxiety, depression, glaucoma, osteoarthritis and spinal stenosis. Resident 1's most recent ISP (individualized service plan) dated 02/07/2023 indicated Resident 1 cannot make needs known, has an activated power of attorney (POA), needs total assistance with self care and uses a sit to stand lift and broda chair. The ISP states "Resident is to be transferred with a sit to stand with 2 staff."<br><br>Surveyor reviewed a facility incident report for Resident 1 dated 03/24/2023. The incident report stated, "During shift change AM staff walked into residents [sic] room. Residents [sic] room found in shambles window open and resident on the floor in bathroom partially in bedroom. Resident complained of specific right leg and shoulder pain. When moving resident complained if [sic] hurt and was very sore. Hospice was called and staff informed to call paramedics to lift off the floor. In meantime staff covered resident up with a blanket put pillow under [his/her] head and layed with [her/him] until help arrived. Resident kept saying "I wish the lord would just take me, please lord." Resident assisted paramedics in getting resident off the floor. Staff noticed scrape and rugburn on right leg. Director [Administrator A] informed. Staff shut residents window and cleaned up residents [sic] room. Hospice arrived at 7:51 for evaluation."<br><br>A facility progress note for Resident 1 dated 03/24/2023 AM (morning) stated, "Resident was found on the floor in [his/her] room upon shift change. Resident complained of right hip and shoulder pain. Hospice was called and informed of incident. Hospice advised staff to call paramedics to assist getting resident off the floor. | N 161 | | |

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| N 161 | Continued From page 17<br>Upon entering residents room staff noticed window was wide open and room was in shambles. Unsure of how long resident was on the floor. Staff waited for paramedics. Got resident to [his/her] bed. Hospice came to evaluate. Resident now laying in bed sleeping. Director notified as well as incident report filled out."<br><br>According to the website https://www.wunderground.com/history, the temperature outside the facility on 03/24/2023 was approximately 25 degrees at 6:00 AM.<br><br>On 10/02/2023 at 12:15 PM Surveyor interviewed Administrator A regarding the incident report. Administrator A verified Resident 1 is not ambulatory and would not be able to open his/her bedroom window. Administrator A stated s/he did not conduct an investigation into the incident, injuries, or how the window got open and how the room was left in "shambles."<br><br>Resident 4<br>Resident 4 was admitted to the facility on 03/20/2023 with diagnoses to include dementia, polymyalgia, rheumaticia and hyperlipidemia. Resident 4 resides on the memory care unit at the facility.<br><br>On 09/13/2023 at 2:00 PM, Surveyor interviewed Assistant Director E. Assistant Director E stated on 06/24/2023 Resident 4 had a shower and was noted to have bruising to arm and a cut on elbow after the shower. Assistant Director E reported this to Administrator A and also instructed staff to chart it. [Photo 6 and 7] Then on 06/26/2023, Assistant Director E received a screenshot from another staff member. The screenshot was of a conversation Medication Passer D was having | N 161 | | |

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| N 161 | Continued From page 18<br>with Administrator A on 06/26/2023. Medication Passer D stated, "[Resident 4] got a shower forcefully but [s/he] took it." Administrator A replied, "Wow so how many caregivers did it take to help?" [Photo 8] Assistant Director E was unsure if Administrator A did anything about that message. On 07/05/2023, Caregiver GG came to get Assistant Director E to show him/her a bruise that Resident 4 had on his/her right leg. [Photo 9] Assistant Director E told Caregiver GG to chart it and Assistant Director E sent a picture to Administrator A. Administrator A stated it was an older bruise. [Photo 10 and 11] Assistant Director E was unsure if any additional investigation was conducted into the bruises.<br><br>On 09/13/2023, Surveyor requested shower documentation, progress notes and the investigation into the bruises.<br><br>Surveyor reviewed the shower documentation. The following was noted:<br>06/24/2023 shower completed in AM, "no concerns but very aggressive during shower"<br>06/30/2023 shower completed "no concerns"<br>07/05/2023 shower completed in PM, "Resident has a big bruise on the right leg"<br>07/12/2023 shower completed in PM, "has bruises all over"<br><br>Surveyor was provided Caregiver H, Caregiver GG, Assistant Director E, Medication Passer D, Caregiver KK, Caregiver I, Caregiver SS and Caregiver TT statements related to the 06/24/2023 bruises. There was no other documentation provided such as a timeline of events or a conclusion as to what may have happened. The facility provided no investigations into the bruising noted on the 07/05/2023 and 07/12/2023 shower sheets. | N 161 | | |

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| N 161 | Continued From page 19<br><br>On 10/02/2023 at 12:15 PM, Surveyor interviewed Administrator A. Administrator A stated the only documentation into the bruises on 06/24/2023 were the caregiver statements, no further information was gathered and no action was taken by the facility. Regarding the 07/05/2023 and 07/12/2023 shower documentation, Administrator A stated s/he was unaware of the bruising noted on the shower sheets until now. Administrator A stated staff are trained on reporting unknown bruises to Administrator.<br><br>Cross Reference N0348 DHS 83.32(3)(d) Rights of Residents: Free from Mistreatment | N 161 | | |
| {N 196} | 83.14(2)(a) Licensee ensures facility complies with laws<br><br>The licensee shall ensure the CBRF and its operation comply with all laws governing the CBRF.<br><br>This Rule is not met as evidenced by:<br>Based on staff interviews, observations and record review, the licensee did not ensure the Community Based Residential Facility (CBRF) and its operation complied with all laws governing the CBRF.<br><br>This is a repeat deficiency. See Statements of Deficiency (SOD) 8DXE13, dated 12/19/2022.<br><br>The facility is licensed to serve up to 56 residents who may be advanced age, physically disabled, have irreversible dementia/Alzheimer's disease, and/or be terminally ill. | {N 196} | | |

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| {N 196} | Continued From page 20<br><br>Findings Include:<br><br>Prior to conducting the on-site facility visit, Surveyor reviewed the survey history and noted the following:<br><br>On 11/03/2022, 11/07/2022, and 11/09/2022, with information gathered through 12/19/2022, the Division of Quality Assurance conducted on-site investigations of 10 complaint investigations, 7 self-report reviews, and a verification visit at Care Partners Assisted Living Hortonville. As a result of the investigation, 7 of 10 complaints were substantiated. Two deficient practices were repeat deficiencies. One of the repeat deficient practices had been cited two times previously. As a result of the visit, 13 deficiencies were cited in SOD #8DXE13 dated 12/19/2022. The Statement of Deficiency and Notice and Order letter was sent to the provider via certified electronic mail on 05/15/2023. The licensee was ordered to comply with the requirements specified by Wis. Stat. ch. 50 and Wis. Admin. Code ch. DHS 83 and special orders as soon as practicable and without delay, within 45 days of receipt.<br><br>The notice of special orders included:<br><br>ORDER NOT TO ADMIT NEW OR ADDITIONAL RESIDENTS<br><br>Based on the results of the Department's investigation, and pursuant to Wis. Stat. § 50.03(5g)(b)7., EFFECTIVE UPON RECEIPT OF THIS NOTICE and ORDER, the Department of Health Services HEREBY ORDERS that Care Partners Assisted Living Hortonville NOT ADMIT ANY NEW OR ADDITIONAL RESIDENTS until all violations in Statement of Deficiency (SOD) | {N 196} | | |

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| {N 196} | Continued From page 21<br>8DXE13 are corrected, compliance is verified by the Department, and this Order is rescinded in writing.<br><br>SPECIAL ORDERS<br><br>Based on the results of the Department's investigation, and pursuant to Wis. Stat. § 50.03(5g)(b), EFFECTIVE UPON RECEIPT OF THIS NOTICE and ORDER, the Department of Health Services HEREBY ORDERS that Care Partners Assisted Living Hortonville:<br><br>1. Pursuant to Wis. Stat. § 50.03(5g)(b)6., EFFECTIVE IMMEDIATELY, the licensee shall ensure the provision of services to meet residents' physical and mental health needs. The licensee shall develop and implement corrective measures in consultation with a registered nurse (RN) not currently affiliated with the licensee. The RN will have knowledge of assisted living regulations (e.g., Wis. Admin. Code ch. 83, Wis. Stat. ch. 50) and knowledge of the client groups served by Care Partners Assisted Living Hortonville.<br><br>Consultation will include the development (or revision) of written procedures and staff training (as appropriate) to address:<br><br>Behavior Management<br>The procedure shall include, but is not limited to: (a) identifying specific behavior patterns that are or may be harmful to the resident or others (e.g., aggression, elopement, or other behavioral safety risks), (b) assessing and documenting contributing factors to the behaviors, (c) developing and implementing the Individualized Service Plan (ISP) with specific individualized interventions to reduce incidences of these | {N 196} | | |

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| {N 196} | Continued From page 22<br>behaviors, (d) staff response when the identified interventions are not effective, (e) monitoring the effectiveness of any behavioral intervention including the use of PRN psychotropic medications, and (f) notifying the resident's legal representative and physician when there is a significant change in a resident's mental condition.<br><br>Infection Control<br>-Including how the provider will implement an infection control program based on current standards of practice to prevent the development and transmission of communicable disease and infections. The infection control program will include, at a minimum, current guidance for the prevention, identification, and monitoring of respiratory infections, including COVID-19 and influenza, along with Transmission-Based Precautions to be used when caring for residents. Resources are available at: https://www.dhs.wisconsin.gov/covid-19/assisted-living.htm and https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html<br><br>Additionally:<br>- All managers and resident care staff (as appropriate) will receive in-service training regarding the facility's written procedures required by Order #1.<br>- Training will be documented in employee files and will include the date/duration of training, the signature/qualifications of the instructor, and an outline of course content.<br>- Consultation activities, including dates of consultation, will be documented, signed and dated by the consultant.<br>- A copy of the written procedures and all documentation as evidence of meeting the | {N 196} | | |

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requirements in Order #1 will be made available to department representatives upon request."

On 09/11/2023, Surveyors conducted an on-site verification visit for SOD #8DXE13:

RN Consultant
The Special Orders for the Department included the requirement for the provider to hire an outside RN consultant who will assist with the development of written procedures and staff training.

On 09/11/2023, at approximately 12:00 PM, as a part of the verification visit, Surveyors asked to review all documentation involving the RN consultant. Surveyors were given an undated letter from the consulting RN as a verification of his/her involvement. Surveyor reviewed the document and noted the RN consultant was present at the facility for a tour and discussion on 06/20/2023 and 06/21/2023. The letter reviewed an estimate of preliminary recommendations only. The RN did an assessment of what would be needed but was not hired on as a consultant to be involved in the development and training. The letter included a disclaimer as a second paragraph:

"* Please note that this assessment does not meet the regulatory requirement under SOD outlining RN consultant responsibility to the facility. Davis Clinical Consulting is happy to assist you as the assigned RN consultant to ensure your facility meets regulatory requirements."

On 10/02/2023, at approximately 11:00 AM, Surveyors interviewed Administrator A, Regional RN B and Administrator C (Administrator at a

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| {N 196} | Continued From page 24<br>sister facility.) Regional RN B verified s/he was aware the letter was a preliminary assessment and did not meet the special-order requirement. Regional RN B stated s/he believed the RN consultant was hired but the provider "never heard back" from the company. Regional RN B verified no further actions were taken to acquire a consulting RN after they did not hear back. Regional RN B stated they could not provide evidence of a signed contract to show they hired the RN Consultant after the initial estimate but stated s/he believed the services were paid for. Surveyors asked for e-mails and the invoice to verify the provider hired the consultant. Regional RN B stated s/he would "look into it." No further documentation was received.<br><br>On 10/05/2023, at approximately 11:00 AM, Surveyor conducted an interview with the RN consultant company. Consultant Representative PP confirmed the RN consultant provided an estimate only, with their recommendations for what the provider would need to come into compliance if they were hired to be the RN Consultant. Consultant Representative PP provided e-mails that corroborated his/her interview and noted the Consultant company reached out to Regional Director JJ to see if they would like to contract with the company for their consultation services after the initial estimate was completed. Consultant Representative PP stated Regional Director JJ did not respond.<br><br>Infection Control<br>On 09/13/2023, at approximately 4:30 PM, Surveyor interviewed Regional RN B and Administrator A. Surveyor reviewed the Statement of Deficiency (SOD) from the survey conducted on 12/19/2022. Surveyor asked if the facility's infection control policy had been reviewed or | {N 196} | | |

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| {N 196} | Continued From page 25 | {N 196} | | |

revised since the survey conducted on 12/19/2022 to address COVID-19 and current standards of practice. Regional RN B replied that there had not been changes to the policy. Regional RN B stated s/he was aware the policy was required to be updated and had submitted a draft to the corporate office on 07/19/2023, 22 days after the date of correction deadline on 06/28/2023. Regional RN B stated the draft had yet to be approved and the infection control program remained the same. Regional RN B stated the same policy is used for all of the corporation's facilities and, once corrected, will be implemented in all.

The ordered employee training and documentation of training of the providers policies and procedures for behavior management and infection control were not completed.

As a result of Licensee QQ not upholding his/her responsibilities as the licensee, 3 of 4 complaints investigated from 09/11/2023 through 10/10/2023 were substantiated and the following 20 deficiencies were identified, including 10 repeat violations:

N0158 DHS 83.12.(2)(a) Caregiver: Investigating Abuse & Neglect
Based on record review and interview, the provider did not immediately protect residents and thoroughly investigate and document an allegation of abuse and misappropriation of property for 2 of 2 (Resident 3 and 10) residents reviewed.

This is a repeat deficiency. See Statements of Deficiency (SOD) 8DXE13, dated 12/19/2022.

N0161 DHS 83.12(3) Investigate Injuries of

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| {N 196} | Continued From page 26<br><br>Unknown Source<br>Based on record review and interview, the provider did not investigate injuries that were not observed by any person or the injury to a resident that appears suspicious because of the extent of the injury or the location of the injury on the resident for 2 of 2 (Resident 1 and 4) residents reviewed.<br><br>N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies With Laws<br>Based on staff interviews, observations and record review, the licensee did not ensure the Community Based Residential Facility (CBRF) and its operation complied with all laws governing the CBRF.<br><br>This is a repeat deficiency. See Statements of Deficiency (SOD) 8DXE13, dated 12/19/2022.<br><br>N0207 DHS 83.15(1)(a)-(e) Administrator Qualifications<br>Based on record review and interview, the provider did not ensure Administrator A met the qualifications of a CBRF administrator.<br><br>This is a repeat deficiency. See Statements of Deficiency (SOD) 8DXE13, dated 12/19/2022.<br><br>N0346 DHS 83.32(3)(b) Rights Of Residents: Confidentiality<br>Based on observation and interview the provider did not ensure resident information was kept secured and confidential. Surveyor observed multiple sources of resident private health information left open, unattended, and unsecured from unauthorized access in the facility. The provider utilized a phone application (CREW app) between staff of multiple sister facilities that contained resident Protected Health Information | {N 196} | | |

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| {N 196} | Continued From page 27<br>(PHI), was not a secured internet application, and was accessed through staff personal phones when not in the facility.<br><br>This is a repeat deficiency. See Statements of Deficiency (SOD) 8DXE13, dated 12/19/2022.<br><br>N0348 DHS 83.32(3)(d) Rights Of Residents: Free From Mistreatment<br>Based on observation, record review and interview, the provider did not ensure 2 of 2 (Resident 3 and 10) residents reviewed were free from abuse, neglect and/or misappropriation of property.<br><br>N0352 DHS 83.32(3)(h) Rights Of Residents: Receive Medication<br>Based on record review and interview the provider did not ensure Resident 7 received medication as prescribed by his/her physician. Resident 7 was delayed in beginning his/her antibiotic treatment as the provider did not make reasonable efforts to obtain the medication and instead waited for the pharmacy to deliver the medication over 24 hours after the resident returned from the hospital. Additionally, Resident 7 did not receive 2 doses of a scheduled 10 day course of antibiotic which resulted in requiring a longer course of antibiotic treatment and increased risk of antibiotic resistance.<br><br>This is a repeat deficiency. See Statements of Deficiency (SOD) KDDT11, dated 12/13/2018.<br><br>N0353 DHS 83.32(3)(i) Rights Of Residents: Adequate Treatment<br>Based on Record review and interview the provider did not ensure 2/2 residents (Resident 7 and 8) received treatment that was prompt and adequate to meet their needs. Resident 8's family | {N 196} | | |

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| {N 196} | Continued From page 28<br>reported a change in condition to the provider regarding a known medical issue and Resident 8 was not seen by a medical professional or treated for 4 days. Resident 7 had symptoms of an infection and was not seen by a medical professional for 7 days and was further delayed greater than 24 hours in receiving the ordered antibiotic treatment.<br><br>This is a repeat deficiency. See Statements of Deficiency (SOD) 8DXE12, dated 02/02/2022.<br><br>N0358 DHS 83.32(3)(n) Rights Of Residents: Safe Environment<br>Based on observation, interview and record review, the provider did not ensure a safe environment for 2 of 2 (Resident 1 and 11) residents reviewed.<br><br>N0362 DHS 83.33(1)(d) Grievance Procedure: Written Summary<br>Based on interviews and record review, the provider did not provide a written summary of all grievances with the findings, conclusions, and any action taken to residents in response to grievances for at least 4 residents (Residents 1, 3, 8, and 12).<br><br>This is a repeat deficiency. See Statements of Deficiency (SOD) 8DXE13, dated 12/19/2022.<br><br>N0388 DHS 83.35(3)(c) Implement, Follow The Individual Service Plan<br>Based on record review and interview, the provider did not ensure the ISP (individual service plan) was implemented and followed for 2 of 2 (Resident 1 and 2) residents reviewed.<br><br>N0389 DHS 83.35(3)(d) Service Plans Updated Annually Or On Change | {N 196} | | |

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| {N 196} | Continued From page 29<br><br>Based on record review and interview, the provider did not review and revise the individual service plan (ISP) when there was a change in resident's needs, abilities or physical or mental condition for 1 of 1 (Resident 2). Additionally, the provider did not ensure the resident or the resident's legal representative signed the ISP, acknowledging their involvement in, understanding of and agreement with the ISP for 2 of 2 (Resident 1 and 2) residents reviewed.<br><br>N0396 DHS 83.36(1)(a) Adequate Staff To Meet Resident Needs<br>Based on observation, interview, and record review, the provider did not ensure an adequate amount of staff were present to meet the residents' needs. The staff and residents report long wait times, cares being delayed, and lack of supervision for memory care residents.<br><br>This requirement is being cited for a third time. See Statements of Deficiency (SOD) KDDT11, dated 12/13/2018, SOD 8DXE12, dated 02/02/2022, and SOD 8DXE13 dated 12/19/2022.<br><br>N0409 DHS 83.37(1)(j) Proof-Of-Use Record<br>Based on record review and interview, the provider did not ensure schedule II drugs were audited, signed out, and dated for proof-of-use on a daily basis for 3 of 3 medication carts.<br><br>N0415 DHS 83.37(2)(d) Documentation Of Medication Administration<br>Based on observation, interview and record review, the provider did not ensure staff administering the medication or treatment documented in the resident record the name, dosage, date and time of the medication taken or treatment received and initialed the medication | {N 196} | | |

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| {N 196} | Continued From page 30<br>administration record (MAR).<br><br>N0423 DHS 83.27(3)(g) Medication Storage: Controlled Substances<br>Based on interview and record review, the provider did not provide separately locked and securely fastened boxes or drawers or permanently fixed compartments within the locked medications area for storage of schedule II drugs.<br><br>N0432 DHS 83.38)(1)(h) Medication Administration<br>Based on observation, interview and record review, the provider did not provide medication administration appropriate to the resident's needs for 1 of 1 (Resident 1) residents reviewed.<br><br>N0439 DHS 83.39(1) Infection Control Program<br>Based on interview, record review and observations, the provider did not establish and follow an infection control program based on current standards of practice to prevent the development and transmission of COVID-19.<br><br>The provider did not revise an existing infection control policy or develop a new policy related to COVID-19. The provider required staff who were COVID-19 positive to work without a waiver and with residents who were COVID-19 negative and medically vulnerable.<br><br>This requirement is being cited for a second time. See Statements of Deficiency (SOD) 8DXE12, dated 02/02/2022 and SOD 8DXE13, dated 12/19/2022.<br><br>N0441 DHS 83.39(3) Hand Washing<br>Based on observation, staff interviews and record review, the provider did not follow and maintain | {N 196} | | |

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| {N 196} | Continued From page 31<br>hand washing procedures according to CDC (Centers for Disease Control and Prevention) standards to help prevent the development and transmission of disease and infection for 5 of 5 (Resident 1, 4, 5, 6 and 7) residents reviewed.<br><br>This requirement is being cited for a third time. See Statements of Deficiency (SOD) 8DXE12, dated 02/02/2022 and SOD 8DXE13, dated 12/19/2022.<br><br>N0489 DHS 83.44(2)(a) Rooms Clean And Free From Odors<br>Based on observation, record review and interview, the provider did not make reasonable attempts to keep all rooms free from odors for 4 of 4 residents (Residents 4, 7, 8, and 9) reviewed.<br><br>These actions affected 38 residents.<br><br>Based on information obtained during the visit, observations and interviews, the licensee did not ensure its operations complied with all laws governing the CBRF and that previous deficiencies were completed within 45 days.<br><br>Cross Reference<br>N0158 DHS 83.12.(2)(a) Caregiver: Investigating Abuse & Neglect<br>N0161 DHS 83.12(3)(a) Investigate Injuries of Unknown Source<br>N0207 DHS 83.15(1)(a)-(e) Administrator Qualifications<br>N0346 DHS 83.32(3)(b) Rights Of Residents: Confidentiality<br>N0348 DHS 83.32(3)(d) Rights Of Residents: Free From Mistreatment<br>N0352 DHS 83.32(3)(h) Rights Of Residents: Receive Medication<br>N0353 DHS 83.32(3)(i) Rights Of Residents: | {N 196} | | |

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| {N 196} | Continued From page 32<br>Adequate Treatment<br>N0358 DHS 83.32(3)(n) Rights Of Residents: Safe Environment<br>N0362 DHS 83.33(1)(d) Grievance Procedure: Written Summary<br>N0388 DHS 83.35(3)(c) Implement, Follow The Individual Service plan<br>N0389 DHS 83.35(3)(d) Service Plans Updated Annually Or On Change<br>N0396 DHS 83.36(1)(a) Adequate Staff To Meet Resident Needs<br>N0409 DHS 83.37(1)(j) Proof-Of-Use Record<br>N0415 DHS 83.37(2)(d) Documentation of Medication Administration<br>N0423 DHS 83.27(3)(g) Medication Storage: Controlled Substances<br>N0432 DHS 83.38)(1)(h) Medication Administration<br>N0439 DHS 83.39(1) Infection Control Program<br>N0441 DHS 83.39(3) Hand Washing<br>N0489 DHS 83.44(2)(a) Rooms Clean And Free From Odors | {N 196} | | |
| {N 207} | 83.15(1)(a)-(e) Administrator Qualifications<br><br>The administrator of a CBRF shall be at least 21 years of age and exhibit the capacity to respond to the needs of the residents and manage the complexity of the CBRF. The administrator shall have any one of the following qualifications:<br>(a) An associate degree or higher from an accredited college in a health care related field.<br>(b) A bachelor's degree in a field other than in health care from an accredited college and one year experience working in a health care related field having direct contact with one or more of the client groups identified under s. HFS 83.02(16).<br>(c) A bachelor ' s degree in a field other than in | {N 207} | | |

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| {N 207} | Continued From page 33<br>health care from an accredited college and have successfully completed an assisted living administrator ' s training course approved by the department or the department's designee.<br>(d) At least 2 years experience working in a health care related field having direct contact with one or more of the client groups identified under s. HFS 83.02(16) and have successfully completed an assisted living administrator ' s training course approved by the department or the department's designee.<br>(e) A valid nursing home administrator ' s license issued by the department of regulation and licensing.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the provider did not ensure Administrator A met the qualifications of a CBRF administrator.<br><br>This is a repeat deficiency. See Statements of Deficiency (SOD) 8DXE13, dated 12/19/2022.<br><br>Findings Include:<br><br>The facility is licensed to serve up to 56 residents who may be advanced age, physically disabled, have irreversible dementia/Alzheimer's disease, and/or be terminally ill.<br><br>On 09/11/2023, Surveyor conducted a verification visit and interviewed Administrator A at approximately 11:00 AM. Administrator A confirmed s/he did not have an associate degree in healthcare related field, a bachelor's degree and experience, or 2 years experience and the completion of an administrator course. Administrator A stated while s/he remained the | {N 207} | | |

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| {N 207} | Continued From page 34 | {N 207} | | |

administrator since the last survey (On 12/19/2022 when it was identified a 2nd time s/he was not qualified to be an administrator,) s/he had still yet to take the required administrator course or any other means to meet the qualification. At approximately 12:30 PM, Surveyor interviewed Regional RN B and Administrator C (an administrator at a sister facility.) The circumstances related to Administrator A's lack of qualification addressed in SOD 8DXE13 were reviewed:

During a previous survey, concluded on 02/02/2022, Regional RN B held the title of Administrator for the facility while the Activity Director (Administrator A) began training for the position. At the time of the survey, Regional RN B stated Administrator A would be competing the administrator's training course within the month and would then reach out to the department to transfer the title of the position to him/her. Regional RN B stated until the course was complete s/he was providing oversight and was the acting Administrator.

On 11/03/2022, Surveyor reviewed the department's records and discovered Administrator A was now listed as the facility Administrator.

The department record showed on 02/03/2022 (the day after the February 2022 survey), correspondence was received from the provider via email regarding the title and acting position of Administrator, which is termed "Directorship" by the provider and saved in the department record:

"February 3, 2022
ATTENTION: ... Assisted Living Regional Director

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| CARE PARTNERS ASSISTED LIVING HORTONVILLE | 112 HARRIS WAY HORTONVILLE, WI 54944 |

| (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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| {N 207} | Continued From page 35<br>Dear ...,<br>This is to update you that [Administrator A] has accepted the promotion to the Directorship position at Care Partners Assisted Living, LLC, 112 Harris Way, Hortonville, WI 54944, effective January 1, 2022 ...<br>Until [Administrator A] completes the CBRF Administrator Course, [Regional RN B], who is the<br>Regional Nurse assigned to our Care Partners facility in H01tonville [sic], will continue to serve as Director of Record [sic]there ... [Licensee AA]"<br><br>"06/01/2022<br>ATTENTION: ... Assisted Living Regional Director<br>Dear ...,<br>This is to correct our announcement letter to you of February 3, 2022 regarding [Administrator A] who accepted the promotion to the Directorship position at Care Partners Assisted Living, LLC, 112 Harris Way, Hortonville, WI 54944, effective January 1, 2022 ... thank you for updating your records with the correct information ... [Licensee AA]"<br><br>On 11/03/2022, Surveyor interviewed Administrator A at 1:10 PM. Administrator A addressed him/herself at the "Director" of the facility. Administrator A stated s/he had not yet completed the administrator course and was unsure when s/he would. Administrator A stated Regional RN B and other administrators were available if s/he had a question, but they were not present at the facility. After review of the responsibilities for the role of Administrator in DHS 83, Administrator A confirmed his/her job responsibilities aligned with the code requirements for the position and that s/he was currently functioning alone as the Administrator with occasional guidance from Regional RN B. | {N 207} | | |

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| {N 207} | Continued From page 36<br><br>Administrator A was aware the administration course was needed but was unaware it was a requirement prior to assuming the position if the title transfer was requested and the previous administrator was no longer present and acting in the role.<br><br>On 11/07/2022, at 9:20 AM, Surveyors interviewed Administrator A, Regional RN B, and Regional Director JJ. Regional RN B confirmed Administrator A had not yet taken the required administrator course. Regional Director JJ stated his/her belief that Regional Director B still was the legal administrator for the facility. Surveyors presented the form showing Administrator A listed as the Administrator after Licensee QQ contacted the Department with an update to the announcement letter "... regarding [Administrator A] who accepted the promotion to the Directorship position ... effective January 1, 2022." Surveyors reviewed Chapter 83: "Licensee shall notify the department within 7 days after there is a change in the administrator." Licensee QQ notified the Department greater than 1 month after Administrator A accepted the role, but before Administrator A was qualified for the role without a Department waiver to allow for the provision of Regional RN B supervising Administrator A until the requirements were completed.<br><br>On 11/07/2022, at approximately 11:30 AM, Regional Director JJ stated s/he would be signing Administrator A up for the required course in February 2023.<br><br>On 09/11/2023, Surveyor interviewed Regional RN B at approximately 4:30 PM with Administrator A and Administrator C present. After review of the regulations, the administrators acknowledged the requirement for the course to | {N 207} | | |

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| {N 207} | Continued From page 37<br>be completed prior to assuming the role and notifying the department. Regional RN B stated the reason Administrator A had not yet completed the administrator's course was because the courses through a particular training company were canceled for 2023.<br><br>Surveyor Note: The company offered courses in 2022 and there are other companies and other locations that offered the administrators course in 2023. The requirement for the course to be completed prior to assuming the role of administrator was identified and addressed with the provider during the survey completed on 02/02/2022. The provider did not ensure Administrator A was qualified prior to assuming the role of administrator and was subsequently cited in the following survey SOD 8DXE13, dated 12/19/2022. The survey addressed Administrator A could not remain in the role of administrator until the requirements were completed. The provider was aware of Administrator A was unqualified x 2 surveys and continued to allow Administrator A to be the facility Administrator.<br><br>After review of the previous citation and code requirements, Regional RN B could not state why Administrator A was allowed to maintain the position s/he was determined to be unqualified for.<br><br>On 09/13/2023, at approximately 12:00 PM, Surveyors interviewed Regional RN B and Administrator C. The administrators acknowledged Administrator A had not completed the training requirements prior to assuming the role of administrator and had been allowed to continue as the facility administrator after 2 surveys, including 1 citation, identified it as a code violation. | {N 207} | | |

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| {N 207} | Continued From page 38<br><br>On 09/13/2023, at approximately 6:00 PM, Surveyors interviewed Regional RN B and Administrator C during the exit interview. After a review of the survey findings the administrators stated they would "get to work" with Administrator A to ensure follow through for the various identified areas of concern. Regional RN B and Administrator C had no plans to remove Administrator A as the administrator. The provider was actively planning on continuing to allow Administrator A to function as the administrator after it was identified as a code violation for the 3rd time in a survey.<br><br>On 10/02/2023, Surveyors returned on-site and observed Administrator A still held the position of Administrator while continuing to not meeting the requirements to qualify as an administrator.<br><br>On 10/02/2023, at approximately 12:00 PM Surveyors interviewed Regional RN B and Administrator C. Regional RN B stated Administrator A had yet to sign up for the administrator course and did not have a plan in place to ensure a qualified Administrator would assume the role in the interim until the course was completed.<br><br>The provider was aware Administrator A was not qualified for the role and continued to have him/her function in the role without Department approval. | {N 207} | | |
| {N 346} | 83.32(3)(b) Rights of Residents: Confidentiality<br><br>In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Confidentiality. Confidentiality of health and | {N 346} | | |

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| {N 346} | Continued From page 39<br>personal information and records, and the right to approve or refuse release of that information to any individual outside the CBRF, except when the resident is transferred to another facility or as required by law or third-party payment contracts and except as provided in s.146.82(2) and (3), Stats. The CBRF shall make the record available to the resident or the resident ' s legal representative for review. Copies of the record shall be made available within 30 days, if requested in writing, at a cost no greater than the cost of reproduction.<br><br>This Rule is not met as evidenced by:<br>Based on observation and interview the provider did not ensure resident information was kept secured and confidential. Surveyor observed multiple sources of resident private health information left open, unattended, and unsecured from unauthorized access in the facility. The provider utilized a phone application (CREW app) between staff of multiple sister facilities that contained resident Protected Health Information (PHI), was not verified to be a HIPAA secured internet application, was accessed through staff personal phones when not in the facility, and did not apply the Minimum Necessary HIPAA standard.<br><br>This is a repeat deficiency. See Statements of Deficiency (SOD) 8DXE13 dated 12/19/2022.<br><br>Findings Include:<br><br>On 07/18/2023, the Department received a complaint alleging the provider was not ensuring resident' private health information was protected | {N 346} | | |

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| {N 346} | Continued From page 40<br>against unauthorized access.<br><br>https://www.hipaajournal.com/considered-phi-hipaa/#:~:text=PHI%20includes%20individually%20identifiable%20health,or%20payment%20for%20the%20treatment. (retrieval date 01/03/2024)<br><br>What is Considered PHI under HIPAA? 2024 Update<br><br>"... Under HIPAA PHI is considered to be an individual's health, treatment, and payment information, and any further information maintained in the same designated record set that could identify the individual or be used with other information in the record set to identify the individual.<br><br>... protected health information means individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium.<br><br>...health information is any information relating a patient´s condition, the past, present, or future provision of healthcare, or payment thereof. It becomes individually identifiable health information when identifiers are included in the same designated record set, and it becomes protected when it is transmitted or maintained in any form (by a covered entity)<br><br>...All formats of PHI records are covered by HIPAA. These include (but are not limited to) spoken PHI, PHI written on paper, electronic PHI, and physical or digital images that could identify the subject of health information. It is important to remember that PHI records are only covered by | {N 346} | | |

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| {N 346} | Continued From page 41<br>HIPAA when they are in the possession of a covered entity or business associate.<br><br>...The different between PHI and ePHI is that ePHI refers to Protected Health Information that is created, used, shared, or stored electronically - for example on an Electronic Health Record, in the content of an email, or in a cloud database. Both PHI and ePHI are subject to the same protections under the HIPAA Privacy Rule, while the HIPAA Security Rule mostly relates to ePHI.<br><br>...The Privacy Rule applies to both paper and electronic health information despite the language used in the original Health Insurance Portability and Accountability Act leading to a misconception that HIPAA only applies to electronic health records. While the protection of electronic health records was addressed in the HIPAA Security Rule, the Privacy Rule applies to all types of health information regardless of whether it is stored on paper or electronically, or communicated orally.<br><br>... PII stands for Personally Identifiable Information, which can be PHI (Protected Health Information) if it is stored in the same designated record set as PHI. This is because, in order to protect the health and payment information that qualifies as PHI, any information that could be used to identify the subject of the health and payment information (for example, PII) also has to be protected while it remains in the same designated record set."<br><br>https://www.cdc.gov/mmwr/pdf/other/m2e411.pdf (retrieval date 01/03/2024)<br><br>" ...Individually identifiable health information. A subset of health information, including | {N 346} | | |

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| {N 346} | Continued From page 42<br><br>demographic information collected from an individual, and 1) is created or received by a health-care provider, health plan, employer, or health-care clearinghouse; and, 2) relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual; and, that identifies the individual or where there is a reasonable basis to believe the information can be used to identify the individual [45 CFR § 164.501]<br><br>...Limited data set. Protected health information that excludes certain direct identifiers of the individual or of relatives, employers, or household members of the individual. Direct identifiers to be excluded can be found in 45 CFR § 164.514(e)(2).<br><br>...Minimum necessary. For any type of disclosure that a covered entity makes on a routine and recurring basis, that the covered entity must implement policies and procedures (which may be standard protocols) that limit the protected health information disclosed to the amount reasonably necessary to achieve the purpose of the disclosure. For all other disclosures, covered entities must develop and implement criteria designed to limit the protected health information disclosed to the information reasonably necessary to accomplish the purpose for which disclosure is sought and review requests for disclosure on an individual basis in accordance with such criteria ...<br><br>...Protected health information (PHI). Individually identifiable health information that is transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other | {N 346} | | |

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| {N 346} | Continued From page 43<br>form or medium. PHI excludes individually identifiable health information in: (i) education records covered by the Family Education Rights and Privacy Act (20 U.S.C. 1232g); (ii) records described at 20 U.S.C. 1232g(a)(4)(B)(iv); and (iii) employment records held by a covered entity in its role as employer [45 CFR § 160.103]."<br><br>Observations of PHI<br>On 09/13/2023, Surveyors toured the facility and observed areas where resident information was left unsecured, not within caregiver's visual control for time that allowed for any passersby to review the private information without staff's knowledge:<br><br>10:23 AM- The Memory Care Unit (MC) binder containing 9/9 resident from the MC's private health information was observed sitting out on a side table in the common room for greater than 5 minutes.<br><br>10:28 AM- The MC medication room was left open for greater than 5 minutes. The room contained resident private health information and records. (Photos 12, 13, 14, and 15.)<br><br>On 09/13/2022, at approximately 4:00 PM, Surveyors interviewed Administrator A, Regional RN B, and Administrator C (an administrator from a sister facility.) Surveyors discussed the observations of resident private health information being left unattended, unsecured, and open to passersby. Administrator A, Regional RN B, and Administrator C acknowledged the resident private health information was not being kept secured against unauthorized access at all times.<br><br>CREW Phone APP | {N 346} | | |

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| {N 346} | Continued From page 44<br><br>On 09/13/2023, at 10:36 AM, Surveyors interviewed Caregiver H. Caregiver H stated, "We were all still using the CREW app until last Friday." Caregiver H stated Administrator A used the app to communicate with staff and noted the app was not only used for staff issues/ scheduling. Caregiver H stated resident information was still sent through the app and Administrator A would delete the texts with information about residents when they came through. Caregiver H stated the CREW app was the main way caregiver had been communicating up until the previous Friday (09/08/2023.)<br><br>On 09/13/2023, at 2:00 PM, Surveyors interviewed Assistant Director E. Assistant Director E stated the staff were expected to use the CREW app for communication up until the app was discontinued on 09/08/2023. Assistant Director E stated although the purpose was supposed to be for staff communication only, the staff continued to use it to communicate resident information. Assistant Director E stated the provider was aware from the last survey (SOD 8DXE13, dated 12/19/2022) the app was not Health Insurance Portability and Accountability Act (HIPAA) secured but chose to continue to use the app. Assistant Director E stated the provider supported Administrator A continuing to utilize the App and stated s/he was told the continued use of the app is up to Administrator A's discretion. Assistant Director E stated Administrator A would modify the record by deleting messages with resident information within the app so it would not be reviewed by the Surveyors during an audit.<br><br>At approximately 4:00 PM, Surveyors interviewed Administrator A with Regional RN B and Administrator C present. Administrator A confirmed all caregivers had the CREW App on | {N 346} | | |

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| {N 346} | Continued From page 45<br>their personal phones and could access the app while outside of the facility up until the app was discontinued in use on 09/08/2023. None of the administrators could state if the CREW App was HIPAA compliant and/or protected resident information. After a review of the previous survey findings (SOD 8DXE13, dated 12/19/2022) Regional RN B and Administrator A stated they had not found out if the app was HIPAA compliant or secured as they previously stated they would do. Administrator A stated the facility began using the CREW App in the beginning of September 2022. Administrator A stated the intention was for only general information for staff updates such as scheduling, and facility/ provider wide updates to be shared on the CREW App. Administrator A stated s/he would remind staff to only use the app for scheduling and acknowledged the staff continued to send resident private information on the app after the last survey. Administrator A stated s/he would delete messages with resident information. Administrator A stated s/he was aware deleting the messages did not ensure they were deleted within the app history and could not confirm if the app company stored, shared, sold, etc. the information within. Administrator A stated the information shared on the CREW App was visible to all caregiving staff, including staff who worked at other campuses. Administrator A stated caregivers at other locations, who did not work with the residents being discussed on the app, would also receive the resident PHI when caregivers sent it, verifying a breach in HIPAA Minimum Necessary standards. Neither Administrator A nor Regional RN B could state why they continued to use the app when they did not know if it was HIPAA compliant, did not find out if it was HIPAA compliant, was identified in the last survey as being used in a way that violated resident's rights, and was a great risk to the | {N 346} | | |

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| {N 346} | Continued From page 46<br>resident's privacy and safety. Regional RN B reiterated it was the administrator's choice to continue to use the app.<br><br>The provider was aware the PHI was being distributed without limitations for Confidential Information, Individually Identifiable Health Information, Limited Data Set, Minimum Necessary, Personally Identifiable Information (PII), or Protected Health Information (PHI.) The provider was cited for the violation of resident's rights in the previous survey SOD 8DXE13 dated 12/19/2022. The provider did not follow up to verify if the app was HIPAA compliant and information protected and chose to continue to use the app. The provider was aware the staff continued to use the app for sharing resident private information and chose to modify the record by deleting the messages so they could not be reviewed while knowing the messages containing information may still be present and unsecured within the app company's data. | {N 346} | | |
| N 348 | 83.32(3)(d) Rights of Residents: Free from mistreatment<br><br>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.<br><br>This Rule is not met as evidenced by:<br>Based on observation, record review and | N 348 | | |

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| CARE PARTNERS ASSISTED LIVING HORTONVILLE | 112 HARRIS WAY HORTONVILLE, WI 54944 |

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| N 348 | Continued From page 47<br>interview, the provider did not ensure 2 of 2 (Resident 3 and 10) residents reviewed were free from abuse, neglect and/or misappropriation of property.<br><br>Resident 3 had 4 oxycodone tablets unaccounted for.<br><br>Resident 10 had 30 pills of Lorazepam delivered on 02/28/2023. On 09/27/2023, Caregiver S discovered the 30 pills were missing.<br><br>Findings Include:<br><br>On 03/28/2023, the Department received a complaint regarding an allegation of abuse/neglect that had occurred at the facility.<br><br>A facility policy titled, "ABUSE/MISCONDUCT" dated 12/12/12 states, "...Care Partners/Country Terrace believes that all people deserve dignified, loving care with services provided to maximize their potential for living and independence. Our plan shall assure protection of each resident from possible abuse; initial education and on-going education for all staff members on the plan; procedures to ensure appropriate implementation and continuation of this plan; systems for reporting abuse and annual evaluation of the plan.<br>DEFINITIONS...<br>"Misappropriation of property" means any of the following: A. The intentional taking, carrying away, using, transferring, concealing or retaining possession of a resident's movable property without the resident's consent and with the intent to deprive the resident of possession of the property...<br><br>Resident 3 | N 348 | | |

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| N 348 | Continued From page 48<br><br>On 07/10/2023, the department received a MIR(Misconduct Incident Report) regarding an allegation of caregiver misappropriation related to 30 missing oxycodone tablets for Resident 3. In addition, the department received a facility self report dated 07/28/2023 regarding Resident 3 missing an additional 8 oxycodone tablets.<br><br>On 09/11/2023 and 09/13/2023, Surveyors conducted an onsite visit to the facility. Surveyor requested all documentation related to the investigations.<br><br>On 09/13/2023, Surveyor reviewed Resident 3's "Proof of Use Sheet" for Oxycodone 5 mg (milligram) tablet to be administered as needed. The sheet indicates Resident 3 had a total of 15 tablets delivered on 05/16/2023. Resident 3 was administered 1 tablet on the following days:<br>05/22/2023 leaving 14 remaining<br>06/01/2023 leaving 13 remaining<br>06/02/2023 leaving 12 remaining<br>A line that is scribbled out, date is not legible, however, the amount given was "1" by Caregiver H with initials of Administrator A next to name, leaving 11 remaining<br>A line that is scribbled out, date is not legible, however, the amount given was "1" by Assistant Director E with initials of Administrator A next to name, leaving 10 remaining<br>06/15/2023 leaving 8 remaining<br>The sheet does not explain the count discrepancy between 06/02/2023 and 06/15/2023, nor the reason for the scribbled out lines.<br><br>On 09/13/2023 at 2:00 PM, Surveyor interviewed Assistant Director E. Surveyor showed Assistant Director E the above mentioned proof-of-use sheet. Assistant Director E stated Administrator A signed Assistant Director E's name on the proof | N 348 | | |

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| N 348 | Continued From page 49<br>of use sheet. Assistant Director E stated s/he did not pass oxycodone to Resident 3 and did not sign the proof of use sheet and directed Administrator A to cross out Assistant Director E's name. Assistant Director E did not know what happened to the 4 missing pills.<br><br>On 09/13/2023 at 2:30 PM Surveyor interviewed Administrator A. Surveyor discussed proof of use sheet with Administrator A. Administrator A acknowledged the discrepancy on the proof of use sheet. Administrator A verified s/he scribbled out the 2 lines on the proof-of-use sheet. Administrator A was unable to explain or provide documentation of an investigation into the additional 4 missing oxycodone tablets.<br><br>On 09/13/2023 at 3:30 PM, Surveyor interviewed Regional RN B regarding the misappropriation allegation and the additional discrepancy found on the proof of use sheet. Regional RN B was unable to explain or provide documentation of an investigation into the 4 missing oxycodone tablets.<br><br>Resident 10<br>On 09/28/2023, the department received information that the facility had contacted law enforcement due to another case of missing medications.<br><br>On 10/02/2023, Surveyors conducted an onsite visit to the facility. Surveyors interviewed Administrator A regarding the missing medications. Administrator A stated on 09/27/2023 s/he was made aware of a discrepancy of the number of narcotic cards that were on the medication cart. Staff counted only 11 narcotic cards when the sheet indicated there should be 12 cards on the medication cart. | N 348 | | |

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| N 348 | Continued From page 50<br><br>Caregiver S had told Administrator A that s/he thought it was Resident 10's Lorazepam card that was missing. Administrator stated s/he came to the facility and looked but could not locate the missing card. Administrator C (of sister facility) came the next day and immediately found that the reason there was a discrepancy is because a staff member pulled an empty card from the cart and didn't write it down on the sheet. Administrator A and Administrator C stated the sheet is new for staff since the last time state was in the building so staff just forgot to mark it as empty and off the sheet. Administrator C stated they spoke with Resident 10's hospice nurse and hospice didn't think the Lorazepam was ever filled and delivered to the facility. Surveyor requested documentation from the pharmacy regarding delivery of the Lorazepam tablets.<br><br>The pharmacy provided a document that indicated Resident 10's 30 pills of Lorazepam were delivered on 02/28/2023 at 8:00 PM and signed by Assistant Director E.<br><br>On 10/02/2023 at 12:15 PM, Surveyor interviewed Administrator A, Regional RN B and Administrator C regarding the pharmacy documentation. All 3 verified the pharmacy did deliver the 30 pills of Lorazepam on 02/28/2023 and the facility could not account for the missing 30 pills.<br><br>Cross Reference N0158 DHS 83.12(2)(a) Caregiver: Investigating Abuse & Neglect<br>Cross Reference N0161 DHS 83.12(3)(a) Investigate Injuries of Unknown Source | N 348 | | |
| N 352 | 83.32(3)(h) Rights of Residents: Receive medication | N 352 | | |

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| N 352 | Continued From page 51<br><br>In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Receive medication. Receive all prescribed medications in the dosage and at intervals prescribed by a practitioner. The resident has the right to refuse medication unless the medication is court ordered.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview the provider did not ensure Resident 7 received medication as prescribed by his/her physician. Resident 7 was delayed in beginning his/her antibiotic treatment as the provider did not make reasonable efforts to obtain the medication that was ready at a pharmacy for pickup and instead waited for the pharmacy to deliver the medication over 24 hours after the resident returned from the hospital. Additionally, Resident 7 did not receive 2 doses of a scheduled 10-day course of antibiotic which resulted in requiring a longer course of antibiotic treatment and increased risk of antibiotic resistance.<br><br>This is a repeat deficiency. See Statements of Deficiency (SOD) KDDT11, dated 12/13/2018.<br><br>Findings include:<br><br>Combating Antibiotic Resistance \| FDA www.fda.gov/consumers/consumer-updates/combating-antibiotic-resistance (Retrieval date, 10/05/2023)<br><br>"Antibiotics are drugs used for treating infections caused by bacteria ... Misuse and overuse of these drugs, however, have contributed to a phenomenon known as antibiotic resistance. This resistance develops when potentially harmful | N 352 | | |

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| N 352 | Continued From page 52 | N 352 | | |

bacteria change in a way that reduces or eliminates the effectiveness of antibiotics ... Antibiotic resistance is a growing public health concern worldwide. When a person is infected with an antibiotic-resistant bacterium, not only is treatment of that patient more difficult, but the antibiotic-resistant bacterium may spread to other people.
When antibiotics don't work, the result can be
" longer illnesses
" more complicated illnesses
" more doctor visits
" the use of stronger and more expensive drugs
" more deaths caused by bacterial infections
Examples of the types of bacteria that have become resistant to antibiotics include ... urinary tract infections ...
When you are prescribed an antibiotic to treat a bacterial infection, it's important to take the medication exactly as directed ... even if you are feeling better. If treatment stops too soon, and you become sick again, the remaining bacteria may become resistant to the antibiotic that you've taken ... Do not skip doses. Antibiotics are most effective when they are taken as prescribed ..."

On 07/18/2023, the Department received a complaint regarding medication.

On 09/13/2023, Surveyor reviewed Resident 7's record and noted Resident 7 was admitted on 08/12/2022 with diagnoses including Dementia, chronic non healing surgical wound, diabetes, and hypertension, and insomnia.
Surveyor reviewed observation notes spanning 08/29/2023 through 09/05/2023 when Resident 7 began to have symptoms of a urinary tract infection (UTI) through his/her hospital visit for the infection on 09/04/2023 and return to the facility

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| N 352 | Continued From page 53<br>on 09/04/2023 at approximately 6:00 PM. Surveyor reviewed Resident 7's hospital discharge instructions from 09/04/2023 that noted Resident 7 was prescribed "Cephalexin 500 mg 4 times daily for the next 10 days." The discharge instructions noted the medication was ready for pick up on 09/04/2023 at a pharmacy within 20 miles of the facility. Surveyor reviewed Resident 7's September 2023 Medication Administration Record (MAR) and noted the antibiotic was not started until 09/05/2023 at 8 PM, 26 hours after Resident 7 arrived back from the hospital on 09/04/2023 at approximately 6:00 PM. The subsequent doses were not given until 09/06/2023. The medication totaled 40 pills to be given over 10 days 09/05/2023 through 09/15/2023. The record indicated medication was not given for the 12 PM dose on 09/09/2023 which caused the 12:00 PM dose medication to be given last on 09/16/2023. The last 4:00 PM dose was not given on 09/15/2023 causing the last dose to be given on 09/16/2023. A total of 5/40 doses were not given as prescribed.<br><br>On 10/02/2023, at approximately 12:00 PM, Surveyor interviewed Administrator A and Regional RN B who each verified Resident 7 did not begin the antibiotic treatment until 26 hours after discharge from the hospital. Administrator A and Regional RN B stated it is their expectation the staff would review the discharge paperwork upon the resident's arrival to the facility and note any orders that need prompt attention. Administrator A and Regional RN B could not state why the orders were not reviewed upon Resident 7's return to note the medication needed to be given 4 times a day beginning the next morning. Regional RN B stated after Resident 7 came back from the hospital on 09/04/2023 at 6:00 PM, the discharge instructions | N 352 | | |

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| N 352 | Continued From page 54<br>were not reviewed until the morning of 09/05/2023 by Receptionist Y. Regional RN B stated the medication was switched to their "regular" pharmacy that delivers medication. Regional RN B acknowledged when there is a critical need for a medication that is ready at an alternate pharmacy the provider does have the capability of picking up the medication. Instead of retrieving the medication that was ready for pickup at the pharmacy, the provider chose to have the order transferred to a pharmacy that could deliver the medication. Regional RN B stated the provider was waiting for the medication to arrive from the pharmacy and it did not arrive until 09/05/2023 in the evening. Regional RN B stated they were aware the new pharmacy would take additional time to deliver the medication. The provider chose to change the pharmacy for the convenience of having the medication delivered, knowing it would result in the resident missing initial doses. Regional RN B acknowledged the provider had the capability of receiving the medication to begin the dose as it was prescribed to begin on 09/05/2023 for the 8:00 AM dose but did not take reasonable steps to procure the medication or ensure its timely delivery. Regional RN B acknowledged the delay in receiving an antibiotic had the potential for harm to the resident. Both administrators verified the 12:00 PM dose on 09/09/2023 and the 4:00 PM dose on 09/15/2023 were not refused by the resident and were not given, causing the medication schedule to be pushed back an additional day. Both Administrator A and Regional RN B acknowledged the potential for harm and risk associated with not consistently receiving antibiotic treatments as ordered.<br><br>Cross Reference<br>N0353 DHS 83.32(3)(i) Rights Of Residents: | N 352 | | |

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| N 352 | Continued From page 55<br>Adequate Treatment | N 352 | | |
| N 353 | 83.32(3)(i) Rights of Residents: Adequate treatment<br><br>In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Prompt and adequate treatment. Receive prompt and adequate treatment that is appropriate to the resident ' s needs.<br><br>This Rule is not met as evidenced by:<br>Based on Record review and interview the provider did not ensure 2/2 residents (Resident 7 and 8) received treatment that was prompt and adequate to meet their needs. Resident 8's family reported a change in condition to the provider regarding a known medical issue and Resident 8 was not seen by a medical professional or treated for 4 days. Resident 7 had symptoms of an infection and was not seen by a medical professional for 7 days and was further delayed greater than 24 hours in receiving the ordered antibiotic treatment.<br><br>This is a repeat deficiency. See Statements of Deficiency (SOD) 8DXE12, dated 02/02/2022.<br><br>Findings include:<br><br>Resident 7<br>Surveyor reviewed Resident 7's record and noted Resident 7 was admitted on 08/12/2022 with diagnoses including Dementia, chronic non healing surgical wound, diabetes, and hypertension, and insomnia. Surveyor reviewed Resident 7's observation notes: | N 353 | | |

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| N 353 | Continued From page 56<br><br>8/29/2023 PM, " ... Resident was going to use the toilet many times during the day ..."-Caregiver GG<br>08/30/2023, " ... resident is having belly pains ..."-Medication Passer D<br>09/01/2023 AM, " ... resident continued to have pain in [his/her] belly area. Staff sent message to bluestone hopefully something can be given soon."-Medication Passer D<br>09/01/2023 PM, " ... Resident continues to have a lot of pain ... resident can't stay sit [sic] for much time[s/he] [sic] feel [sic] uncomfortable. Resident [sic] went to the bathroom many time[sic] ...didn't eat very well. [sic]Went to bed early."-Caregiver GG<br>09/03/2023 AM, " ...staff toileted [him/her] multiple times. Staff was able to get a urine sample [sic] staff dropped it off at hospital."-Medication Passer D<br>09/03/2023 PM "Resident was in bed until right before supper ... refused supper."-Caregiver LL<br>09/04/2023 AM, Resident did not eat breakfast. Resident continues to be in a lot of pain ... resident was sent to hospital ... paramedics mention signs of UTI and also high blood sugar."-Medication Passer D<br>09/04/2023 PM, "Resident came back around 6 Pm from [sic] hospital."- Caregiver LL<br>09/05/2023 AM, "Resident refused breakfast. Resident is very restless and going to the toilet quite often due to [his/her] UTI ... resident still not feeling well ... very restless ..."- Caregiver KK<br><br>Bluestone Medical Notes:<br>Surveyor reviewed Resident 7's Bluestone medical notes which indicated the Bluestone medical provider was notified about a change in condition on 08/29/2023. On 08/30/2023 the Bluestone provider asked for any signs/ symptoms of a UTI to be communicated. On 09/01/2023, the Bluestone provider is updated | N 353 | | |

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| N 353 | Continued From page 57<br>with Resident 7's vital signs and discovers the staff have been updating the Bluestone provider for Resident 7 under another resident's file. The staff request an order for a Urinary Analysis (UA) and the Bluestone provider asks for any signs and symptoms of a UTI twice, in 2 separate messages. The staff then respond that Resident 7's urine has an odor. On 09/02/2023, after requesting any signs or symptoms of a UTI from the facility staff 3 times, the Bluestone provider sends an order for a UA. On 09/04/2023, the staff note the UA was sent to the hospital but the resident is weak, lethargic, and continuing to complaint of abdominal pain. Resident 7 was subsequently emergently sent to the hospital.<br><br>Hospital Discharge and Medication Orders and Interview:<br>Surveyor reviewed the hospital discharge summary dated 09/04/2023 and noted an antibiotic treatment was to start " ... 4 times daily for the next 10 days." Surveyor reviewed the Mediation Administration Record for September and noted the prescribed antibiotic was not started until 8 PM on 09/05/2023, approximately 26 hours after Resident 7 returned from the hospital and continued to have significant pain and restlessness due to his/her diagnosed infection. An interview on 10/04/2023 at approximately 12:00 PM, with Regional RN B revealed the staff were aware the medication was ordered, were aware of the risk associated with not receiving the antibiotics timely, and did not make a reasonable effort obtain the medication. The staff did not follow through to promptly get the medication but instead waited until it was delivered.<br><br>09/25/2023 at 9:20 AM, Surveyor interviewed Caregiver RR. Caregiver RR coroborated | N 353 | | |

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| N 353 | Continued From page 58<br>observations notes written by Medication Passer D. Caregiver RR stated Medication Passer D noticed Resident 7 would be "pulling at his/her brief, crying in pain" between 08/31/2023 and 09/04/2023. Caregiver RR stated Medication Passer D indicated Resident 7 had "a severe UTI or yeast infection, (his/her) genital area was swollen, and brief was saturated all the time ... (Medication Passer D) said (Resident 7) needs to be sent out and was trying to get management to send (him/her) out ... trying to get urine catch ... (Resident 7) was lethargic, not acting normal." Caregiver RR told Assistant Director E, "(S/he) needs to be sent out because (s/he) might be going septic and (his/her) urine smells bad." Caregiver RR told Medication Passer D s/he needed to send Resident 7 out. Caregiver RR stated, "Bluestone and hospice were called, and the next day (Resident 7) was running a fever." Caregiver RR stated, "The next day after that Resident 7 was sent out to the ER. If they waited another day (Resident 7) could have died."<br><br>Summary:<br>Resident 7 began to have signs and symptoms of a UTI on 08/29/2023. The symptoms were not adequately communicated to the provider for 3 days until a UA order was obtained on 09/02/2023. The urine was not sent in until 09/03/2023. By 09/04/2023 the resident was so ill s/he needed emergent medical attention at the hospital. The resident was sent back on 09/04/2023 at approximately 6:00 PM with orders to begin a 10-day treatment of antibiotics. The provider didn't not promptly procure the medication and allowed the Resident to go over 24 hours without receiving his/her antibiotic treatment. From the time symptoms were first noticed to the time the resident began to receive treatment was approximately 8 days. While the | N 353 | | |

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provider continued to monitor the resident, they took days between communication and steps to get the resident treatment. The resident experienced pain and was put at risk for significant harm by waiting for provider to respond to the critical change in condition.

Resident 8
Record review:
Surveyor reviewed Resident 8's record and noted Resident 8 was admitted on 09/12/2022 with diagnoses including osteoarthritis, rheumatoid arthritis, dehydration/fluid and electrolyte imbalance, diabetes mellitus type 2, hypertension, disorders of the reproductive system, and constipation. Resident 8's initial assessment dated 08/31/2022 identifies him/her as occasionally incontinent and requiring assist with bathing, dressing, and hygiene. Resident 8's Individual Service Plan (ISP) dated 06/06/20233, notes Resident 8 is diagnosed with dementia with Lewy bodies although it is not listed among his/her diagnoses on his/her facesheet. The ISP notes Resident 8 requires an assist for bathing, toileting every 2 hours, and requires staff assistance for a "wash up" twice a day.

Surveyor reviewed Resident 8's Bluestone home health care notes:
07/16/2023, " ... staff found that others may not be pulling [his/her] [genitals] back and it is not being cleaned properly. Due to this, [s/he] I starting to form small blisters under [genital skin] and it is causing burning sensations as we believe it is closing up slightly." -Caregiver X
The notes detail the Bluestone provider advising staff retraining to ensure proper care is received and to use an already prescribed antifungal cream. The resident's discomfort was not addressed.

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| N 353 | Continued From page 60<br><br>07/17/2023, "Received a phone call from [Family Member K] about concern of groin area. [S/he] is upset that it is not being cleaned properly and appears to be closing up again ... can we please get an update on skin closure and redness ..." -Bluestone medical tech.<br>07/17/2023," Do you want an update about how it looks today? As [Caregiver X] posted yesterday morning about it." -Administrator A.<br>No messaged update was given as was requested by the Bluestone provider in the notes.<br><br>The provider was aware Resident 8 was experiencing skin breakdown with associated pain on 07/16/2023. The Bluestone medical provider asked for an update on 07/17/2023 and Administrator A questioned if an update was needed as they had been updated the day before. As reviewed in the care notes, no prompt treatment was advocated for and treatment provided did not adequately meet the resident needs for pain management.<br><br>Interviews:<br>On 09/13/2023, at 11:03 AM, Surveyors interviewed Family K, Resident 8's family member. Family K stated his/her concerns about Resident 8 not receiving timely care to meet his/her needs. Family K stated Resident 8 has a medical condition that requires regular cares and cleaning to the urethra that, when not completed, result in skin breakdown, pain, and infections. Staff are to assist him/her with washing his/her genital area and applying medication twice a day as well as requiring 2-hour toileting. Family K stated the condition was severe enough that it was scheduled for surgical intervention and as such, the provider needed to monitor the condition for any changes while ensuring regular care was provided. Family K stated the | N 353 | | |

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caregivers had not been toileting Resident 8 every 2 hours and as a result s/he would frequently find Resident 8 wet and sitting in odorous soiled clothes and bed sheets. Family K stated it was evident the cares were not being regularly completed as resident began to have pain, skin rashes and there was a strong urine odor in the hallway and inside Resident 8's room. Family K stated s/he frequently needs to seek caregivers out to assist Resident 8 with peri cares and incontinence cleaning. Family K stated s/he addressed the issue of Resident 8 not being toileted every 2 hours with the staff at a meeting and frequently with Administrator A. Family K stated Administrator A had sheets for the staff to sign that the cares were actually being completed in Resident 8's bathroom for a few weeks but then the sheets began to be left unsigned and then were discontinued. Family K stated on 07/16/2023 Resident 8 was found sitting in urine and complaining of pain to his/her groin area. Family K stated s/he told Assistant Director E and requested Resident 8 be seen by a medical person qualified to assess the resident. Family K stated Assistant Director E said s/he would let Administrator A and the home healthcare service know. Family K stated the provider did not offer to have the resident seen by their regional RN or call for an urgent assessment from the home health agency despite reporting the resident was in pain. Family K stated on 07/20/2023 s/he returned to the facility to find Resident 8 had not been assessed or received treatment. Family K stated Administrator A was unaware Resident 8 requested medical attention on 07/16/2023. Family K stated Administrator A said the home health company was present at the facility on Thursday (7/20/2023) and that Resident 8 "was not on their list" today. Administrator A stated s/he could see if Resident 8 could be added to their

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schedule for a check in but not an assessment. Family K stated they had to advocate and insist a 3rd time that Resident 8 be seen and assessed by a qualified medical person as Resident 8 was still in pain. Family K stated to Administrator A "[S/he] needs to be looked at!" Family K stated Administrator A then went to check on Resident 8 and Administrator A stated Resident 8 "looked ok" to him/her. Family K stated Administrator A is not qualified to make assessments as s/he is not an RN. Family K expressed frustration that Resident 8 had to wait 4 days to be assessed by a medical professional and that it took Family K advocating for Resident 8 three times before it was done. Family K stated "I told them [Resident 8] needed to be looked at on that Sunday. [Resident 8] was in pain and [his/her] [urethra] was pinkish red ... I don't know why they didn't have their RN look at it ... or use urgent care ... [Resident 8] wasn't seen until Thursday when I came in and had to insist twice!"

09/25/2023 at 9:20 AM, Surveyor interviewed Caregiver RR. Caregiver RR stated, "Staff don't change (Resident 8) at all ... (the provider) had to replace (his/her) mattress because it was saturated in urine. About 3 weeks ago, the wheelchair seat and pad were dripping with urine. S/he spits tobacco all over so staff think s/he is disgusting. (Resident 8) hates it here ..."

On 09/13/2023, at approximately 4:30 PM, Surveyors interviewed Administrator A with Regional RN B and Administrator C present. Administrator A acknowledged Resident 8 has a documented need for staff assistance and medication twice daily for his/her urethral care and that the condition is severe enough that it requires an upcoming surgical intervention. Administrator A stated s/he recalled when Family

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| N 353 | Continued From page 63<br><br>K was present at the facility asking for Resident 8 to be seen by the home health company on 07/20/2023. Administrator A stated Family K told him/her that they were there on the previous weekend (07/16/2023) and reported Resident 8 had reddened skin and was reporting discomfort to his/her urethral area. Administrator A stated s/he explained to Family K Resident 8 was not on the home health care list to be seen that day (07/20/2023) but that s/he would try to get him/her added to their schedule. Administrator A stated Family K insisted Resident 8 be seen and then Administrator A went to Resident 8's room with other staff to assess Resident 8. Administrator A denied Resident 8 had skin break down but acknowledged Resident 8 was complaining of groin pain. After review of the code requirements, Administrator A acknowledged Resident 8 should have received prompt and adequate treatment on 07/16/2023 when the groin blisters and pain was first reported. Administrator A acknowledged the increased risk of harm to the resident by not receiving prompt and adequate treatment when a change was noted to his/her medical condition that the provider was aware was severe enough to require x2 daily medication treatments and an upcoming surgery.<br><br>Cross Reference<br>N0352 DHS 83.32(3)(h) Rights Of Residents: Receive Medication | N 353 | | |
| N 358 | 83.32(3)(n) Rights of Residents: Safe environment<br><br>In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Safe environment. Live in a safe environment. The CBRF shall safeguard residents from | N 358 | | |

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environmental hazards to which it is likely the residents will be exposed, including both conditions that are hazardous to anyone and conditions that are hazardous to the resident because of the residents ' conditions or disabilities.

This Rule is not met as evidenced by:
Based on observation, interview and record review, the provider did not ensure a safe environment for 2 of 2 (Resident 1 and 11) residents reviewed.

Resident 1 was being transferred using a sit to stand lift. Medication Passer D did not ensure Resident 1's feet were in the proper position. While moving the sit to stand to the bathroom, the harness came off and Resident 1 fell backwards on buttocks.

Resident 11 was being transferred using a sit to stand lift. Medication Passer D did not use the correct sling for the lift.

Findings Include:

On 07/18/2023, the Department received concerns related to falls and transfers.

On 09/11/2023, 09/13/2023 and 10/02/2023, Surveyors conducted onsite visits to the facility. A sample of residents was selected, including the resident records of Resident 1 and 11.

Resident 1
Resident 1 was admitted to the facility on 03/31/2018 with diagnoses to include the following: Alzheimer's Disease, anxiety, depression, glaucoma, osteoarthritis and spinal stenosis. Resident 1's most recent ISP

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| N 358 | Continued From page 65<br>(individualized service plan) dated 02/07/2023 indicated Resident 1 cannot make needs known, has an activated power of attorney (POA), needs total assistance with self care and uses a sit to stand lift and broda chair. The ISP states "Resident is to be transferred with a sit to stand with 2 staff."<br><br>On 09/11/2023 at 11:30 AM, Surveyor interviewed Family Member Q and R. Family Member Q verified s/he was the activated POA for Resident 1. Family Member Q stated there was an instance where Resident 1 fell because a Medication Passer Didn't have Resident 1's feet in the correct position. Family Member R stated s/he was in the room when this happened. Family Member Q and R questioned if the facility filled out an incident report and if the caregiver received any training/disciplinary action related to the incident.<br><br>On 09/11/2023, Surveyor requested incident reports for Resident 1. On 09/13/2023, Surveyor reviewed an incident report dated 07/12/2023 with no time noted. The report stated, "[Resident 1] was being transferred from toilet to chair. Feet were not properly flat on floor of the sit to stand. As I mentioned to [Medication Passer D] as [s/he] pushed the stand lift over the bump the harness came off of stand and [Resident 1] fell backwards falling on [his/her] butt. [S/he] is feisty this afternoon." The report does not indicate any immediate action was taken. The report states family was a witness and physician and social worker were notified. Administrator A signed the report with directions to monitor resident for bruising.<br><br>On 09/11/2023, Surveyor requested documentation of any training Medication Passer | N 358 | | |

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| N 358 | Continued From page 66<br><br>D received after the incident on 07/12/2023 with Resident 1. On 09/18/2023, Administrator A provided Surveyor with a statement dated 07/12/2023 stating, "The morning of July 12th, 2023 staff member [Medication Passer D] was transferring resident [Resident 1] and while transferring [him/her] [s/he] had fallen out of [his/her] sit to stand. When I had gotten to the facility Hospice was already in the building and had noticed the sling for the sit to stand strap was broken. Hospice was going to look into getting a new sling and for the time being we had just borrowed another sling. I had sat down with the staff member afterwards to explain the importance of safety when transferring and ensuring feet are flat and the sling is on securely before transferring."<br><br>Resident 11<br>Resident 11 was admitted to the facility on 09/07/2022 with diagnoses to include pre-senile dementia with paranoia without behavioral disturbance and anxiety. Resident 11's most recent ISP dated 09/10/2022 states Resident 11 uses a sit to stand for all transfers.<br><br>On 10/02/2023 at approximately 11:45 AM, Surveyor observed Medication Passer D transferring Resident 11 with a sit to stand lift. Medication Passer D was observed operating the lift while Resident 11 was holding the lift with both hands. Resident 11 was observed to have a sling around his/her waist but no belt/strap to connect Resident 11 to the sling. The 2 top loops of the sling were hooked to the top of the sit to stand lift. The 2 bottom loops of the sling were not attached to the lift. Medication Passer D moved Resident 11 from the wheelchair to the bathroom in Resident 11's room. | N 358 | | |

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| N 358 | Continued From page 67<br><br>At approximately 12:00 PM, Surveyor interviewed Medication Passer D regarding the use of the sling during a sit to stand transfer. Medication Passer D stated s/he puts the sling around the resident, then takes 2 top loops and makes sure they are hooked on to the lift. Medication Passer D stated the bottom 2 loops of the sling just hang down, they do not attach to the lift.<br><br>At approximately 1:45 PM, Surveyor interviewed Administrator A regarding a sit to stand transfer. Surveyor and Administrator A went to Resident 11's room to look at the sit to stand lift. Administrator A demonstrated with the sling in Resident 11's room how to place the sling around the resident. During demonstration, Administrator A stated there should be a different sling for this sit to stand lift. Administrator A verified the sling did not have a belt/strap to wrap around Resident 11's waist. Administrator A verified the sling was the wrong one to use for a transfer with this sit to stand lift. Administrator A stated they will have to go to the other unit to get a different sling. | N 358 | | |
| {N 362} | 83.33(1)(d) Grievance procedure: written summary<br><br>The CBRF shall provide a written summary of the grievance, the findings and the conclusions and any action taken to the resident or the resident ' s legal representative and the resident ' s case manager. The CBRF shall maintain a copy of the investigation.<br><br>This Rule is not met as evidenced by:<br>Based on interviews and record review, the provider did not provide a written summary of all | {N 362} | | |

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grievances with the findings, conclusions, and any action taken to residents in response to grievances for at least 4 residents (Residents 1, 3, 8, and 12).

This is a repeat deficiency. See Statements of Deficiency (SOD) 8DXE13, dated 12/19/2022.

Findings include:

On 07/18/2023 and 07/28/2023 the Department received complaints alleging management staff were not responsive when resident concerns were reported.

On 09/11/2023, Surveyors reviewed the provider's Grievance Policy and Procedure:

"POLICY AND PROCEDURE titled "COMPLAINT-GRIEVANCE"

Policy: The resident or the resident's guardian, agent or designated representative shall have the right to advocate assistance through the grievance procedure ...

2. ... Where an issue cannot be resolved by the frontline supervisor, or where there has been an allegation of disregard for a resident's rights, staff should encourage the resident to file a grievance with the Complaint/Grievance form (RES 11) ...The written summary of the grievance the findings and conclusions and any action taken shall be provided to the resident or the residence guardian agent or designated representative and the residence care manager if any and shall be inserted in the residence record ...

3. All verbal and/or written complaints/grievances are to be submitted to the Director, unless the

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| {N 362} | Continued From page 69<br>grievance involves the Director, and then it should be reported to the Owner. Any person investigating the facts associated with a grievance shall not have had any involvement in the issue leading to the grievance ... If a grievance is filed with the facility and the resident believes the grievance is not resolved within fifteen (15) days after filing, the resident may file the grievance with Pare Partners/ Country Terrace's Corporate Office ...<br><br>4. The Director shall investigate the matter and respond to the resident in a timely fashion and report findings to higher management ..."<br><br>On 09/11/2023, at approximately 9:20 AM, Surveyor interviewed Resident 1's Family Members Q and R. Family Member Q stated s/he has brought grievances, including care concerns, to Administrator A's attention multiple times. Family Member Q stated the grievances have been left "unresponded to" or Administrator A will have a temporary plan that is not followed through with. Family Member Q stated s/he has never received a written summary of his/her grievances with findings, conclusions, and actions taken in response. Family Member Q stated each time a concern is brought to Administrator A's attention s/he will assure Family Member Q it will be handled with no follow-through or will deny knowledge of the grievance or any previous discussions. Family Member Q stated the issues arising from unresolved grievances lead to him/her documenting his/her concerns. Family Member Q stated s/he was hopeful for change after the last SOD was issued and again hopeful when the provider announced there would be a meeting for the families. Surveyor reviewed Family Member Q's notes: | {N 362} | | |

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| CARE PARTNERS ASSISTED LIVING HORTONVILLE | 112 HARRIS WAY HORTONVILLE, WI 54944 |

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| {N 362} | Continued From page 70<br><br>"June 21st 2023. A meeting was posted by Care Partners for this day at 12:30. The invite was for those that have the POA title for a family member at Care Partners. I attended with my [spouse,] and there were 9 other families represented at this meeting ... Care Partners had in attendance [Regional RN B,] [Administrator A,][Regional Director JJ,] and another [director] from corporate. The meeting was started with a wondering if there were concerns. The meeting very quickly turned vocal by a number of those in attendance. [Family Member R] and I going into the meeting didn't know what to expect or who was going to be in attendance. We honestly thought that our experiences were going to be singled out and it was just bad luck for our family. Turned out we were not alone, and that is putting it mild. I witnessed intense conversation by family members with specifics directed at [Administrator A,] and [Regional RN B.] [Administrator A] for not following through was a main point, and [Regional RN B] for treating family members with lack of respect. That is when I chimed in and added our thoughts, which were very consistent to those that had spoken. The meeting turned out to very vocal on the part of the families represented, and myself included ...<br><br>So the meeting adjourned after about 90 minutes. A few things I noticed during the meeting with all the feedback from the families. [Administrator A] was making no notes, and very few were being made by [Regional RN B] or [Regional Director JJ] from headquarters. So I asked the question,,, [sic] Did anyone take minutes for this meeting ?[sic] (meaning staff) [sic]well [sic] the answer was crickets. No one was taking notes..."<br><br>Family Member Q stated the provider did not follow up with the grievances s/he brought forth | {N 362} | | |

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| {N 362} | Continued From page 71<br>during the meeting on June 21 and no written summary, conclusion, or actions taken was provided.<br><br>Family Member Q stated Resident 1's family has learned to have a witness present when discussing a grievance with Administrator A as they have been "made to look unreasonable to staff" and have been "accused of saying things in the past that were not true." Family Member Q stated they have also been turned away when trying to report a grievance as documented in their notes:<br><br>"July 10th 2023. [Family Member R] and I went in to Care Partners at 3:00pm. We asked to see [Administrator A] in [his/her] office, and I asked [Receptionist Y] at the front desk to be present as a witness ... This meeting started out with asking what [Administrator A] knew about [Resident 1's] fall at 6:30 in the morning. It was very apparent [Administrator A] was also trying to cover it up, and be dishonest. I interrupted [Administrator A] and let [him/her] know that we knew who was on staff and we didn't appreciate being lied to by [Medication Passer D] again, or [him/herself.] The meeting on my part got more vocal, as five years of Care Partners frustration spilled out. I will not apologize for what I said, as it was the truth. Please view [Receptionist Y's] report of the meeting as I understand [s/he] was asked to give [his/her] recollection of that meeting. When I was lecturing [Administrator A], [Regional RN B] walked in and said this meeting is over and you will not speak to our staff that way. I responded and said I have a right to voice my opinion. [Family Member R] my [spouse] was in the room and said if there is any concern as to what was said, [s/he] let [Regional RN B] know that we had a witness in the room ([Receptionist Y] as | {N 362} | | |

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| {N 362} | Continued From page 72<br><br>[Regional RN B] didn't know [Receptionist Y] was behind the door that [Regional RN B] opened ... [Regional RN B] demanded I leave the office, and starred me down trying to intimidate me with [his/her] presence ... I left the office and went to the [Memory care] side to visit with [Resident 8.]"<br><br>On 09/11/2023, at 2:45 PM, Surveyors conducted an interview with Resident 12's Family Member GG. Family Member GG stated s/he has brought grievances, including care concerns, to Administrator A's attention multiple times. Family Member GG stated the grievances have been left unaddressed or Administrator A will have a temporary plan that is not followed through with. Family Member GG stated s/he has never received a written summary of his/her grievances with findings, conclusions, and actions taken in response. Family Member GG stated when s/he brings a grievance to Administrator A's attention, "[Administrator A] will say 'I'll make a chart!' or 'I'll make a list!' to fix the issue, but there is no follow through."<br><br>On 09/13/2023, at 11:03 AM, Surveyor conducted an interview with Resident 8's Family Member K. Family Member K stated s/he has brought grievances, including care concerns, to Administrator A's attention multiple times. Family Member K stated the grievances have been left unaddressed or Administrator A will have a temporary plan that is not followed through with. Family Member GG stated s/he has never received a written summary of his/her grievances with findings, conclusions, and actions taken in response. Family Member K stated s/he has had to keep watch over the cares Resident 8 receives as the interventions Administrator A puts into place, (care and toileting schedule list/chart) will only be implemented temporarily and not followed | {N 362} | | |

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| {N 362} | Continued From page 73 | {N 362} | | |

through with. Family member K expressed frustration that s/he feels s/he has to continually advocate for Resident 8 as the grievances s/he present to Administrator A are ignored or only temporarily addressed.

On 09/12/2023, at 10:30 AM, Surveyor interviewed Resident 3. Resident 3 stated s/he moved out of the facility sometime at the end of July 2023 because "everything was so horrible." Resident 3 mentioned medications being stolen, concerns with meals not meeting nutritional values and staff attitudes while helping residents. Resident 3 indicated s/he has a close friend who was aware of these concerns as well. Resident 3 gave permission to Surveyor to talk with friend.

On 09/12/2023, at 10:50 AM, Surveyor interviewed Friend MM. Friend MM indicated s/he and Resident 3 had several concerns related to pain medication, food, staff attitudes. Friend MM indicated they had 2 meetings with Regional RN B. The first meeting was held sometime during the first 2 weeks of June 2023 and told Regional RN B about the concerns with nutrition, delivery of medications being late, cleanliness, and staffing levels. Friend MM stated, "nothing was done, Regional RN B never came back, nothing."

On 09/13/2023, at approximately 4:00 PM, Surveyors interviewed Administrator A with Regional RN B and Administrator C (Administrator at a sister facility) present. Surveyors requested all documentation of grievance summaries and related meetings that were received or occurred after January of 2023 to indicate all grievances were investigated, resolved, and resolutions communicated to residents. Administrator A stated any grievances and resolutions were communicated verbally to

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| {N 362} | Continued From page 74<br>the residents, families, and/or their legal representatives, however written summaries were not provided or located in the resident files. After review of SOD 8DXE13 (dated 12/19/2022) Administrator A verified s/he was previously made aware of the code requirements for grievances and acknowledged the written requirements had not been completed for grievances received. Administrator A stated a meeting was held on 07/21/2023 with all resident families to address grievances and give families the chance to discuss concerns. Administrator A stated multiple families voices grievances to the administrators present (Administrator A, Regional RN B, and Regional Director JJ.) Administrator A stated s/he believed Regional Director JJ took notes on the meeting but could not provide notes or any documentation to show the grievances were recorded when requested. Administrator A verified s/he did not follow up with the families or provide written summaries with findings, conclusions, and actions taken in response. | {N 362} | | |
| N 388 | 83.35(3)(c) Implement, follow the individual service plan<br><br>Implementation. The CBRF shall implement and follow the individual service plan as written.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the provider did not ensure the ISP (individual service plan) was implemented and followed for 1 of 1 (Resident 1) residents reviewed.<br><br>Resident 1's ISP dated 02/07/2023 indicated Resident 1 has a bed alarm, chair alarm and an alarm for recliner. Additionally, fall incident reports dated 06/09/2023, 07/08/2023, | N 388 | | |

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| N 388 | Continued From page 75 | N 388 | | |

07/18/2023, 09/05/2023 indicated interventions in place for Resident 1 included being on 15 minute checks and to ensure alarms were working. Resident 1's record did not contain documentation of 15 minute checks. Resident 1's record did contain documentation of alarms to be checked if on and under Resident 1, however, this intervention was not consistently implemented across all shifts.

Findings Include:

On 07/18/2023, the Department received a complaint regarding ISP's. Additionally, on 07/31/2023, the Department received a facility self report regarding Resident 2's suicide attempt and hospitalization.

On 09/11/2023, 09/13/2023 and 10/02/2023, Surveyors conducted an onsite visit to the facility. A sample of residents were selected, including the records of Resident 1 and 2.

Resident 1
Resident 1 was admitted to the facility on 03/31/2018 with diagnoses to include the following: Alzheimer's Disease, anxiety, depression, glaucoma, osteoarthritis and spinal stenosis. Resident 1's most recent ISP (individualized service plan) dated 02/07/2023 indicated Resident 1 cannot make needs known, has an activated power of attorney (POA), needs total assistance with self care and uses a sit to stand lift and broda chair. The ISP also indicates Resident 1 has safety concerns related to falls and requires the use of a bed alarm, chair alarm and an alarm in recliner to maintain a healthy environment.

Surveyor reviewed fall incident reports for

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Resident 1 and noted the following:
06/09/2023 - Resident 1 fell out of bed. Administrator A noted to "...check every 15 min[minute] during the day.
07/08/2023 - Resident 1 fell while in room. Administrator A noted to "check every 15 minutes..."
07/18/2023 - Resident 1 fell while in room. Administrator A noted to "notify hospice of bed alarm not working, use a spare alarm for now..."
09/05/2023 - Resident 1 found on floor in room. Administrator A noted to "make sure alarms are on at all times...keep 15 min checks"

On 09/18/2023 at 8:50 AM, Surveyor requested documentation of Resident 1's 15 minute checks being completed. At 2:20 PM, Administrator A sent Surveyor additional documentation for Resident 1 including an updated ISP which stated, "9/18/23 15 min checks discontinued. staff to continue to use baby monitor and keep resident in high traffic area when in broda." The additional documentation did not include documentation that 15 minute checks were documented after the falls on 06/09/2023, 07/08/2023 and 09/05/2023.

Surveyor reviewed Resident 1's June, July, August and September 2023 MAR (medication administration record). The MARs indicated staff were to initial each shift (AM, PM and NOC) that chair alarms were applied to all surfaces at all times (chair, recliner, bed). The following was noted:
NOC's alarms were not documented on 06/01/2023, 06/08/2023, 06/09/2023, 06/13/2023, 06/17/2023, 06/18/2023, 06/19/2023, 06/26/2023, 06/27/2023, 06/29/2023, 07/01/2023, 07/24/2023-07/31/2023, 08/05/2023, 08/07/2023, 08/09/2023, 08/11/2023, 08/14/2023-08/18/2023,

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| N 388 | Continued From page 77<br>08/25/2023-08/27/2023, 08/31/2023, and 09/01/2023-09/09/2023<br>AM's alarms were not documented on 06/02/2023-06/06/2023, 06/10/2023-06/12/2023, 06/15/2023, 06/16/2023, 06/20/2023-06/22/2023, 06/24/2023, 06/25/2023, 06/28/2023, 06/30/2023, 07/04/2023, 07/05/2023, 07/08/2023, 07/12/2023, 07/13/2023, 07/22/2023, 08/12/2023, 08/15/2023, 08/19/2023-08/23/2023, and 08/28/2023-08/30/2023<br>PM's alarms were not documented on 07/20/2023, 07/31/2023, 08/09/2023, 08/13/2023, 08/17/2023, 08/20/2023, 09/01/2023 and 09/08/2023<br><br>On 09/11/2023 at approximately 11:30 AM, Surveyor interviewed Family Member Q and R. Family Member Q and R indicated one of them visits Resident 1 almost daily due to continued concerns with staffing and care. Family Member Q indicated Resident 1 has had numerous falls and Family Member Q and R did not feel caregivers were checking on Resident 1 every 15 minutes as Family Member Q had requested. Additionally, Family Member R had indicated that on multiple visits to see Resident 1, Resident 1's chair or bed alarm had not been working properly.<br><br>On 10/10/2023 at 9:50 AM, Surveyor interviewed Hospice Aide OO. Hospice Aide OO indicated s/he has been providing cares to Resident 1 for "quite awhile, probably a year...very familiar" with Resident 1. Hospice Aide OO indicated there have been instances when Resident 1's alarms have not worked. Hospice Aide OO indicated that some of those instances were because the batteries were removed. Hospice Aide OO indicated s/he did not think Resident 1 could remove the batteries, the bed alarm is kept under the bed and there would be no way Resident 1 | N 388 | | |

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| N 388 | Continued From page 78<br>could pull batteries out of it, it is very hard to get batteries out.<br><br>On 10/02/2023 at approximately 10:00 AM, Surveyor interviewed Caregiver G. Caregiver G indicated Resident 1's bed alarm is not working and hasn't worked over the weekend. Caregiver G and Surveyor went to Resident 1's room. Caregiver G was unable to locate the bed alarm pad and box on Resident 1's bed.<br><br>On 10/02/2023 at approximately 10:10 AM, Surveyor interviewed Medication Passer D. Medication Passer D stated there are no batteries for Resident 1's chair alarm and the bed alarm also hasn't been working.<br><br>On 10/02/2023 at approximately 12:15 PM, Surveyor observed Family Member R in Resident 1's room along with Activity Director DD. Family Member R indicated s/he brought an alarm from home because the one on bed was not working. Family Member R indicated Activity Director DD just went to get new batteries out of a facility drawer and now the alarm works again.<br><br>On 10/02/2023 at 12:15 PM, Surveyor interviewed Administrator A. Administrator A verified the fall interventions did include 15 minute checks after the falls. Administrator A stated s/he did not have evidence of the 15 minute checks being completed. Additionally, Administrator A had indicated the s/he was aware of the use of chair/bed alarms and concerns from Resident 1's family members that the alarms were not working. Administrator A had stated the MAR was updated so staff were reminded to check alarms every shift. Administrator A reviewed the above MAR's and verified staff did not indicate if the alarms were checked on the | N 388 | | |

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| N 388 | Continued From page 79<br>above dates and shifts.<br><br>On 09/13/2023 at approximately 3:30 PM, Surveyor interviewed Administrator A, Regional RN B and Administrator C regarding Resident 1's 15 minute checks and alarm placement. Regional RN B stated that him/herself and Administrator A review incident reports and progress notes to determine if ISP interventions need to be updated and if they do, Administrator A and Regional RN B make those changes to MAR or ISP. Regional RN B stated that during shift report, outgoing caregivers are to go through the MAR, any incidents that occurred during the shift and any changes made to the ISP with the incoming caregivers to ensure all caregivers are aware of the changes and also to ensure the previous shift had completed all tasks on MAR and interventions were in place and effective. | N 388 | | |
| N 389 | 83.35(3)(d) Service plans updated annually or on changes<br><br>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. | N 389 | | |

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| N 389 | Continued From page 80<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the provider did not review and revise the individual service plan (ISP) when there was a change in resident's needs, abilities or physical or mental condition for 1 of 1 (Resident 2). Additionally, the provider did not ensure the resident or the resident's legal representative signed the ISP, acknowledging their involvement in, understanding of and agreement with the ISP for 2 of 2 (Resident 1 and 2) residents reviewed.<br><br>Resident 1 was admitted to the facility on 03/31/2018. Resident 1's most recent ISP is dated 02/07/2023. Resident 1's ISP did not include Resident 1's legal representative's signature.<br><br>Resident 2 was admitted to the facility on 07/05/2022. Resident 2's most recent ISP is dated 08/12/2023. Resident 2's ISP did not include Resident 2's legal representative's signature. Additionally, Resident 2 was found smoking in resident's room. Resident 2's ISP did not contain Resident 2's smoking abilities, interventions and goals to prevent another occurrence.<br><br>Findings Include:<br><br>On 07/18/2023, the Department received a complaint regarding ISP's. Additionally, on 07/31/2023, the Department received a self report regarding the fire department responding to facility smoke alarms due to resident smoking in room.<br><br>On 09/11/2023 and 09/13/2023, Surveyors conducted an onsite visit to the facility. A sample of residents was selected, including the records | N 389 | | |

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| N 389 | Continued From page 81<br>of Resident 1 and 2.<br><br>Resident 1<br>Resident 1 was admitted to the facility on 03/31/2018 with diagnoses to include the following: Alzheimer's Disease, anxiety, depression, glaucoma, osteoarthritis and spinal stenosis. Resident 1's most recent ISP (individualized service plan) dated 02/07/2023 indicated Resident 1 cannot make needs known, has an activated power of attorney (POA), needs total assistance with self care and uses a sit to stand lift and broda chair. The ISP does not contain Resident 1's legal representative's signature.<br><br>On 09/11/2023 at 11:30 AM, Surveyor interviewed Family Member Q. Family Member Q verified s/he is Resident 1's legal representative. Family Member Q stated on June 8th, 2023 a meeting was scheduled to review Resident 1's ISP. Resident 1's social worker, county representative, Administrator A and Family Member Q were invited. Family Member Q stated everyone showed up except Administrator A or a representative from the facility. Family Member Q stated the meeting continued without Administrator A and a plan of care was developed for Resident 1 and to be discussed with Administrator A for their review and agreement. Family Member Q stated the facility never got back to Family Member Q and nothing was ever signed by Family Member Q agreeing to the ISP. Family Member Q stated this was not the first time Administrator A didn't review the ISP. Family Member Q stated, "this has happened twice before where there was no plan review by Care Partners."<br><br>On 09/13/2023 at 3:30 PM, Surveyor interviewed | N 389 | | |

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| N 389 | Continued From page 82<br><br>Administrator A regarding Resident 1's ISP. Administrator A stated ISP meetings are held every 6 months unless there are major changes to the ISP. Administrator A indicated there was a meeting held in August 2023 for Resident 1 and the ISP was faxed to Family Member Q. Family Member Q did not return the signed ISP. Administrator A verified no follow up contact with Family Member Q was made to discuss the ISP and why Family Member Q did not sign the most recent ISP.<br><br>Resident 2<br>On 07/31/2023, the Department received a facility self report indicating the fire/police were called to the facility due to fire alarms going off. Attached to the self report form was a statement from Administrator A stating, "Wednesday July 26th I had an incoming call from my [Assistant Director E] at 8:16pm stating the fire alarm was going off. [S/he] stated there no was [sic] fire or smoke and [s/he] was trying to reset the alarm. I had contacted [Maintenance Director F] and [s/he] stated to evacuate the building and wait for the fire department to come and clear the building for the all clear. I had then contacted [Assistant Director E] back and told [him/her] everyone needed to be evacuated and to wait for the fire department to show up. All residents and staff members had all evacuated safely. Fire Department did not see any fire or smoke inside the building at all, the reason the fire alarms were going off was because a resident's room [Resident 2] detected there was smoke in [his/her] room from a cigarette."<br><br>Resident 2 was admitted to the facility on 07/05/2022 with diagnoses to include diabetes mellitus, mental illness, suicidal thoughts, borderline personality disorder and failure to | N 389 | | |

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| N 389 | Continued From page 83<br>thrive. Resident 2's most recent ISP dated 08/12/2023 indicated Resident 2 is independent with toileting, grooming, mobility and has a guardian (legal representative). Resident 2's ISP did not contain a signature by Resident 2 or his/her legal representative.<br><br>A smoking assessment dated 11/22/2022 indicated Resident 2 can smoke safely and independently. Resident 2's ISP did not contain Resident 2's smoking abilities, interventions and goals for safety while smoking.<br><br>On 09/11/2023 at approximately 10:30 AM, Surveyor interviewed Resident 2. Resident 2 admitted to smoking in room one time and hasn't done it again. Resident 2 stated s/he knows s/he needs to go out to patio to smoke. Resident 2 stated that was "so unlike me."<br><br>On 09/13/2023 at 3:30 PM, Surveyor interviewed Administrator A. Administrator A verified Resident 2's ISP did not contain a signature by Resident 2 or his/her legal representative. Additionally, Administrator A verified the ISP was not updated to reflect Resident 2's current smoking abilities, interventions and goals for safety while smoking. | N 389 | | |
| {N 396} | 83.36(1)(a) Adequate staff to meet resident needs.<br><br>The CBRF shall provide employees in sufficient numbers on a 24-hour basis to meet the needs of the residents.<br><br>This Rule is not met as evidenced by:<br>Based on observation, interview, and record review, the provider did not ensure an adequate amount of staff were present to meet the | {N 396} | | |

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| {N 396} | Continued From page 84 | {N 396} | | |

residents' needs. The staff and residents report long wait times, cares being delayed, and lack of supervision for memory care residents.

This requirement is being cited for a third time. See Statements of Deficiency (SOD) KDDT11, dated 12/13/2018, SOD 8DXE12, dated 02/02/2022, and SOD 8DXE13 dated 12/19/2022.

Findings Include:

The facility is licensed to serve up to 56 residents who may be advanced age, physically disabled, have irreversible dementia/Alzheimer's disease, and/or be terminally ill. At the time of survey, the memory care census was 9, and 29 residents lived on the AL side.

The Department received 2 complaints on 07/18/2023 and 07/28/2023, alleging the provider did not have enough staff to provide adequate care for the residents and/or issues resulting directly from lack of staff present. The complaints alleged the lack of staff has been negatively affecting the residents and causing the residents to not receive proper care and treatment.

On 09/11/2023, at approximately 11:00 AM, Surveyor toured the facility with Administrator A. The facility is separated into Memory Care (MC) and Assisted Living (AL) sides. The MC and AL sides were separated by delayed egress doors with a security code to enter and exit. Administrator A lead Surveyor into the MC where there was 1 caregiver present for the 9 residents who reside in the MC unit. Surveyor observed the sole caregiver was not present to supervise when Resident 7, who has a history of becoming physically aggressive with other residents (See SOD 8DXE13, dated 12/19/2022), began to roam

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| {N 396} | Continued From page 85<br>the living space. Surveyor observed when the caregiver in the MC unit is in a resident's room or in the medication room, residents are left unsupervised in the common areas. Surveyor asked about the safety of leaving residents in the common area of the MC unit unsupervised while the 1 caregiver tends to other residents. Administrator A stated there are other staff in the facility to help if needed. Surveyor observed the other staff were in the AL side and were not supervising the residents in the MC unit and would not be available unless alerted to the need. Surveyor observed an auxiliary cook staff was in the kitchen area of the MC unit at times but not consistently throughout the observations. The kitchen has a large open service counter window that faces the MC dining area but does not have a clear view of the common space where residents gather. No other personnel were observed in the MC unit. Surveyor observed the residents in the MC unit had rooms equipped with a call light system. The light would light up outside their rooms but did not send a message or alarm to notify the caregivers. Administrator A confirmed the caregivers would only know a call light was going off if they walked down the hall and saw it.<br><br>While on-site on 09/11/2023, 09/13/2023, and 10/02/2023, Surveyors observed the MC unit door was frequently alarming when Resident 7 would attempt to elope from the MC unit. The alarms happened greater than 10 times during each onsite visit. The alarms would at times be sounding for multiple minutes before a caregiver would attend to the concern.<br><br>On 09/11/2022, Surveyors reviewed resident and facility records. | {N 396} | | |

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| {N 396} | Continued From page 86<br><br>Resident 7:<br>Resident 7 was admitted to MC of the facility on 08/12/2022 as an elopement risk. Diagnoses include dementia with behaviors and insomnia. The "Step Assessment Tool", dated 08/05/2022 and completed by Administrator A, includes memory loss, wandering, elopement and fall risks, as well as physically resistive to care and offensive/violent behavior. The original Individual Service Plan (ISP), dated 08/15/2022, includes "Supervision - 15-minute checks due to elopement risk", "wandering" behavior, "Can be verbally and physically aggressive with staff", and "Has tendencies to be verbally aggressive with staff as well as be physical with staff members." The "Behavior Management Plan" (not dated) notes, "[Resident 1] will have outburst of anger by yelling at staff and swearing. [Resident 1] will also try to elope out the doors/windows when [s/he] gets upset. [S/he] has had threatening episodes with objects such as scissors. Possible Precipitators: Taking items [s/he] believes are [his/her] items. When [s/he] sees people outside, or through the memory care doors."<br><br>The observation notes from 07/01/2023 -09/11/2023 note 39 times when Resident 7 was restless, anxious, attempting to elope, and/or having behaviors that required intervention. Resident 7 is documented as frequently roaming the common space of the facility and occasionally having behaviors involving other residents. Resident 7 is left unsupervised when the only caregiver in the secured MC unit is tending to other residents in their rooms or is required to leave the locked unit to assist in the AL side.<br><br>On 09/11/2023, at approximately 11:20 AM, Surveyor interviewed Caregiver I. Caregiver I stated staffing levels are low and have caused | {N 396} | | |

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| {N 396} | Continued From page 87<br><br>newer caregivers to take on full resident care responsibilities before they are ready. Caregiver I stated while working on the MC unit s/he typically works alone. Caregiver I stated at times at night there is only 1 caregiver and 1 medication passer for the whole building, both AL and MC sides. Caregiver I stated "everyday memory care is left alone" when s/he is called to assist on the AL side. Caregiver I stated s/he is new to working in healthcare and felt, in terms of being able to manage the needs for all 9 MC residents alone, s/he was "thrown to the wolves." Caregiver I stated s/he did not recall being trained in client groups. Caregiver I stated, "I've never dealt with these people ... Alzheimer's and dementia ... it's all trial and error for me." Caregiver I stated s/he is continually concerned when s/he works alone in MC because when s/he is assisting a resident in their room s/he is unable to supervise the other residents. Caregiver I stated it was only recently that the caregivers began to use walkie talkies but that the walkie talkies wouldn't help if s/he was in a resident room and didn't know something happened to a resident in the commons space. Caregiver I stated s/he could try to call for assistance if another caregiver was needed but if s/he was busy with a resident, s/he wouldn't know that anything happened to alert him/her to know to call for assistance.<br><br>Caregiver I stated the staff are overworked and due to decreased staffing levels cares are not being done as needed for residents. Caregiver I stated s/he works the MC and AL side and stated there have been times when s/he came in to work the AL side at 3:00 PM and s/he could tell Resident 9 "had been sitting in [BM.]" Caregiver I stated it was clear when s/he changed Resident 9 s/he "had been sitting in it for hours." Caregiver I stated although Resident 9 is on the Al side s/he | {N 396} | | |

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has some memory care needs and requires a 2 assist. Caregiver I stated Resident 9 is supposed to be toileted every 2 hours but is not, as it takes 2 caregivers to change him/her and, with lack of staff, it is difficult to get 2 caregivers to have the time to change him/her. Caregiver I stated s/he was working on the AL side when s/he noticed Resident 9 had a BM in his/her briefs at approximately 6:00 PM. Caregiver I stated when s/he approached Assistant Director E for assistance Assistant Director E stated, "don't make more work for yourself, we change [Resident 9] at 9 [PM.]"

On 09/11/2023, at approximately 4:00 PM, Surveyor interviewed Administrator A, Regional RN B and Administrator C (Administrator from a sister facility.) Regional RN B stated Caregiver I brought the concern regarding the comment made to him/her to not change Resident 9 and not "make more work for yourself" to the administrator's attention. Regional RN B stated s/he would look into it. Upon the exit interview on 10/02/2023 at approximately 12:00 PM, no additional information or resolution was given to the Surveyors to show the administrators addressed or investigated the concern.

On 09/11/2023, at approximately 12:30 PM, Surveyor interviewed Resident 8. Resident 8 stated there are times when s/he used his/her call light and it takes up to 30 minutes before a caregiver responds to assist.

On 09/13/2023, Surveyor interviewed Resident 14 at 8:48 AM. Resident 14 stated when s/he used his/her call light for assistance "it can take a while." Resident 14 put on his/her call light and Surveyor observed it took approximately 18 minutes before the caregiver came to check on

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the resident. Surveyor observed Resident 14 ambulate with a wheeled walker to the common space at the end of the resident's hall near the activity room. The area is away from the main space in the MC unit where the dining room and tv are located and is not within caregiver's direct visual control. Resident 14 stated s/he is "unsteady" on his/her feet and has fallen in the past. At 9:01 while standing with his/her walker Resident 14 stated, "I feel dizzy" Surveyor observed no caregivers were in sight and Resident 14 did not have a call pendant or way to alert the staff s/he needed assistance. Resident 14 sat down on the chair and stated, "oh that is low!" and stated s/he didn't know if s/he would be able to get up from the chair. When asked how s/he would get a hold of someone to help Resident 14 stated, "I don't know." Resident 14 stated s/he has difficulty with ambulation and, because there are not enough staff to help, when s/he needs something s/he has to seek caregivers out by coming out of his/her room to "find" someone. Resident 14 gave an example of ice water and Kleenex. Resident 14 stated s/he asks the caregivers for water and they don't bring it to him/her. Resident 14 stated s/he has to walk down to the kitchen and ask for ice water and his/her cup will sometimes sit empty until s/he has to find someone and ask again. Resident 14 stated, "I can't get Kleenex. I gave them the empty box a few days ago." Resident 14 stated s/he asked for more Kleenex a few days ago and has not received any. Resident 14 stated it takes a long time for him/her to get what s/he needs, and s/he has to "seek" caregiver out because they won't bring what s/he needs to him/her.

On 09/13/2023, at 9:35 AM, Surveyor interviewed Caregiver S. Caregiver S stated, "[Administrator C] said we only need 3 [caregivers] in [AL] and 1

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| {N 396} | Continued From page 90<br><br>in [MC.] Our residents are not like [Administrator C's] residents [residents at a sister facility.] ... our resident like to be up before 7 AM. We have to start AM med [sic] pass because it takes 2 hours. It takes up so much time. [Resident 16] likes to get up at 7:00 AM and on Saturday [09/09/2023] [s/he] wasn't up until 9:00 AM because there was no one to help ... no one is documenting in the record, no charting is getting done because we are so busy." Caregiver S stated Residents 9, 13 and occasionally 20 on the AL side require 2 staff to assist with cares and frequently have to wait long times for cares to be completed until 2 staff are available. Caregiver S stated for a short while they were able to have 2 caregivers in the MC unit but, "Just recently everyone quit. It made us go down to one person in memory care. Everyone quit due to management, really [Administrator A.] All staff have pick up extra shifts." Caregiver S commented on the lack of staff creating a situation where residents were not receiving timely cares to meet their needs.<br><br>On 09/13/2023, Surveyor interviewed Resident 15 at 10:03 AM. Resident 15 stated When s/he puts on his/her call light, it can take up to 40 minutes to get help. Resident 15 expressed great concern, sadness and fear when s/he recalled a resident who was in hospice care and in need of critical end of life assistance. Resident 15 stated s/he watched the resident's call light go off for 20 minutes without help and then the person passed away. Resident 15 stated there is a high amount of staff turnover. Resident 15 stated, "The previous staff, they were the best kids you could have hoped for. They left because of [Administrator A.] They just don't fudging care because they just hire new people quick. They just don't give a darn and the people who end up suffering are the residents. If you need something | {N 396} | | |

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you should be able to get it. This is our home, and they are supposed to be here for us. I need my feet lotioned and I can't get it in a timely manner. I sat here for 45 minutes waiting for someone because they were so short staffed. This is not a rare thing. There are times when there is one person on this whole wing (AL) and one in the other wing (MC.) They tell us that they are short staffed."

On 09/13/2023, Surveyors observed the MC was left unattended from approximately 2:10-2:25 PM.

On 09/13/2023, at approximately 12:45PM, Surveyor interviewed Caregiver J. Caregiver J stated Administrator C was from another sister facility and told Administrator A and Regional RN B only 1 caregiver was needed in the MC unit so that is all they would schedule. Caregiver J stated staffing 1 person in the MC unit was not appropriate for the level of cares the resident required. Caregiver J stated Administrator A will say they are able to call over to the AL side for assistance but in reality, the AL caregivers rarely come when asked to help. Caregiver J stated s/he would work alone in the MC unit and it was difficult to get any caregivers from the AL side to come help "even to go to the bathroom." Caregiver J stated Resident 7 has physically aggressive behaviors and has been verbally aggressive with other residents Caregiver J stated, "[Resident 7] tries to escape all day. I was getting so overwhelmed." Caregiver J stated at times there may be up to 4 other caregivers working in the AL side but that they are too busy to help when they are called to assist in the MC unit. Caregiver J stated, "I asked 4 times for help, and no one came. I had to go to the bathroom so bad and I needed someone to watch [Resident 7] ... it takes 2 to change [Resident 1]... [Resident 1]

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| {N 396} | Continued From page 92<br>has had to wait sometimes up to 2 hours to be changed ..." until another caregiver can assist. Caregiver J stated when s/he works on the MC unit s/he has no time to chart in the resident's records and struggles to complete all resident cares because there is no one to assist and supervise residents while other residents are being tended to.<br><br>On 09/13/2023, at approximately 12:00 PM, Surveyor interviewed Administrator A with Regional RN B and Administrator C present. Administrator A discussed the current staffing plan for the facility and stated there would typically be 1 caregiver in the MC unit and caregivers would call for assistance if needed. Administrator A stated the staffing plan had not changed since the last survey. Administrator A stated the provider would try to have 3-4 caregivers on the AL side during AM and PM shifts with one caregiver on during the overnight shift and 1-2 caregivers designated to the MC unit during all shifts. Administrator A confirmed there were residents who require a 2 assist in the AL and MC aside of the building (Residents 13 and 9 for AL and Residents 1, 10, and 11 for MC) Surveyor asked if the 1 caregiver designated to the secured MC unit was ever required to leave the unit to help assist with the 2 assist residents in the AL side. Interim Director C stated the caregiver on the MC unit was expected to assist with transfers in the AL side. Administrator A stated caregivers in MC would at times leave the secured unit unattended while assisting on the AL side. The MC and AL sides were separated by delayed egress doors with a security code to enter and exit.<br><br>The provider had been cited for not having an adequate number of staff to meet resident needs | {N 396} | | |

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| CARE PARTNERS ASSISTED LIVING HORTONVILLE | 112 HARRIS WAY HORTONVILLE, WI 54944 |

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| {N 396} | Continued From page 93<br><br>3 times prior, with the citation and enforcement orders from SOD # 8DXE12, dated 02/02/2022, that required a change to the staffing pattern to meet resident needs:<br><br>"July 18, 2022<br>SOD #8DXE12,<br>NOTICE and ORDER, NOTICE OF VIOLATION, ORDER TO COMPLY<br>WITH REQUIREMENTS:<br><br>AS SOON AS PRACTICABLE AND WITHOUT DELAY, within 45 days of receipt of this notice, the licensee shall achieve and maintain substantial compliance with all requirements. All operational and resident records required as evidence of compliance with applicable rules will be available to department representatives upon request ...<br><br>Ensure staffing patterns will be sufficient to meet the personal care needs of residents, to ensure needed supervision, to provide needed services (e.g., toileting, bathing, medication management, interventions to prevent falls, personal cares, meals), and to facilitate a safe evacuation of the building in the event of an emergency.<br>- Provide sufficient, qualified staff members on duty and immediately available at all times, when a resident or residents (as a group) require the assistance of two or more staff members to address care and service needs, to provide supervision, or to evacuate the building in an emergency.<br>- Implement a fall management program to include (a) documenting comprehensive assessments to identify and address risks and incidents, (b) developing the Individualized Service Plan (ISP) with specific measures to address fall risks and prevent injuries, (such as | {N 396} | | |

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| {N 396} | Continued From page 94<br>increased supervision, therapy services, environmental modifications, positioning or other assistive devices, or assistance with ambulation, toileting, bathing), (c) staff response when falls occur, including monitoring for, and documentation of, changes in resident status following a fall, and (d) immediate notification of legal representative and physician when there is an incident, injury, or significant change.<br><br>Additionally:<br>- All managers and resident care staff (as appropriate) will receive in-service training regarding the provider's written procedures required by Order #1.<br>- Training will be documented in employee files and will include the date/duration of training, the signature/qualifications of the instructor, and an outline of course content.<br>- A copy of the written procedures and all documentation as evidence of meeting the requirements in Order #1 will be made available to department representatives upon request."<br><br>The special order was not complied with and resulted in a third citation SOD 8DXE13 (dated 12/19/2022) which included a special order not to admit any new residents.<br><br>Administrator A could not state why the provider continued to allow only 1 staff present in the MC unit after it was cited 3 times as unsafe and not meeting resident needs. Administrator A reviewed the list of residents as confirmed all 9 residents in the MC unit required 24-supervision. Administrator A confirmed at least 1 resident (Resident 7) will wander the halls including entering other resident rooms, taking items, and/or follow the caregivers. Administrator A identified Resident 7 as having multiple | {N 396} | | |

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| {N 396} | Continued From page 95<br>elopements and a history of physically aggressive behaviors towards staff and other residents. Administrator A and Regional RN B acknowledged when 1 caregiver in MC is assisting in a resident room, s/he would not know if an altercation was happening with resident in the common room and therefore would not be able to assist or call for assistance.<br><br>After reviewing the noncompliance with the enforcement requirements, the continued potential for resident harm when left without supervision to meet residents' needs, and lack of cares provided during the exit interview, on 09/13/2022 at approximately 4:00 PM with Administrator A, Regional RN B and Administrator C, the provider continued to not ensure adequate staffing for the safety of the residents. Surveyors returned on 10/02/2023 and found the MC unit continued to be staffed with 1 caregiver.<br><br>Cross Reference<br>N0348 DHS 83.32(3)(d) Rights Of Residents: Free From Mistreatment<br>N0353 DHS 83.32(3)(i) Rights Of Residents: Adequate Treatment<br>N0358 DHS 83.32(3)(n) Rights Of Residents: Safe Environment<br>N0362 DHS 83.33(1)(d) Grievance Procedure: Written Summary<br>N0489 DHS 83.44(2)(a) Rooms Clean And Free From Odors | {N 396} | | |
| N 409 | 83.37(1)(j) Proof-of-use record.<br><br>Proof-of-use record. The CBRF shall maintain a proof-of-use record for schedule II drugs, subject to 21 USC 812 (c), and Wisconsin ' s uniform controlled substances act, ch. 961, Stats, that | N 409 | | |

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| N 409 | Continued From page 96<br>contains the date and time administered, the resident ' s name, the practitioner ' s name, dose, signature of the person administering the dose, and the remaining balance of the drug. The administrator or designee shall audit, sign and date the proof-of-use records on a daily basis.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the provider did not ensure schedule II drugs were audited, signed out, and dated for proof-of-use on a daily basis for 1 of 1 (Resident 3) residents reviewed.<br><br>Resident 3 was prescribed oxycodone. Resident 3's proof-of-use sheet contained discrepancies. Facility staff did not audit the proof-of-use sheets timely to discover the discrepancies and conduct an investigation.<br><br>Findings include:<br><br>A facility policy titled, "CONTROLLED SUBSTANCES" dated 01/15/2014 stated, "It is the policy of Care Partners Assisted Living, LLC/Country Terrace of Wisconsin, Inc. to keep Schedule II controlled substances separately locked and secured in fastened boxes, drawers, or fixed compartments within the locked medication area. Controlled substances include Schedule II drugs. The Schedule II Drugs will also be accounted for through a count record that will be audited daily by the Director, or her/his designee...3. The amount of each controlled substance in storage will be counted and compared to the Proof of Use Form (RES 34) to assure that all medications are accounted for. This will be done at each shift change. When all controlled substances are accounted for, the two | N 409 | | |

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| N 409 | Continued From page 97 | N 409 | | |

staff members completing the count will sign the Controlled Substances - Count Record (Form RES 33). 4. If the remaining balance of a controlled substance in storage does not match the Proof of Use Form (RES 34), the Director or Assistant Director is to be notified to handle the investigation and a call will be placed to the Regional Nurse for further instructions. 5. The Controlled Substances - County Record (Form RES 33) shall be audited each day by the Director or his/her designee. The Director will appoint lead staff on weekends and/or in the Director's absence, (person administering medications), to audit and initial the form RES 33, to assure compliance with narcotic counts from previous twenty-four (24) hour period."

On 07/10/2023, the Department received a facility self report regarding narcotic misappropriation. The report indicates a supply of 30 oxycodone tablets was delivered for Resident 3 on 06/19/2023. The tablets were signed for and placed in the medication cart. The staff assigned to that medication cart left at 2am and never returned after 06/19/2023. On 06/30/2023, both proof-of-use sheets and empty bubble pack were discovered in common area furniture drawer by Resident 3. Law enforcement was contacted and an internal investigation conducted. On 07/28/2023, the Department received a second facility self report regarding additional oxycodone tablets missing for Resident 3. The report indicated on 07/15/2023 staff slid Resident 3's bubble pack of 8 oxycodone tablets under the nurse's office door because there was no proof of use sheet with the bubble pack. On 07/21/2023, when Resident 3 requested the medication, staff were unable to locate the bubble pack in the nurse's office. Law enforcement was called to the facility and an internal investigation conducted.

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| N 409 | Continued From page 98<br><br>On 09/11/2023 and 09/13/2023, Surveyors conducted onsite visits to the facility.<br><br>On 09/13/2023, Surveyor reviewed one Resident 3's "Proof of Use Sheet" for Oxycodone 5 mg (milligram) tablet to be administered as needed. The sheet indicates Resident 3 had a total of 15 tablets delivered on 05/16/2023. Resident 3 was administered 1 tablet on the following days:<br>05/22/2023 leaving 14 remaining<br>06/01/2023 leaving 13 remaining<br>06/02/2023 leaving 12 remaining<br>A line that is scribbled out, date is not legible, however, the amount given was "1" by Caregiver H with initials of Administrator A next to name, leaving 11 remaining<br>A line that is scribbled out, date is not legible, however, the amount given was "1" by Assistant Director E with initials of Administrator A next to name, leaving 10 remaining<br>06/15/2023 leaving 8 remaining<br>The sheet does not explain the count discrepancy between 06/02/2023 and 06/15/2023, nor the reason for the scribbled out lines.<br><br>On 09/13/2023 at 2:00 PM, Surveyor interviewed Assistant Director E. Surveyor showed Assistant Director E the above mentioned proof-of-use sheet. Assistant Director E stated Administrator A signed Assistant Director E's name on the proof-of-use sheet. Assistant Director E stated s/he did not pass oxycodone to Resident 3 and did not sign the proof-of-use sheet and directed Administrator A to cross out Assistant Director E's name. Assistant Director E did not know what happened to the 4 missing pills.<br><br>On 09/13/2023 at approximately 3:00 PM, Surveyor interviewed Administrator A. Surveyor | N 409 | | |

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| N 409 | Continued From page 99<br>discussed proof-of-use sheet with Administrator A. Administrator A acknowledged the discrepancy on the proof-of-use sheet. Administrator A verified s/he scribbled out the 2 lines on the proof-of-use sheet. Administrator A was unable to explain or provide documentation of an investigation into the additional 4 missing oxycodone tablets.<br><br>On 09/13/2023 at 3:30 PM, Surveyor interviewed Regional RN B regarding the misappropriation allegation and the additional discrepancy found on the proof-of-use sheet. Surveyor discussed that the card with 8 missing oxycodone tablets, should have had 12 pills in it. Regional RN B stated, "I thought we sent in a report to the department about the missing card?" Surveyor explained the report did notify the department of the missing card but did not contain any information as to how many pills were on the card. Regional RN B was unable to explain or provide documentation of an investigation into the 4 missing oxycodone tablets.<br><br>On 09/13/2023, Surveyor reviewed the provider's "Controlled Substances - Count Record (RES 33)" for June 2023 for all controlled substances in the medication carts.<br><br>Between 06/02/2023 and 06/15/2023, Surveyor noted employees had counted the controlled substances on hand and found that the quantity of each medication counted was in agreement with the quantity stated on each Controlled Substance-Proof-of-use Form in each resident's record. However, two employees were not always signing off on the form as directed per facility policy. These dates included: 06/01/2023 - 06/07/2023, 06/09/2023, 06/10/2023, and 06/12/2023 - 06/15/2023. | N 409 | | |

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| N 409 | Continued From page 100<br><br>On 09/13/2023 at 3:30 PM, Surveyor interviewed Registered Nurse (RN) B and Administrator C (of sister facility). Surveyor reviewed the "Controlled Substances - Count Record" with both of them. RN B and Administrator C verified the records did not 2 signatures on the above dates which was required per facility policy. RN B and Administrator C were unable to explain the discrepancy for the 4 missing oxycodone tablets, nor were they able to provide documentation of an investigation into the 4 missing oxycodone tablets. RN B and Administrator C had indicated they would be reviewing the the controlled substance policy with staff and implementing additional procedures to ensure staff were auditing the proof-of-use sheets daily and notifying management when there are discrepancies.<br><br>In summary, Resident 3 was prescribed oxycodone. Resident 3's oxycodone controlled substance proof-of-use sheet contained a discrepancy. Facility staff did not audit the proof-of-use sheets to discover the discrepancy. The discrepancy was found after over a month later when Resident 3's oxycodone tablets were missing for the second time.<br><br>Cross Reference N0158 DHS 83.12(2)(a) Caregiver: Investigating Abuse and Neglect | N 409 | | |
| N 415 | 83.37(2)(d) Documentation of medication administration.<br><br>Documentation of medication administration. As required under s. DHS 83.42(1)(o), at the time of medication administration, the person administering the medication or treatment shall document in the resident record the name, | N 415 | | |

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| N 415 | Continued From page 101<br>dosage, date and time of medication taken or treatments performed and initial the medication administration record. Any side effects observed by the employee or symptoms reported by the resident shall be documented. The need for any PRN medication and the resident ' s response shall be documented.<br><br>This Rule is not met as evidenced by:<br>Based on observation, interview and record review, the provider did not ensure staff administering the medication or treatment documented in the resident record the name, dosage, date and time of the medication taken or treatment received and initialed the medication administration record (MAR).<br><br>Resident 1's June 2023 MAR contained 7 days where staff did not document if Resident 1 refused/received medications or treatments. Resident 1's July 2023 MAR contained 4 days where staff did not document if Resident 1 refused/received medications or treatments. Resident 1's August 2023 MAR contained 7 days where staff did not document if Resident 1 refused/received medications or treatments. Resident 1's September 2023 MAR contained 2 days where staff did not document if Resident 1 refused/received medications or treatments.<br><br>Resident 2's August MAR contained 9 days where staff did not document if Resident 2 refused/received medications or treatments. Resident 2's September MAR contained 2 days where staff did not document if Resident 2 refused/received medications or treatments.<br><br>Medication Passer D was observed during | N 415 | | |

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| N 415 | Continued From page 102 | N 415 | | |

medication pass to sign the MAR before administering medications for 5 of 5 (Resident 1, 4, 5, 6 and 7) residents observed.

Findings Include:

On 07/18/2023, the department received a complaint regarding medication administration.

On 09/11/2023 and 09/13/2023, Surveyors conducted an onsite visit to the facility. A sample of resident records were requested, including the resident records of Resident 1 and 2.

A facility policy titled, "MEDICATIONS STORAGE/ADMINISTRATION/DOCUMENTATIO N" dated 12/12/12 states, "...Chart on the MAR as soon as the medication is consumed..."

Resident 1
Surveyor reviewed Resident 1's MAR for June, July, August and September 2023. Additionally, Surveyor reviewed Resident 2's MAR for August and September 2023. Review of the MARs showed days where medication administration or treatments were not documented as indicated by no medication passer's initials on specific dates.

RESIDENT 1: Missing Documentation on MARs:

Ensure drink 1 can twice daily with lunch and dinner:
12PM dose on 07/23/2023, 08/15/2023, 08/25/2023
4PM dose on 06/05/2023, 06/16/2023, 06/20/2023, 07/21/2023, 08/11/2023, 08/13/2023, 08/16/2023 and 09/01/2023

Quetiapine Fumarate 50mg (milligrams) take 1 tablet by mouth at 8AM, 4PM and 8PM:

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| N 415 | Continued From page 103<br>8AM dose on 07/23/2023<br>4PM dose on 06/05/2023, 06/16/2023, 06/20/2023, 07/21/2023, 08/11/2023, 08/13/2023, 08/16/2023 and 09/01/2023<br>8PM dose on 07/28/2023<br><br>ABHR -10 gel apply 0.5mL (milliliters) topically every 6 hours for anxiety agitation:<br>2PM dose on 07/23/2023, 08/15/2023, 08/25/2023<br>8PM dose on 06/04/2023, 06/17/2023, 06/18/2023, 07/27/2023, 07/28/2023<br><br>Sensi-Care protect barrier apply topically to buttocks and groin twice daily:<br>8AM dose on 07/23/2023<br>8PM dose on 06/09/2023, 07/28/2023<br><br>Tramadol HCL 50mg take 1/2 tablet (25mg) by mouth 3 times a day:<br>8AM dose on 07/23/2023<br>2PM dose on 07/23/2023, 08/01/2023<br>8PM dose on 06/09/2023, 07/28/2023, 08/02/2023<br><br>Levothyroxine 50mcg (micrograms) take 1 tablet by mouth daily:<br>7AM dose on 07/23/2023<br><br>ACT fluoride Dental Rinse use 1 capful daily in the morning after breakfast:<br>8AM dose on 07/23/2023<br><br>Cranberry with Vitamin C take 1 softgel daily:<br>8AM dose on 07/23/2023<br><br>Docusate Sodium 50mg/5mL take 10mL (100mg) every other day:<br>8AM dose on 07/23/2023 | N 415 | | |

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| N 415 | Continued From page 104<br>Escitalopram 20mg take 1 tablet daily:<br>8AM dose on 07/23/2023<br><br>Neomycin/Polymyxin B/Dexametha place 0.5" (inch) strip into conjunctival sac of bilateral eye twice daily:<br>8AM dose on 07/23/2023<br>8PM dose on 07/28/2023<br><br>Nystatin Powder apply topically to groin twice daily until healed:<br>8AM dose on 07/23/2023<br>8PM dose on 07/28/2023<br><br>Polyethylene Glycol mix 17gm in 4-8 ounces of liquid and drink by mouth daily:<br>8AM dose on 07/23/2023<br><br>Senna tablet give one daily:<br>8AM dose on 07/23/2023<br><br>Senna Lax 8.6mg tablet take 1 tablet twice daily:<br>8PM dose on 09/01/2023 and 09/02/2023<br><br>Resident 2<br>RESIDENT 2: Missing Documentation on MARs:<br><br>Humalog 75/25 Mix kwikpen prime with 2 units. inject 33 units once daily:<br>12PM dose on 08/04/2023, 08/26/2023 and 08/27/2023<br><br>Test blood sugar 3-4 times daily:<br>4PM test on 08/01/2023, 08/02/2023, 08/03/2023, 08/05/2023<br>8PM test on 08/01/2023, 08/02/2023, 08/03/2023, 08/05/2023, 08/29/2023 and 09/05/2023<br><br>Acetaminophen 325mg take 2 tablets (650mg) three times daily: | N 415 | | |

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| N 415 | Continued From page 105<br>2PM dose on 08/14/2023<br><br>Trulicity 3mg/0.5mL pen inject 0.5mL (3mg)- once weekly:<br>Missed weekly dose on 09/06/2023<br><br>Medication Pass Observation<br>On 09/13/2023 at 7:50 AM, Surveyor observed medication pass for Resident 5 with Medication Passer D. Medication Passer D donned gloves and prepared medications for administering. Once prepared, Medication Passer D used a pen to write initials on Resident 5's MAR (Medication Administration Record) indicating the medications were given. Medication Passer D then proceeded to walk out of the medication room and to Resident 5's room to administer medications. After administering medications, Medication Passer D returned to the medication room, threw medication cup away and removed gloves.<br><br>Medication Passer D donned a new pair of gloves and continued with medication pass for Resident 6. Medication Passer D prepared medications for administering. Once prepared, Medication Passer D then used a pen to write initials on Resident 6's MAR indicating the medications were given. Medication Passer D then proceeded to walk out of the medication room and to Resident 6's room to administer medications. After administering medications, Medication Passer D returned to the medication room, threw medication cup away and removed gloves.<br><br>Medication Passer D donned a new pair of gloves and continued with medication pass for Resident 4. Medication Passer D prepared medications for administering. Once prepared, Medication Passer D then used a pen to write initials on Resident 4's MAR indicating the medications were given. | N 415 | | |

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| N 415 | Continued From page 106<br><br>Medication Passer D then proceeded to walk out of the medication room and to Resident 4's room to administer medications. After administering medications, Medication Passer D returned to the medication room, threw medication cup away and removed gloves.<br><br>Medication Passer D donned a new pair of gloves and continued with medication pass for Resident 1. Medication Passer D prepared medications for administering. Once prepared, Medication Passer D then used a pen to write initials on Resident 1's MAR indicating the medications were given. Medication Passer D then proceeded to walk out of the medication room and to Resident 1 who was sitting in dining room with family to administer medications. After administering medications, Medication Passer D returned to the medication room, threw medication cup away and removed gloves.<br><br>Medication Passer D donned a new pair of gloves and continued with medication pass for Resident 7. Medication Passer D prepared medications for administering including crushing the medications and adding them to a cup with pudding. Medication Passer D then used a pen to write initials on Resident 7's MAR indicating the medications were given. Medication Passer D then proceeded to walk out of the medication room and to Resident 7 who was in living room to administer medications. Resident 7 took a spoonful of medications, and then needed to go to the bathroom. Medication Passer D assisted Resident 7 to the bathroom. Resident 7 did not want to take the rest of the medications. Medication Passer D brought the medication cup with the crushed medications and pudding back to the medication room and put it in the medication cart. | N 415 | | |

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| N 415 | Continued From page 107<br><br>On 09/13/2023 at 3:30 PM, Surveyor interviewed Administrator A and Regional Registered Nurse (RN) B regarding the above observations and MAR review for Resident 1 and 2. Administrator A verified the dates did not have staff initials. Administrator A indicated staff probably passed the medications but just forgot to document that the medications were passed. Regional RN B agreed with Administrator A. Additionally, Regional RN B indicated s/he teaches the medication class to staff and teaches staff to initial the MAR after administering the medications not before. | N 415 | | |
| N 423 | 83.37(3)(g) Medication storage: controlled substances.<br><br>Controlled substances. The CBRF shall provide separately locked and securely fastened boxes or drawers or permanently fixed compartments within the locked medications area for storage of schedule II drugs subject to 21 USC 812 (c), and Wisconsin ' s uniform controlled substances act, ch. 961, Stats.<br><br>This Rule is not met as evidenced by:<br>Based on interview and record review, the provider did not provide separately locked and securely fastened boxes or drawers or permanently fixed compartments within the locked medications area for storage of schedule II drugs.<br><br>On 07/15/2023, Resident 3's oxycodone unit dose card was slid under the nurse's office door. The door is locked, however, the unit dose card was not separately locked or securely fastened within | N 423 | | |

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| N 423 | Continued From page 108<br>the room. On 07/21/2023, the oxycodone unit dose card was reported missing.<br><br>Findings Include:<br><br>On 07/28/2023, the Department received a facility self report regarding oxycodone tablets missing for Resident 3. The report indicated on 07/15/2023 staff slid Resident 3's unit dose card of 8 oxycodone tablets under the nurse's office door because there was no proof of use sheet with the unit dose card. On 07/21/2023, when Resident 3 requested the medication, staff were unable to locate the unit dose card in the nurse's office. Law enforcement was called to the facility and an internal investigation conducted.<br><br>A facility policy titled, "CONTROLLED SUBSTANCES" dated 01/15/2014 stated, "It is the policy of Care Partners Assisted Living, LLC/Country Terrace of Wisconsin, Inc. to keep Schedule II controlled substances separately locked and secured in fastened boxes, drawers, or fixed compartments within the locked medication area. Controlled substances include Schedule II drugs."<br><br>On 09/11/2023 and 09/13/2023, Surveyors made an onsite visit to the facility.<br><br>On 09/13/2023 at 2:00 PM, Surveyor interviewed Assistant Director E. Assistant Director E verified s/he received a call on 07/15/2023 from Caregiver H that Resident 3's unit dose card of oxycodone that was in medication cart did not have a proof of use sheet. Assistant Director E stated per policy, the unit dose card needs to have a proof of use sheet with it. Assistant Director E stated s/he directed Caregiver H and another caregiver to "stick together, stay on | N 423 | | |

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| N 423 | Continued From page 109<br>speaker phone with me and walk to the nurse's office door and slide the oxycodone card under the door. I heard them kick the door, so I know they did." Assistant Director E stated the oxycodone were then reported missing on 07/21/2023. Assistant Director E verified the nurse's office door is locked with only 4 people (Administrator A, Assistant Director E Receptionist Y, and Caregiver X) having keys to the room. Assistant Director E stated s/he did not let any one know about the oxycodone being slid under the door, as s/he assumed when one of the other 3 would go into the room next and they would see the oxycodone card laying on the floor. Assistant Director E verified the oxycodone unit dose card was slid under the door and not placed in the lock box within the nurse's office. Assistant Director E stated approximately a week later, the oxycodone card was missing.<br><br>Cross Reference:<br>N0158 DHS 83.12(2)(a) Caregiver: Investigating Abuse and Neglect<br>N0172 DHS 83.12(6) Documentation Requirements for Written Report | N 423 | | |
| N 432 | 83.38(1)(h) Medication administration.<br><br>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. | N 432 | | |

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This Rule is not met as evidenced by:
Based on observation, interview and record review, the provider did not provide medication administration appropriate to the resident's needs for 1 of 1 (Resident 1) residents reviewed.

During medication pass, Medication Passer D applied ABHR (Ativan, Benadryl, Haldol, Reglan) gel to Resident 1's chest instead of wrist. Medication Passer D then used same soiled gloved hand to apply eye ointment to Resident 1's right eye. Medication Passer D did not apply eye ointment to left eye as ordered.

Findings Include:

On 07/18/2023, the Department received a complaint regarding medications.

On 09/11/2023 and 09/13/2023, Surveyors conducted an onsite visit to the facility. A sample of residents was selected, including Resident 1. Resident 1 was admitted to the facility on 03/31/2018 with diagnoses to include the following: Alzheimer's Disease, anxiety, depression, glaucoma, osteoarthritis and spinal stenosis. Resident 1's most recent ISP (individualized service plan) dated 02/07/2023 indicated Resident 1 cannot make needs known, has an activated power of attorney (POA), needs total assistance with self care and uses a sit to stand lift and broda chair. Resident 1's ISP indicates "both the left and right eye are to be getting ointment at 8am and 8pm." Resident 1's ISP indicates Resident 1 has tendencies to be verbal and physical with staff with behaviors. Staff is to try to put music on and let Resident 1 try to

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calm down that way and if that does not work, hospice is to be called before any as needed medication is given. The ISP does not mention the use of ABHR gel. The ISP does not reference the hospice plan of care regarding the ABHR gel or eye ointment.

Resident 1's September 2023 MAR (Medication Administration Record) and hospice medication list indicate Resident 1 is to receive:
" ABHR-10 gel topically every 6 hours for anxiety agitation.
" Neomycin/polymyxin B/Dexametha place 0/5"(inch) strip into conjunctival sac of bilateral eye twice daily for blepharitis (an inflammation of the eyelids due to an infection at the base of the eyelashes or when the tiny oil glands at the base of the eyelashes become clogged.)

On 09/11/2023 at 11:30 AM, Surveyor interviewed Family Member Q and R. Family Member Q verified s/he was the activated POA for Resident 1. Family Member Q and R both expressed concerns with Resident 1's medication administration. Family Member Q and R stated Resident 1 uses ABHR gel for agitation. The gel was being applied to Resident 1's chest and back on alternating days. Resident 1 developed a rash on chest and back because of the gel. [Photo 1 and 2] Family Member Q stated that s/he requested the gel to be applied to Resident 1's wrists on alternating days. Family Member Q and R indicated this is not being done consistently by staff. Additionally, Family Member Q and R had concerns about Resident 1's eye and the application of the eye ointment. Family Member Q stated the ointment was prescribed because Resident 1 was diagnosed with blepharitis. [Photo 3, 4 and 5] Family Member Q and R did not feel staff were administering the eye ointment per

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prescription because Resident 1's eye was not getting better.

On 09/13/2023 at 7:50 AM, Surveyor observed medication pass with Medication Passer D. Surveyor observed a white piece of paper hanging in the medication room with the words, "[Resident 1] please put ABHR gel on alternating wrists." The words were highlighted in pink. Medication Passer D donned a new pair of gloves touched medication cards, drawer handles, bag with eye ointment, bag with ear drops and bag of ABHR gel syringes. Medication Passer D then popped out medication into gloved hand and dropped the medication into the medication cup, this was done for all oral medications. Medication Passer D put the medication cards away. Medication Passer D took the medication cup and emptied it into a bag and crushed the medications in the bag. Medication Passer D grabbed a small cup and added pudding and the crushed medications. Medication Passer D then used a pen to write initials on Resident 1's MAR indicating the medications were given. Medication Passer D then proceeded to walk out of the medication room and to Resident 1 who was sitting in dining room with Family Member R to administer medications. Medication Passer D took ABHR gel syringe and emptied contents onto gloved hand. Medication Passer D then took gloved hand and wiped the gel onto Resident 1's chest. Without changing gloves or sanitizing hands, Medication Passer D administered Resident 1's oral medications. Medication Passer D continued with same pair of gloves and placed eye ointment on soiled gloves and rubbed the soiled gloved hand directly on Resident 1's right eye. Medication Passer D did not put eye ointment on left eye. Medication Passer D did not change gloves or sanitize hands and

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| N 432 | Continued From page 113<br>administered Resident 1's ear drops. After administering medications, Medication Passer D returned to the medication room, threw medication cup away and removed gloves.<br><br>On 09/18/2023 at 3:30 PM, Surveyor interviewed Family Member R. Family Member R verified Medication Passer D rubbed the ABHR gel on Resident 1's chest, not on wrists. Family Member R also verified Medication Passer D used a soiled gloved hand to rub the eye ointment onto Resident 1's right eye. Family Member R stated the family has purchased q-tips for staff to use to apply the eye ointment. Family Member R stated, "I have seen staff do this before."<br><br>On 09/13/2023 at 3:30 PM, Surveyor shared the above observation with Regional Registered Nurse B and Administrator C (of sister facility). Regional RN B verified a discussion with staff about placing the ABHR gel on Resident 1's wrists occurred and staff are taught to use an applicator when placing eye ointment on the eye. Regional RN B indicated Medication Passer D did not follow the policy for applying eye ointment. | N 432 | | |
| {N 439} | 83.39(1) Infection control program.<br><br>The licensee shall establish and follow an infection control program based on current standards of practice to prevent the development and transmission of communicable disease and infection.<br><br>This Rule is not met as evidenced by:<br>Based on interview, record review and observations, the provider did not establish and | {N 439} | | |

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| {N 439} | Continued From page 114<br>follow an infection control program based on current standards of practice to prevent the development and transmission of COVID-19.<br><br>The provider did not revise an existing infection control policy or develop a new policy related to COVID-19. The provider required staff who were COVID-19 positive to work without a waiver and with residents who were COVID-19 negative and medically vulnerable.<br><br>This requirement is being cited for a second time. See Statements of Deficiency (SOD) 8DXE12, dated 02/02/2022 and SOD 8DXE13, dated 12/19/2022.<br><br>Findings Include:<br><br>The facility is licensed to serve up to 56 residents who may be advanced age, physically disabled, have irreversible dementia/Alzheimer's disease, and/or be terminally ill.<br>Infection control Policy:<br><br>According to the Department's COVID-19 Assisted Living webpage:<br><br>"Assisted living facilities care for residents who are elderly and/or have chronic medical conditions that place them at higher risk of developing severe complications from COVID-19. The guidance is designed to assist facilities in improving their infection prevention and control practices to prevent the transmission of COVID-19 and keep residents and the staff who care for them safe from infection."<br><br>"Universal Screening - Assisted living facilities should actively screen anyone entering the facility for fever and symptoms of COVID-19 or known | {N 439} | | |

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| {N 439} | Continued From page 115<br><br>exposure to someone with COVID-19. The required screening includes, all staff, visitors, hospice, clergy, external healthcare personnel, surveyors, and all vendors. Every individual should be asked about COVID-19 symptoms (for example, fever [measured temperature 100.0 °F or higher or subjective fever], cough, shortness of breath, sore throat, or muscle aches, and must have their temperature checked daily) ...Visitors who have a fever and/or are symptomatic for COVID-19 should not be allowed to enter the facility."<br><br>"Rapidly Identify and Properly Respond to Residents with Suspected or Confirmed COVID-19: Older adults with COVID-19 may not show common symptoms such as fever or respiratory symptoms. Less common symptoms can include new or worsening malaise, headache, or new dizziness, nausea, vomiting, diarrhea, loss of taste or smell. Additionally, more than two temperatures higher than 99.0°F might also be a sign of fever in this population. Identification of these symptoms should prompt isolation and further evaluation for COVID-19. Designate one or more facility employees to ensure all residents have been screened at least daily for fever and symptoms consistent with COVID-19."<br><br>The webpage also provides guidance to providers for admissions/discharges, visitation, communal dining, activities, testing, isolation/quarantine, use of face masks/source control and return to work guidance for staff who contract the virus.<br><br>Source: https://www.dhs.wisconsin.gov/COVID-19/assisted-living.htm, retrieval date 09/26/2023. | {N 439} | | |

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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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| {N 439} | Continued From page 116<br><br>Statement of Deficiency (SOD) #8DXE13 dated 12/19/2022 and Notice and Order letter was sent to the provider via certified electronic mail on 05/15/2023. The licensee was ordered to comply with the requirements specified by Wis. Stat. ch. 50 and Wis. Admin. Code ch. DHS 83 and special orders as soon as practicable and without delay, within 45 days of receipt (06/28/2023.)<br><br>The notice of special orders indicated:<br><br>"SPECIAL ORDERS<br><br>Based on the results of the Department's investigation, and pursuant to Wis. Stat. § 50.03(5g)(b), EFFECTIVE UPON RECEIPT OF THIS NOTICE and ORDER, the Department of Health Services HEREBY ORDERS that Care Partners Assisted Living Hortonville:<br><br>1. Pursuant to Wis. Stat. § 50.03(5g)(b)6., EFFECTIVE IMMEDIATELY, the licensee shall ensure the provision of services to meet residents' physical and mental health needs. The licensee shall develop and implement corrective measures in consultation with a registered nurse (RN) not currently affiliated with the licensee. The RN will have knowledge of assisted living regulations (e.g., Wis. Admin. Code ch. 83, Wis. Stat. ch. 50) and knowledge of the client groups served by Care Partners Assisted Living Hortonville.<br><br>Consultation will include the development (or revision) of written procedures and staff training (as appropriate) to address:<br>...<br>Infection Control<br>-Including how the provider will implement an infection control program based on current | {N 439} | | |

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| {N 439} | Continued From page 117<br>standards of practice to prevent the development and transmission of communicable disease and infections. The infection control program will include, at a minimum, current guidance for the prevention, identification, and monitoring of respiratory infections, including COVID-19 and influenza, along with Transmission-Based Precautions to be used when caring for residents. Resources are available at: https://www.dhs.wisconsin.gov/covid-19/assisted-living.htm and https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html<br><br>Additionally:<br>- All managers and resident care staff (as appropriate) will receive in-service training regarding the facility's written procedures required by Order #1.<br>- Training will be documented in employee files and will include the date/duration of training, the signature/qualifications of the instructor, and an outline of course content.<br>- Consultation activities, including dates of consultation, will be documented, signed and dated by the consultant.<br>- A copy of the written procedures and all documentation as evidence of meeting the requirements in Order #1 will be made available to department representatives upon request."<br><br>On 09/11/2023 and 09/13/2023, Surveyors conducted an onsite verification visit for SOD 8DXE13:<br><br>On 09/13/2023, at approximately 4:00 PM, Surveyors interviewed Regional RN B, Administrator A, and Administrator C. Surveyor requested the current policy and procedure for infection control including COVID-19 as a part of | {N 439} | | |

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| {N 439} | Continued From page 118<br>the verification visit. Surveyor reviewed the SOD from the surveys conducted on 02/02/2022 and 12/19/2022. When asked if the facility's infection control policy had been updated since the survey conducted on 12/19/2022 to address COVID-19 and current standards of practice, Regional RN B stated there had not been changes to the policy. Regional RN B stated s/he was aware the policy was required to be updated and had submitted a draft to the corporate office on 07/19/2023 (22 days after the date of correction deadline on 06/28/2023.) Regional RN B stated the draft had yet to be approved and the infection control program remained the same. Regional RN B stated the same policy is used for all of the corporation's facilities and, once corrected, will be implemented in all.<br><br>As the required enforcement was not completed, the required employee training and documentation of training was not completed.<br><br>On 09/25/2023, at 9:20 AM, Surveyor interviewed Caregiver RR. Caregiver RR stated s/he has worked at the facility multiple times prior to the most recent hire about a month or 2 ago. Caregiver RR stated s/he was running a fever on Friday and tested positive for Covid on Saturday (9/23/2023). Caregiver RR stated s/he called and told Administrator A and Administrator A stated, "If you don't show up, you will be terminated." Caregiver RR stated s/he needed to find own replacement or work. Caregiver RR stated, "They are making staff work who are Covid positive."<br><br>Cross Reference N0441 DHS 83.39(3) Hand Washing | {N 439} | | |

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| N 441 | Continued From page 119 | N 441 | | |
| N 441 | 83.39(3) Hand washing.<br><br>Employees shall follow hand washing procedures according to centers for disease control and prevention standards.<br><br>This Rule is not met as evidenced by:<br>Based on observation, staff interviews and record review, the provider did not follow and maintain hand washing procedures according to CDC (Centers for Disease Control and Prevention) standards to help prevent the development and transmission of disease and infection for 5 of 5 (Resident 1, 4, 5, 6 and 7) residents reviewed.<br><br>This requirement is being cited for a third time. See Statements of Deficiency (SOD) 8DXE12, dated 02/02/2022 and SOD 8DXE13, dated 12/19/2022.<br><br>Findings Include:<br><br>Per CDC (Centers for Disease Control and Prevention) website at https://www.cdc.gov/handhygiene/providers/index with the page last updated on January 8, 2021 entitled "Hand Hygiene in Health Care Settings" indicated, "Multiple opportunities for hand hygiene may occur during a single care episode. Following are the clinical indications for hand hygiene: immediately before touching a patient, when hands are visibly soiled, before performing an aseptic task (e.g., placing an indwelling device) or handling invasive medical devices, before moving from work on a soiled body site to a clean body site on the same patient, after touching a patient or the patient's immediate environment, after contact with blood, body fluids or contaminated surfaces, immediately after glove removal..." | N 441 | | |

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| N 441 | Continued From page 120<br><br>The Morbidity and Mortality Weekly Report dated 10/25/02 and published by the CDC entitled "Guideline for Hand Hygiene in Health Care Settings" indicated recommendations to wash hands after removing gloves and to decontaminate hands after contact with body fluids or excretions and when moving from a contaminated body site to a clean body site during patient care. The above information can also be found at: https://www.cdc.gov/handhygiene/index.html with the page last updated on January 1, 2021.<br><br>A facility policy titled, "Medications Storage/Administration/Documentation" dated 12/12/2012, states, "It is the policy of Care Partners Assisted Living, LLC/Country Terrace of Wisconsin, Inc.("Care Partners/Country Terrace") that all medications are stored, labeled, administered, and documented correctly per state regulations...Administration...Wash hands before starting, in between residents, before and after treatments...Do not touch medications with your hands...Eye Ointment Administration Procedure...Prior to administering eye ointment, explain the procedure to the patient and check the expiration date of the medication...1. Wash hands thoroughly. Gloves should be worn. 2. To facilitate the flow of ointment, hold the tube in your hand several minutes to warm before use. 3. When opening a tube for the first time squeeze out the first 1/4 inch of ointment and discard, as it may be too dry. 4. Position patient with head tilted backward or lying down and gazing upward. 5. Gently pull lower eyelid down to form a pouch. 6. Apply 1/4 to 1/2 inch- of ointment inside the lower eye by gently squeezing the tube. The tip of the tube must not come in contact with the eye, fingers or any surface. 7. Instruct the patient to | N 441 | | |

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| N 441 | Continued From page 121<br>close eye and roll eyeball in all directions to allow for even distribution of the ointment over the eye. 8. After administration keep the eye closed for one (1) or two (2) minutes. Do not squeeze eyes shut as this will force medication from the eye. 9. Wipe off excess ointment with gauze or tissue around eye or ointment tube tip...14. Wash hands thoroughly."<br><br>On 09/13/2023 at 7:50 AM, Surveyor observed medication pass for Resident 5 with Medication Passer D. Medication Passer D donned gloves and touched medication cards and drawer handles. Medication Passer D then punched out medication into gloved hand and dropped the medication into the medication cup, this was done for several medications. Medication Passer D put the medication cards away. Medication Passer D took the medication cup and emptied it into a bag and crushed the medications in the bag. Medication Passer D grabbed a small cup and added pudding and the crushed medications. Medication Passer D then used a pen to write initials on Resident 5's MAR (Medication Administration Record) indicating the medications were given. Medication Passer D then proceeded to walk out of the medication room and to Resident 5's room to administer medications. After administering medications, Medication Passer D returned to the medication room, threw medication cup away and removed gloves. Medication Passer D did not sanitize or handwash after removing gloves.<br><br>Medication Passer D donned a new pair of gloves and continued with medication pass for Resident 6. Medication Passer D touched medication cards, nasal spray bag, inhaler bag and drawer handles with gloved hands. Medication Passer D then punched out medication into gloved hand | N 441 | | |

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| N 441 | Continued From page 122 | N 441 | | |

and dropped the medication into the medication cup, this was done for several medications. Medication Passer D put the medication cards away. Medication Passer D then used a pen to write initials on Resident 6's MAR indicating the medications were given. Medication Passer D then proceeded to walk out of the medication room and to Resident 6's room to administer medications. After administering medications, Medication Passer D returned to the medication room, threw medication cup away and removed gloves. Medication Passer D did not sanitize or handwash after removing gloves.

Medication Passer D donned a new pair of gloves and continued with medication pass for Resident 4. Medication Passer D touched medication cards and drawer handles with gloved hands. Medication Passer D then punched out medication into gloved hand and dropped the medication into the medication cup, this was done for several medications. Medication Passer D put the medication cards away. Medication Passer D then used a pen to write initials on Resident 4's MAR indicating the medications were given. Medication Passer D then proceeded to walk out of the medication room and to Resident 4's room to administer medications. After administering medications, Medication Passer D returned to the medication room, threw medication cup away and removed gloves. Medication Passer D did not sanitize or handwash after removing gloves.

Medication Passer D donned a new pair of gloves and continued with medication pass for Resident 1. Medication Passer D touched medication cards, drawer handles, bag with eye ointment, bag with ear drops and bag of ABHR gel syringes. Medication Passer D then punched out medication into gloved hand and dropped the

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| N 441 | Continued From page 123 | N 441 | | |

medication into the medication cup, this was done for several medications. Medication Passer D put the medication cards away. Medication Passer D took the medication cup and emptied it into a bag and crushed the medications in the bag. Medication Passer D grabbed a small cup and added pudding and the crushed medications. Medication Passer D then used a pen to write initials on Resident 1's MAR indicating the medications were given. Medication Passer D then proceeded to walk out of the medication room and to Resident 1 who was sitting in dining room with family to administer medications. Medication Passer D took ABHR gel syringe and emptied contents onto gloved hand and Medication Passer D then took gloved hand and wiped the gel onto Resident 1's chest. Medication Passer D did not change gloves or wash/sanitize hands. Medication Passer D administered Resident 1's oral medications. Medication Passer D did not change gloves or wash/sanitize hands. Medication Passer D took eye ointment and placed on soiled gloves and rubbed the gloved hand on Resident 1's right eye. Medication Passer D did not change gloves or wash/sanitize hands. Medication Passer D then administered ear drops with same gloved hands. After administering medications, Medication Passer D returned to the medication room, threw medication cup away and removed gloves. Medication Passer D did not sanitize or handwash after removing gloves.

Medication Passer D donned a new pair of gloves and continued with medication pass for Resident 7. Medication Passer D touched medication cards and drawer handles with gloved hands. Medication Passer D then punched out medication into gloved hand and dropped the medication into the medication cup, this was done

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| N 441 | Continued From page 124<br>for several medications. Medication Passer D put the medication cards away. Medication Passer D took the medication cup and emptied it into a bag and crushed the medications in the bag. Medication Passer D grabbed a small cup and added pudding and the crushed medications. Medication Passer D then used a pen to write initials on Resident 7's MAR indicating the medications were given. Medication Passer D then proceeded to walk out of the medication room and to Resident 7 who was in living room to administer medications. Resident 7 took a spoonful of medications, and then needed to go to the bathroom. Medication Passer D assisted Resident 7 to the bathroom. Medication Passer D removed gloves but did not sanitize or handwash after removing gloves.<br><br>On 09/13/2023 at 3:30 PM, the above observations were shared during the exit conference with Administrator A, Regional Registered Nurse (RN) B, and Administrator C (of sister facility). Regional RN B indicated s/he does the medication class with staff and teaches staff to pop pills directly into the cup, not into hand and then into cup. Regional RN B verified they would expect staff to wash/sanitize hands after removing gloves. In addition, Regional RN B indicated Medication Passer D did not follow policy when administering eye and ear drops with soiled gloves.<br><br>Cross Reference:<br>N0439 DHS 83.39(1) Infection Control Program | N 441 | | |
| N 489 | 83.44(2)(a) Rooms clean and free from odors.<br><br>The CBRF shall keep all rooms clean and shall make reasonable attempts to keep all rooms free | N 489 | | |

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| N 489 | Continued From page 125<br>from odors.<br><br>This Rule is not met as evidenced by:<br>Based on observation, record review and interview, the provider did not make reasonable attempts to keep all rooms free from odors for 4 of 4 residents (Residents 4, 7, 8, and 9) reviewed.<br><br>Resident 4's bed sheets were soiled and room had a urine like odor.<br><br>Resident 7's bedroom contained a soiled brief on the closet floor, a bag of food under a table, 2 brown quarter size marks on the bathroom floor, red streaks on the bathroom wall and a strong urine like odor.<br><br>Resident 8 and 9's bedrooms contained a strong urine like odor.<br><br>Findings Include:<br><br>On 07/28/2023, the Department received a complaint regarding resident rooms smelling like urine.<br><br>Resident 4<br>On 09/13/2023, at approximately 8:00 AM, Surveyor conducted medication pass with Medication Passer D. Medication Passer D prepared Resident 4's medications and entered Resident 4's room. Upon entering the room, Surveyor observed Resident 4 sitting in chair with a blanket wrapped around Resident 4. Surveyor noted Resident 4's bed sheets had a large wet circle in the middle of the bed and the room had a urine like odor.<br><br>Surveyor interviewed Medication Passer D upon leaving room. Medication Passer D | N 489 | | |

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| N 489 | Continued From page 126 | N 489 | | |

acknowledged Resident 4's soiled linens and stated that depending on Resident 4's mood, s/he likes to sleep in chair. Medication Passer D did not indicate if s/he was going to address the soiled linens or if s/he would let another caregiver know that Resident 4's linens needed to be changed. Medication Passer D continued to pass medications.

On 09/13/2023, at approximately 12:45 PM, Surveyor interviewed Caregiver G. Caregiver G stated Resident 4 is independent with all cares including toileting, transferring and dressing self. Caregiver G stated staff really don't do much for Resident 4. Caregiver G stated s/he had not seen Resident 4 yet today due to Caregiver G leaving for training around 8am and returning a little after noon. Surveyor requested Caregiver G and Surveyor go to Resident 4's room. Upon entering room, Surveyor and Caregiver G noted the soiled bed sheets to still be on the bed and a strong urine odor in the room. Caregiver G immediately started to take sheets off the bed. Caregiver G and Surveyor noted the bed was wet down to the mattress (Caregiver G had removed 2 mattress pad covers). Caregiver G stated s/he would take care of cleaning the bed and putting new sheets on.

Resident 7
On 10/02/2023, at 11:30 AM, Surveyor observed Resident 7's room. Surveyor observed a strong urine like odor in the room. Additionally, Surveyor observed a soiled brief laying on the floor in the closet, a bag of food under a table, 2 brown quarter sized marks on the floor in the bathroom, red streaks on the wall by the toilet, a plastic mattress cover crumpled up on the floor by the recliner, and no bed sheets on the bed however a bedspread and chux pad were crumpled up on

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| N 489 | Continued From page 127<br>the bed.<br><br>At 12:15 PM, Surveyor interviewed Activity Director DD. Activity Director DD and Surveyor walked into Resident 7's room. Activity Director DD stated, "It stinks in here." Surveyor showed Activity Director DD the closet and s/he stated, "that's a dirty depends." Surveyor showed Activity Director DD the bathroom, "that looks like poop [regarding the brown marks]." Activity Director DD indicated the red streaks on the wall were nail polish and that maintenance has been working hard to get rid of the stains, "it looks a lot better than it was." Activity Director DD verified the food under the table.<br><br>Residents 8 and 9<br>On 09/11/2023, at approximately 9:00 AM, Surveyor toured the facility with Administrator A. During tour, Surveyor observed a very strong urine like odor in the hallway outside of rooms for Residents 8 and 9. Administrator A verified the urine smell was present in the hallway and identified the odor as coming from Resident 8 and 9's rooms. Surveyor observed the urine like odor was very strong in Resident 8 and 9's rooms. Administrator A stated the residents were incontinent of urine and the provider would regularly clean the carpets. Administrator A stated s/he was uncertain the last time the carpets in Resident 8 and 9's rooms had been cleaned but acknowledged the urine like odor was strong enough in the rooms to be clearly noticeable from the hallway.<br><br>Surveyor reviewed Resident 9's record and noted Resident 9 was admitted on 09/09/2020 with diagnoses including difficulty walking, generalized weakness and chronic kidney disease. Resident 9's STEP assessment dated 09/04/202 identifies | N 489 | | |

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| CARE PARTNERS ASSISTED LIVING HORTONVILLE | 112 HARRIS WAY HORTONVILLE, WI 54944 |

| (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 489 | Continued From page 128 | N 489 | | |

him/her as occasionally incontinent and requiring a maximum assist with changing and cleaning. Resident 9's Individual Service Plan (ISP) notes dated 03/15/20233 notes Resident 9 requires a 2 assist for bathing and toileting with goals including of being free from odor.

Surveyor reviewed Resident 8's record and noted Resident 8 was admitted on 09/12/2022 with diagnoses including osteoarthritis, rheumatoid arthritis, dehydration/fluid and electrolyte imbalance, diabetes mellitus type 2, hypertension, disorders of the reproductive system, and constipation. Resident 8's STEP assessment dated 08/31/2022 identifies him/her as occasionally incontinent and requiring assist with bathing, dressing, and hygiene. Resident 8's Individual Service Plan (ISP) notes dated 06/06/20233 notes Resident 8 requires an assist for bathing and toileting with goals including of being free from odor. Resident 8's observation notes dated 06/23/2023 note, "... Resident has been ripping [his/her] depends off and throwing them in the middle of [his/her] floor in [his/her] room." There was no further documentation of interventions provided or behavior management.

On 09/13/2023, Surveyors returned to the facility. At approximately 8:00 AM, Surveyor observed the strong urine odor remained present in the hallway outside of Resident 8 and 9's rooms. After bring the concern to Administrator A's attention on 09/11/2023, 2 days prior, no cleaning intervention had been implemented.

On 09/13/2023, at 11:03 AM, Surveyors interviewed Family K, Resident 8's family member. Family K stated his/her concerns about Resident 8's room and other resident rooms having strong urine like odors. Family K stated

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0016767 | A. BUILDING: _____ B. WING _____ | R-C 10/10/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CARE PARTNERS ASSISTED LIVING HORTONVILLE | 112 HARRIS WAY HORTONVILLE, WI 54944 |

| (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 489 | Continued From page 129<br><br>s/he has discussed the continued issue with staff including Administrator A with no resolve. Family K stated s/he brings in cleaning products for the staff and notices they are not being used. Family K expressed his/her frustration about the provider not maintaining a clean environment for Resident 8.<br><br>On 09/13/2023, at approximately 4:00 PM, Surveyors interviewed Administrator A with Regional RN B and Administrator C present. The administrators acknowledged there is a strong urine like odor noticeable from the hallway outside of Resident 8 and 9's rooms. Administrator A did not have the carpets cleaned after the observation and interview on 09/11/2023. The administrators could not say when the carpeting in the rooms had last been cleaned but acknowledged if the cleaners could not remove the odor the carpet would need to be replaced. | N 489 | | |