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 05/02/2024

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 000}	Initial Comments On 04/25/2024, with information gathered through 05/02/2024, Surveyor conducted a verification visit, one complaint investigation and 2 self report reviews at Care Partners in Hortonville. One (1) of one complaint was unsubstantiated. As a result of the survey, 3 deficient practices were identified. Of the 3 deficient practices identified, 2 were a repeat violations x2. See SOD (Statement of Deficiency) 8DXE14 dated 10/10/2023, SOD 8DXE13 dated 12/19/2022 and SOD QP2D11 dated 03/22/2023 for additional information. Under statutory provisions, a $200 revisit fee is being assessed for the verification visit. Census: 31	{N 000}		
{N 196}	83.14(2)(a) Licensee ensures facility complies with laws The licensee shall ensure the CBRF and its operation comply with all laws governing the CBRF. This Rule is not met as evidenced by: Based on 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. This is a repeat deficiency being issued for the third time. See Statements of Deficiency (SOD) 8DXE13 dated 12/19/2022 and SOD 8DXE14 dated 10/10/2023.	{N 196}		

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

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{N 196}	Continued From page 1 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 the survey, the facility census was 31. Findings Include: Prior to conducting the on-site facility visit, Surveyor reviewed the survey history and noted the following: 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 (8DXE13) 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. See SOD 8DXE13 for additional details and special orders. On 09/11/2023, 09/13/2023 and 10/02/2023 with information gathered through 10/10/2023, the Division of Quality Assurance conducted on-site investigations of 5 complaint investigations, 3 self-report reviews, and a verification visit at Care	{N 196}		

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{N 196}	Continued From page 2 Partners Assisted Living Hortonville. As a result of the investigation, 3 out of 5 complaints were substantiated. Twenty (20) deficient practices were identified. Of the 20 deficient practices identified, 10 were repeat violations. The Statement of Deficiency and Notice and Order letter was sent to the provider via certified electronic mail on 01/11/2024. 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. The notice of special orders included: "ORDER NOT TO ADMIT NEW OR ADDITIONAL RESIDENTS - EXTENDED 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 extends the order issued on May 12, 2023 with Statement of Deficiency (SOD) 8DXE13, that Care Partners Assisted Living Hortonville NOT ADMIT ANY NEW OR ADDITIONAL RESIDENTS until all violations in SOD 8DXE14 are corrected, compliance is verified by the Department, and this Order is rescinded in writing. SPECIAL ORDERS 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:	{N 196}		

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{N 196}	Continued From page 3 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. Consultation will include the development (or revision) of written procedures and staff training (as appropriate) to address: Investigate Injuries of Unknown Source and Caregiver Misconduct - For any injury of unknown source or allegation of caregiver misconduct, the licensee shall immediately take steps to ensure the safety of all residents, conduct an investigation, and maintain documentation of any investigation; - The licensee shall report to the department an allegation of client abuse, neglect or misappropriation of client property committed by any person employed by the entity when the licensee has reasonable cause to believe it has sufficient evidence, or another regulatory authority could obtain the evidence, to show the alleged incident occurred and the licensee has reasonable cause to believe the incident meets or could meet the definition of abuse, neglect or misappropriation. Caregiver misconduct investigations will be reviewed in accordance with the department's reporting requirements and reported if necessary. The Caregiver Manual is available as a reference at: https://www.dhs.wisconsin.gov/publications/p0/p00038.pdf	{N 196}		

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{N 196}	Continued From page 4 - Retroactively, with available information, document a complete investigation report of the alleged incidents of caregiver misconduct described in Statement of Deficiency (SOD) 8DEX14. The investigation will conform to requirements and guidelines specified by Wis. Admin. Codes ch. DHS 13, ch. DHS 83 and The Wisconsin Caregiver Program Manual. - WITHIN 14 DAYS of receipt of this notice, the provider will submit a copy of the investigation report to the Department's Office of Caregiver Quality for department review. Adequate Staff -Staffing patterns will be sufficient to meet the personal care needs of residents, to ensure needed supervision, to provide needed services (e.g., medication management, toileting, bathing, interventions to prevent falls, personal cares, meals), and to facilitate a safe evacuation of the building in the event of an emergency. -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, the licensee will ensure sufficient, qualified staff members are on duty, present and available to assist residents at all times. -Written staff schedules will be current and shall include each employee's full name, job assignment and time worked. Records will be amended, as necessary, to ensure an accurate and complete record of time worked by all facility employees, and/or employees of contract agencies providing routine services to facility residents. Medication Management -Including how the provider will: (a) document medication orders, medication administration,	{N 196}		

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{N 196}	Continued From page 5 missed/refused doses; (b) ensure residents receive medications at the intervals and dosages prescribed; (c) prevent medication errors; (d) respond to medication errors if they occur; (e) obtain prescriptions and refills timely; (f) monitor for adverse side effects; and (g) discontinue and dispose of medications. Infection Control -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 Additionally: - All managers and resident care staff (as appropriate) will receive in-service training regarding the facility's written procedures required by Order #1. - 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. - Consultation activities, including dates of consultation, will be documented, signed and dated by the consultant. - A copy of the written procedures and all documentation as evidence of meeting the requirements in Order #1 will be made available	{N 196}		

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{N 196}	Continued From page 6 to department representatives upon request." On 04/25/2024, Surveyors conducted an on-site verification visit for SOD 8DXE14. RN consultant On 04/25/2024, at approximately 1:00PM, Surveyors interviewed Operations Executive B regarding the special orders to hire an RN consultant. Operations Executive B stated they thought they hired a consultant. However, upon talking with the consulting firm after the issuance of SOD 8DXE14, they found out they only hired a consultant to come and walk through the facility and give them an "estimate" of the work that needed to be done. Operations Executive B verified the facility did not hire a RN consultant to ensure the provision of services to meet residents' physical and mental health needs. Additionally, Operations Executive B indicated an RN consultant did not develop and implement corrective measures, including the review or revision of policy and procedures, nor did an RN consultant train staff on the implementation of the policy and procedures. On 04/30/2024 at approximately 11:00AM, Surveyor interviewed Administrator D. Administrator D indicated s/he had spoken with Operations Executive B last week and was informed "to keep my calendar open for 05/09/2024" because a RN consultant was going to come to the facility. Administrator D stated s/he understood the prior consulting agency provided an "estimate" for services to be rendered, however, the facility did not hire that agency. As a result of Licensee A not upholding his/her responsibilities as the licensee, the following 3 deficiencies were identified, including 2 repeat	{N 196}		

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{N 196}	Continued From page 7 violations: N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies With Laws 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. This is a repeat deficiency being issued for the third time. See Statements of Deficiency (SOD) 8DXE13 dated 12/19/2022 and SOD 8DXE14 dated 10/10/2023. N0412 DHS 83.37(2)(a) Self-Administration By Resident Based on observation, record review and interview, the provider did not ensure 1 of 1 (Resident 1) residents reviewed had physician orders that identified their physical or mental capacity to self-administer their medications. Resident 1 was identified to require assistance from provider staff with medication administration. Resident 1 was observed being given his/her morning medications in his/her room. Caregiver C placed the medication cup on bedside table and left the room, leaving Resident 1 to self-administer without staff oversight. N0433 DHS 83.38(1)(i) Behavior Management Based on observation, interview, and record review, the provider did not ensure Resident 3 received behavior management appropriate to meet his/her needs. The lack of behavior management permitted the existence of a condition which created substantial risk to the health, safety and/or welfare of residents by allowing Resident 3 to continue to reside in the facility without appropriate interventions to	{N 196}		

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{N 196}	Continued From page 8 mitigate risk of reoccurrence after known incidents of Resident 3's touching other residents inappropriately. This is a repeat deficiency being issued for the third time. See SOD QP2D11 dated 03/22/2023 and SOD 8DXE13 dated 12/19/2022. 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. Cross Reference N0412 DHS 83.37(2)(a) Self-Administered By Resident N0433 DHS 83.38(1)(i) Behavior Management	{N 196}		
N 412	83.37(2)(a) Self-administered by resident. Self-administered by resident. 1. The resident shall self-administer prescribed and over-the-counter medications and dietary supplements, unless the resident has been found incompetent under ch. 54, Stats., or does not have the physical or mental capacity to self-administer as determined by the resident ' s physician, or the resident requests in writing that CBRF employees manage and administer medication. 2. Except as specified under sub. (4), when a resident self-administers medications, prescribed and over-the-counter medications and dietary supplements shall remain under the control of the resident. The CBRF shall provide a secure place for the storage of medications in the resident ' s room. 3. A resident with the mental and physical capacity to develop increased independence in	N 412		

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N 412	Continued From page 9	N 412		

medication administration shall receive self-administration instruction.

This Rule is not met as evidenced by:
Based on observation, record review and interview, the provider did not ensure 1 of 1 (Resident 1) resident reviewed had physician orders that identified their physical or mental capacity to self-administer their medications. Resident 1 required assistance from provider staff with medication administration.

Resident 1 was observed being given his/her morning medications in his/her room. Caregiver C placed the medication cup on Resident 1's bedside table and left the room, leaving Resident 1 to self-administer without staff oversight.

Findings include:

On 04/25/2024, Surveyors conducted an onsite verification visit. A sample of residents was selected including the record of Resident 1.

Resident 1 was admitted to the facility on 02/28/2023 with the following diagnoses: neurocognitive disorder, constipation, history of stroke, loose stools, depression, mood disorder and neuropathy. Resident 1 was prescribed approximately 12 medications. Resident 1's most recent ISP (Individualized Service Plan) dated 12/15/2023 indicated, "Medications administered by CBRF [Community Based Residential Facility] staff..." Resident 1's record did not contain any medication administration assessments or physician orders.

On 04/25/2024 at approximately 11:00AM, Surveyor observed Caregiver C bring Resident 1 a cup with his/her medications into Resident 1's

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N 412	Continued From page 10 room. Resident 1 was laying in bed. Caregiver C placed the cup with medications in it on Resident 1's bedside table and informed Resident 1 his/her medications were on the table. Resident 1 acknowledged Caregiver C. Surveyor asked Caregiver C if Resident 1 self-administered medications and s/he stated no, but s/he would get up soon and take them. Caregiver C indicated s/he would go back to Resident 1's room and check to see that s/he took them. Surveyor asked if staff observed Resident 1 ingest his/her medications and s/he said no. On 04/25/2024 at approximately 1:00 PM, Surveyors interviewed Operations Executive B who verified residents should be assessed and resident records should contain documentation for self-administration of medications.	N 412		
N 433	83.38(1)(i) Behavior management. 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: Behavior management. The CBRF shall provide services to manage resident ' s behaviors that may be harmful to themselves or others. This Rule is not met as evidenced by: Based on observation, interview, and record review, the provider did not ensure Resident 3 received behavior management appropriate to meet his/her needs. The lack of behavior management permitted the existence of a	N 433		

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condition which created substantial risk to the health, safety and/or welfare of residents by allowing Resident 3 to continue to reside in the facility without appropriate interventions to mitigate risk of reoccurrence after known incidents of Resident 3's touching other residents inappropriately.

This is a repeat deficiency being issued for the third time. See SOD QP2D11 (dated 03/22/2023) 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.

On 04/25/2024 at approximately 10:00 AM, Surveyors conducted a complaint investigation that involved reviewing resident records. Surveyors noted an incident documented in Resident 3's Nurses Notes on 04/21/2024 detailing Lead Caregiver F's observation of a resident-to-resident incident involving sexual behavior between Residents 2 and 3. Resident 3 had a known history of sexually inappropriate behavior documented in SOD 8DXE13 under Behavior Management and Comprehensive Individualized Service Plan.

Surveyors reviewed Resident 2's and Resident 3's records and facility reports.

RESIDENT 2:
Resident 2 was admitted to the facility on 04/29/2023. Diagnoses include: dementia with behavioral disturbances, muscle weakness, dysphasia, cognitive communication deficit, and a

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history of falls. Resident 2 had an activated Power Of Attorney (POA) for healthcare, POA E.

Resident 2's Individual Service Plan (ISP), dated 03/14/2024, noted s/he requires 24 hours supervision and needs assistance with capacity for self-direction.

Resident 2's Nurse's Notes noted:
04/21/2024 PM, "[Resident 2] was found in [Resident 3's room] making out with [Resident 3.] Staff is pretty sure [Resident 2] didn't really know what was going on."

04/22/2024 AM, "After resident's interaction with [Resident 3] on 4/21/2024 staff noticed bruising on [his/her] thigh, both [chest areas] and on [his/her] lower back."

RESIDENT 3:
Resident 3 was admitted to the facility on 09/12/2022. Diagnoses include: sexually inappropriate behavior, Lewy Bodies dementia, vascular dementia, depression, disorders of the reproductive system, and a history of falls.

Resident 3's Step Assessment Tool, dated 08/31/2022, completed by Former Administrator D noted:
Mental Status - Oriented to person, place and time but may have occasional forgetfulness.
No Behavior concerns noted.

Resident 3's original ISP, dated 09/14/2022, noted:
No supervision noted.
No safety concerns noted.
Other:
Frequency of Services and Service Provided -

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N 433	Continued From page 13 "Can be verbally and physically sexual with staff members at times." Goal/Outcome - "Continue to monitor and note on behaviors." Resident 3's current ISP Dated 12/05/2023 noted: Needs some supervision-medications, dressing, transferring, showering, morning and night cares." There is no intervention, measurable goal, or outcome for supervision needed for behavior management after SOD 8DXE13 identified Resident 3's lack of behavior management as an example of the provider's deficient practice. In a section titled "Other" the ISP noted Resident 3, "Can be verbally and physically sexual with staff members at times and with residents [sic] See behavioral plan [sic] 2 [sic] staff when doing cares ... continue to monitor and note on behaviors." In a section titled "Aggressive/ Combative" the ISP noted, "Resident can become verbally and physically aggressive towards staff * [sic] see behavior management plan." Behavior Management Plan (not dated) that was in place during the previous survey SOD 8DXE13 noted: Behavioral Symptoms: [Resident 3] will make sexual comments to residents and staff members. [Resident 3] will also grab staff members when helping him/her with ADLs. Possible Precipitators: When [Resident 3] is in public areas s/he will make sexual comments. When staff are in his/her room that is when [Resident 3] will try and sexually grab the staff. Interventions: Two staff members will go into [Resident 3's] room at all times. Reminding [Resident 3] what is appropriate and not appropriate. Re-directing his/her comments to another subject.	N 433		

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	0016767	A. BUILDING: _____ B. WING _____	R-C 05/02/2024

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N 433	Continued From page 14 Surveyors were given Resident 3's current Behavioral Management Plan (not dated) and noted: Behavioral Symptoms: Sexual comments to staff and residents. [Sic] Sexual advances. [Sic] Unprompted touching. [Sic] During cares, when in common areas, [sic] at mealtimes. [Sic] will touch when in reach or approach from behind to initiate contact. Possible Precipitators: Receiving cares, bathing, toileting. [Sic] In private and common areas. Interventions: [Sic] 2 staff to be in [sic] resident room for all cares, [sic] when this occurs. If [sic] touched, [sic] or spoken to, [sic] inappropriately. [sic] remind [Resident 3] that you are uncomfortable with [his/her] behavior. Be respectful and firm. Change caregivers if [Resident 3] does not adjust. Remove [Resident 3] or other resident if [s/he] initiates unwanted contact Provide alternative activity or redirect. Deflect/ignore inappropriate comments ... If above is unsuccessful, may administer appropriate PRN medication as prescribed." Surveyor reviewed Resident 3's Medication Administration Record (MAR) and noted no as needed (PRN) or scheduled medication was prescribed for behavior management. Surveyor noted the behavioral plan identified Resident 3's behavior as progressing from sexual comments and grabbing at staff, to making sexual comments to staff and residents and making sexual advances with unprompted touching and approaches from behind. Additionally Resident 3 previously made sexual comments in the common area and was making grabbing attempts with staff when in his/her room. The behavior is noted as progressing to making physical sexual attempts in the common areas	N 433		

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N 433	Continued From page 15 and with other residents. Resident 3 had a diagnosis and significant documented history sexually inappropriate behaviors targeting residents noted in SOD 8DXE13. The record showed the provider was aware of and documented the increase in behavior, the targeting of other residents who may be vulnerable, and did not provide behavior management to meet the resident needs or protect other residents at the facility. The revised Behavior Management Plan did not include measurable goals or additional interventions other than redirection and deflection. The Behavior Management Plan did not provide interventions for medical management of symptoms, behavioral and social assessment and outlets, staff education specific to meet the resident's behavioral needs or increased supervision to protect him/herself and other vulnerable residents from the behaviors. Resident 3's Nurse's Notes dated 01/06/2024-04/25/2024 noted a progressive increase in documented behavior: 01/06/2024 AM Resident 3 was " ... very hostile towards caregivers ..." 01/17/2024 PM Resident 3 was, " ... yelling ... swearing at staff ..." 03/23/2024 AM "Resident stopped a staff member in the hallway and asked why[s/he] didn't stay in [his/her] room after changing [his/her] pants. [S/he] asked [Resident 3] if [s/he] had [sic]needed anything and [Resident 3] said 'no [sic] I just wanted you in my room.' [Resident 3]	N 433		

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N 433	Continued From page 16 kept trying to grab at [staff's] arms. Another staff called [his/her] name so [s/he] was able to walk away." 03/25/2024 AM, "Resident was inappropriate at [sic] staff that got [him/her] ready this morning, making comments about them having nice bodies and how [s/he] hasn't been touched in years." 04/02/20204 AM, " ... staff was trying to check blood sugar when staff asked for [his/her] finger [s/he] grabbed staff member by the [genital] area. Staff member notified director and wrote an incident report." 04/02/2024 PM, Resident 3 " ... allowed a brief change. When staff was done [s/he] tried to grab one [sic] [and/asked] 'climb into bed' with [him/her.]" 04/05/2024 PM, Resident 3, " ... was touching a staff member and 'teasingly' pulling [his/her] hair. Staff said 'please don't pull my hair' and resident said [s/he] could 'do whatever [s/he] wanted.' 04/06/2024 AM, "Resident kept grabbing the arms of other [fe/male] residents ..." 04/08/2024 PM, Resident 3 told staff to " ... get the [explicative] out ..." of his/her room. 04/21/2024 PM, "Staff went to give [Resident 3] [his/her] 8PM meds [sic] and found that [Resident 2] was in [Resident 3's] room with the door shut. [Resident 3] was making out with [Resident 2] and [Resident 3's] pants were partially pulled down. [Resident 2's] [clothing] looked to be pulled up. Staff asked what was going on [Resident 3] told staff to mind their own. [sic] resident [sic] shut the door after getting [Resident 2] out. Staff went	N 433		

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to give [Resident 2] [his/her] meds [sic]and [s/he] was not in [his/her] room. [Resident 2] was beside [Resident 3's] bed. [Resident 3] had no pants on. We explained to [Resident 3] that this is inappropriate as [Resident 2] cannot remember things and is not completely able to be participating in those activities as [s/he] is not [his/her] own person. [Resident 3] told [Resident 2] [s/he] will see [him /her] later. staff is to monitor events such as this."

04/24/2024 AM, "Resident was holding [Resident 2's] hands and rubbing on [his/her] arm in the lobby by [sic] cafeteria. Staff asked [Resident 3] to stop touching on [sic] [Resident 2] and [Resident 3] said [s/he] will do whatever [s/he] wants. Staff explained again it was inappropriate behavior and escorted [Resident 2] to the activity room to separate them.

04/25/2024 AM, "Resident was trying to hold hands with [Resident 2.] staff told [sic] residents to keep hands to themselves. [Resident 3] told staff to 'Go to [expletive.]'

Facility Incident Reports:
04/21/2024 8:00 PM, Lead Caregiver F noted, "During my shift on Sunday April 21st I went in to give [Resident 3] [his/her] 8:00 PM meds [sic.] [His/her] door was shut which I had assumed meant [s/he] was sleeping as [s/he] shuts it when [s/he] does. I knocked and opened the door to find [Resident 3] and [Resident 2] making out behind the door. I gave [Resident 3] [his/her] meds [sic] and asked what was going on. I noticed [Resident 3] had [his/her] pants pulled down and [Resident 3] had [his/her] hands wrapped around [Resident 2's] waist. [Resident 2] was sitting on [his/her] walker. [Resident 3] seemed to have a tight grip on [Resident 2.] I

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called my director and asked what I should do being that [Resident 2] can frequently [sic] confused and I wasn't sure if it was consensual interaction. I had one of the floor runners attempt to get [Resident 2] out of [Resident 3's] room because [Resident 3] had yelled at me and told me [Resident 2] wasn't leaving. I had the floor runner tell [Resident 2] it was getting late and [s/he] should probably get home and go get to bed.[Resident 2] agreed and [s/he] had no visual markings on [him/her] at the time [s/he] went to bed but staff on Monday [4/22/2024] morning informed me of bruising they noticed during [Resident 2's] shower."

04/22/2024, Caregiver G noted, "When doing cares on [Resident 2] ... saw that [s/he] had bruising on[his/her] left side above [his/her] hip. It looked to be like it was from being grabbed on [his/her] side. [S/he] also had bruising on each of [his/her] [chest areas.]"

04/23/2024, Caregiver I noted, "During morning cares on [Resident 2] staff notice small bruising on [his/her] left upper thigh both [chest areas] and on [his/her] lower back near [his/her] tailbone. These marks were noticed the morning after [his/her] interactions with [Resident 3] on 4/21/2024."

04/23/3034, Caregiver H noted regarding Resident 2's bruising., " ...It looks like a possible handprint on left hip and one on each [chest area] ..."

04/22/2024, Caregiver J noted, "When I went in to do [Resident 3's] cares around 7:00 PM I couldn't find [him/her] anywhere in the facility, [sic] due to things being told through staff I went to check [Resident 2's] room and the door was

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N 433	Continued From page 19 locked. I got [Caregiver M] to get a key due to no response when knocking [sic] when staff entered, we found both [Resident 3] and [Resident 2] lying together in bed without clothes. [Resident 3] had covered the bed in feces as well. Staff got them separated after [Resident 3] said [s/he] didn't want to leave because they 'would be getting married.' Staff got both residents cleaned up, new sheets and both in their residing rooms." 04/25/2024 Administrator K noted in a fax to Resident 2' Physician, "On 4/21/2024 [Resident 2] was involved in a resident-to-resident altercation regarding a [fe/male] resident. [S/he] was found in [his/her] room around 8:00 PM. [S/he] was sitting on [sic] walker and the [fe/male] resident had[his/her] arms around [his/her] waist. [S/he] was wearing [his/her] nightgown but there was no sign of complete undress. A body audit was completed right away and there were no marks or bruises noted. The POA was called, and a voice message was left. On 4/22/2024 during AM cares around 7:00 AM, bruises were noted on [Resident 2] by AM caregiver. [Sic] AM Caregiver completed a body audit and noted bruising on [his/her] lower back, left thigh, and both [chest areas.] [Resident 2] has been in good spirits, has had no complaints of pain, and has not requested any PRN pain meds [sic.] Bruising has been noted to be improving during AM cares." Administrator K updated Resident 2's physician 4 days after the 1st incident and did not include the 2nd or 3rd incident. On 04/25/2024 at approximately 2:00 PM, Surveyors interviewed Operations Executive B. Operation Executive B reviewed the incident report and nurses notes. Operation Executive B acknowledged during the investigation of the	N 433		

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incident on 04/21/2024 there were 2 incidents that occurred; the first incident on 04/21/2024 when the residents were initially found and separated, and then a second incident occurring later that evening. After the first incident, the provider was aware of the need for increased behavior management including supervision and allowed for a 2nd incident to occur on 04/21/2024. Additionally, Operations Executive B acknowledged in the initial investigation Caregiver J's statement noted a 3rd incident occurred on 04/22/2024 when Residents 2 and 3 were found in another sexual engagement. Operation Executive B acknowledged the provider conducted an initial investigation for the first incident on 04/21/2024 but did not conduct a separate investigation into the 2nd and 3rd occurrences. Operations Executive B acknowledged the provider's documentation noting Resident 3's diagnosis and history of sexually inappropriate behavior, Resident 2's diagnosis which precluded him/her from being able to make safe decisions for him/herself requiring an activated POA, and the documentation of finding multiple bruises on Resident 2 the morning after the 2 incidents occurred on 04/21/2024. Operations Executive B stated no report regarding the incidents or the allegation of Resident 2's potential abuse was made to the Department. Operations Executive B stated according to the caregivers Resident 2 "wasn't protesting" and therefore did not feel the incidents merited reporting to the Department. Operations Executive B stated the interactions "could have been consensual" while acknowledging s/he did not know, and that Resident 2 does not have the mental or legal capability to consent and may not be able to protest. Operations Executive B confirmed no assessment to determine Resident 2's ability to

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consent, comprehension of the situation, or preferences was conducted. Operations Executive B confirmed no interdisciplinary team members including the ombudsman, social worker, primary physician, or managed care organization team were immediately notified. The POA received a voice message on 04/21/2024 to call back but was not followed up on. Executive Director B stated the POA came to the facility on 04/23/2024 and was unsure if the POA had been updated about the incident.

After the survey process brought the code requirements to the provider's attention, the provider submitted 1 self-report on 04/26/2024 for the first incident that occurred on 04/21/2024. The SR included Nurse Notes and caregiver statements that noted a second incident occurred on 04/21/2024 and 3rd incident on 04/22/2024. The caregiver's statement about the 3rd incident was cut off and did not contain the rest of the attestation, the caregiver's name, or date. No separate investigations or self-reports were made for the 2 additional incidents. Surveyor reached out to the provider on 04/30/2024 and 05/01/2024 for the complete incident report to be submitted. The survey process prompted the provider to follow up with Resident 2's POA and plan to involve the interdisciplinary team to assess the resident going forward. No new interventions or updates to Resident 3's behavioral management plan were included with the report.

Surveyor interviewed Administrator K on 05/02/2024 at 10:41 AM. Administrator K informed Surveyor of the rest of the unidentified caregiver statement in the incident report including the writer (Caregiver J) and dated (04/22/2023) when the 3rd incident occurred. Administrator K confirmed the provider did not

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N 433	Continued From page 22 investigate or submit reports for the 2nd incident on 04/21/2024 or the 3rd incident on 04/22/2024. Administrator K stated after the first incident occurred adequate supervision and behavior management had not been provided as evidenced by a 2nd and 3rd occurrence happening. Administrator K stated when POA E came into the facility (on 04/23/2024) to visit after the provider left a general voice message to return their call, the provider did not inform the POA about the incidents at that time. Administrator K stated after the survey s/he reached out to the POA, MCO, physician, and ombudsman on and 04/25/2024 to inform them about the incidents and initiate a plan. Administrator K stated POA E was updated about all 3 incidents on 04/29/2024 when s/he came to visit. Administrator K stated the provider recognized the behavior plan was not adequate to meet Resident 3's needs and that the lack of behavior management and supervision allowed for a condition of significant risk to other vulnerable residents. Administrator K stated the provider was aware Resident 2 needed to be regularly evaluated by a licensed and qualified provider and interdisciplinary team for ability to consent prior to allowing any further sexual encounters. Cross Reference N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies With Laws	N 433		