STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0012705	A. BUILDING: _____ B. WING _____	R-C 10/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKS AT NORTHERN LIGHTS(THE)	702 BRATLEY DRIVE WASHBURN, WI 54891

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{N 000}	Initial Comments On 09/16/2024, Surveyor conducted a verification visit and complaint investigation at The Oaks at Northern Lights. Data was collected through 10/22/2024. Two of 2 complaints were substantiated. Sixteen violations were identified. Three of 16 violations were repeat deficiencies. See Statement of Deficiencies (SOD) 8G0P11, dated 10/12/2023. Under statutory provisions of Wis. Stat. ch. 50, a $200 revisit fee is being assessed. Census: 13	{N 000}		
N 169	83.12(5)(a) Notification: incident, injury, changes. The CBRF shall immediately notify the resident's legal representative and the resident's physician when there is an incident or injury to the resident or a significant change in the resident's physical or mental condition. This Rule is not met as evidenced by: Based on interview and record review, the provider did not immediately notify residents' legal representatives upon a significant change in condition. Resident 1's legal representatives, Power of Attorney (POA) I and POA J, were not	N 169		

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

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N 169	Continued From page 1	N 169		

immediately notified when Resident 1 was hospitalized on 08/31/2024.

Resident 4's legal representative, Family Member (FM) O, was not immediately notified when Resident 4 experienced a change in condition in October or when Resident 4 was hospitalized on 10/09/2024.

Findings include:

The provider is licensed to care for 17 residents in the client groups advanced aged and irreversible dementia/Alzheimer's disease.

In September and October 2024, the Department received complaints related to the provider's lack of communication.

RESIDENT 1:
On 09/16/2024, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the facility on 11/15/2021, with a primary diagnosis of Alzheimer's disease.

On 08/31/2024, Licensed Practical Nurse (LPN) A wrote the following note in Resident 1's chart: "...writer had been called by staff 5 times since approximately 10am about the residents [sic] combative behavior when they attempted to change [him/her] in bed/attempt to get [him/her] cleaned up and in [his/her] w/c for meals. Each time staff was met with being hit, kicked, grabbed, [s/he] dug [his/her] nails into one staff member leaving marks. So [s/he] was left in bed w a brief inproprly [sic] placed. By 1920 resident was screaming in [his/her] room and again staff attempted to get [his/her] up and [s/he] screamed louder and punched ...called non-emergency Washburn PD (Police Department) and EMS

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N 169	Continued From page 2 (emergency medical services) to have the resident placed on an 'emergency placement hold' in the hospital until the court could intervene." Resident 1 did not return to the assisted living facility, and the provider discharged him/her on 09/06/2024. On 09/18/2024 at 11:55 AM, Surveyor interviewed Adult Protective Services Social Worker (SW) H. SW H stated Resident 1 had a unique power of attorney (POA) situation, where 4 of his/her children had equal healthcare authority. SW H stated LPN A called adult protective services and stated the provider was struggling to control Resident 1's behaviors and wondering what they could do. SW H stated SW L explained to LPN A that if Resident 1's behavior placed Resident 1 or others in imminent danger, the provider could call the police and pursue an emergency protective placement order. SW H stated this happened on 08/31/2024. On 09/17/2024 at 7:28 AM, Surveyor interviewed POA I. POA I said s/he went to the facility on 09/01/2024 to visit Resident 1 and was informed by staff that Resident 1 was hospitalized the night before. POA I stated s/he contacted POA J, who was the main point of contact for the provider, and POA J was also unaware of the situation. On 10/09/2024 at 5:38 PM, Surveyor received an email from LPN A that read, "I was informed by Adult Protective (Services) that because the resident needed a protective placement, Chapter 55, I was not to notify the POA as the hospital would notify once the resident was admitted. I wanted to ensure that I followed their directive."	N 169		

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N 169	Continued From page 3 RESIDENT 4: On 10/10/2024, the Department received a self-report from the provider indicating Resident 4 was found on the floor around 1:20 AM on 10/09/2024. Resident 4 had a bleeding head wound. S/he was taken to the emergency room (ER) and was hospitalized with multiple fractures, a head laceration, and a brain bleed. On 10/21/2024, Surveyor requested Resident 4's legal representative's contact information from Administrator E. Administrator E provided FM O's information via email. On 10/22/2024 at 11:30 AM, Surveyor interviewed FM O. FM O stated a family friend notified FM O that Resident 4 was not doing well. FM O stated s/he was unable to visit Resident 1 until 10/07/2024 because FM O was ill. On 10/07/2024, FM O went to the facility and staff informed him/her that Resident 4 had been in bed for 3 days. FM O stated Resident 4 was weak and could not sit up on his/her own. FM O stated s/he went to LPN A and LPN A stated they had been monitoring Resident 4's condition. LPN A told FM O that s/he had asked Resident 4 to go to the doctor, but Resident 4 refused. FM O stated the provider never contacted FM O to discuss the change in condition or need for medical attention. FM O stated s/he received a call from the hospital on 10/09/2024 around 5:00 AM to discuss Resident 4's injuries. FM O stated s/he was unaware Resident 4 was at the hospital and had no knowledge of a fall or injuries. FM O stated, "The Oaks never called me!" FM O stated s/he called the facility to try and get information and LPN A called FM O back around 8:00 AM. FM O stated LPN A was apologetic and stated staff should have called FM O.	N 169		

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N 169	Continued From page 4 FM O shared that s/he had a conversation with LPN A about 2 weeks before Resident 4's hospitalization about wanting to be called whenever Resident 4 was in pain, had a fall, etc. FM O stated, "[LPN A] assured me [s/he] would notify me... if the hospital didn't call, I would never have known." On 10/22/2024 at 12:07 PM, Surveyor sent Administrator E and LPN A an email asking when and how FM O was notified of Resident 4's incident. Administrator E sent a reply on 12:41 PM with LPN A's progress note that read, "Writer attempted to call POA. left [sic] a VM (voicemail). resident [sic] is admitted to Tamarack w (with) facial fracture, pelvic fracture, T1 and T2 compression fracture." On 10/22/2024 at 1:20 PM, Surveyor interviewed Administrator E. Administrator E stated LPN A had been dismissed. Surveyor discussed concern about the provider's response to changes in condition. Administrator E stated, "Frankly, this is why [LPN A] is being let go." Administrator E stated staff should contact legal representatives immediately after contacting emergency services.	N 169		
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 interview and record review, the licensee did not ensure the provider complied	N 196		

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N 196	Continued From page 5	N 196		

with all laws when it failed to follow special orders and achieve and maintain regulatory compliance.

Findings include:

The provider is licensed to care for 17 residents in the client groups advanced aged and irreversible dementia/Alzheimer's disease.

During the previous survey on 10/12/2023 (see SOD 8G0P11), the previous administrator, Administrator Q, indicated the cited deficiencies were related to his/her lack of experience. The Department substantiated 2 complaints and identified 5 deficiencies.

On 12/13/2023, the Department issued a notice and order letter with Statement of Deficiency (SOD) 8G0P11, that ordered the provider to conduct training with all managers and care staff on the corrective actions to resolve the 5 deficiencies identified in SOD 8G0P11 by 01/27/2024. The orders indicated the training must be documented. On 01/31/2024, the Department received an extension request from the provider, and the Department responded by granting a 30-day extension to the provider to complete the ordered training.

On 09/16/2024, the Department initiated a complaint investigation and verification visit. Surveyor reviewed staff training records and did not find evidence that care staff received the ordered training. Certified Nurse Assistant (CNA) B was hired on 05/04/2022, and his/her record did not include training on the provider's plan of correction.

Between 09/16/2024 and 10/22/2024, 3 of the 5 deficiencies identified in SOD 8G0P11 were

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N 196	Continued From page 6 found to be unresolved (recited), 2 complaints were substantiated, and 14 additional violations were identified. On 09/16/2024 at 10:48 AM, Surveyor interviewed Administrator E and Licensed Practical Nurse (LPN) A. Administrator E stated s/he and LPN A had been in their roles for about 7 months. Administrator E said s/he was the executive director at the assisted living facility (ALF), but the director (LPN A) was responsible for the daily operation at the ALF. This included daily operations, staff training, and resident care. At 11:11 AM, Surveyor interviewed Resident 3. Resident 3 stated s/he was not happy with the recent management changes. Resident 3 voiced concern about the high staff turnover and feeling as if s/he could not bring concerns to LPN A. At 11:50 AM, Surveyor interviewed Resident 2. Resident 2 stated s/he moved to the facility 5 years ago. Resident 2 stated, "It's going downhill ... 5 directors in 5 years ... [LPN A] is the director now ... no joy in this building ... gone downhill with each director." At 1:49 PM, Surveyor overheard LPN A on the phone with Human Resources Director (HR) F. LPN A stated s/he was not aware staff needed delegation. LPN A stated, "This is why I need training. I just got thrown into the position. I keep telling [Administrator E] I need training. I don't know this stuff." At 2:45 PM, Surveyor interviewed Administrator E and LPN A. Surveyor asked LPN A about his/her training. LPN A stated s/he did not get training. Administrator E stated the provider planned to send LPN A to an administrator course but the	N 196		

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N 196	Continued From page 7 first available course won't start until January 2025. On 10/22/2024 at 1:20 PM, Surveyor interviewed Administrator E. Administrator E stated LPN A was no longer in the director role. Administrator E stated the provider planned to bring in a consultant to analyze the provider's needs and help in the hiring process. Administrator E stated they planned to hire a director who had experience with assisted living. Cross references: N0169 DHS 83.12(5)(a) Notification: Incident, Injury, Changes N0214 DHS 83.15(3)(a) Administrator Shall Supervise Daily Operation N0220 DHS 83.17(2)(a) Employees Screened For Communicable Disease N0230 DHS 83.19 Orientation N0239 DHS 83.20(2)(a)-(d) Department-Approved Training Courses N0247 DHS 83.22(1)-(4) Task Specific Training N0353 DHS 83.32(3)(i) Rights Of Residents: Adequate Treatment N0389 DHS 83.35(3)(d) Service Plans Updated Annually Or On Changes N0397 DHS 83.36(1)(b) Qualified Staff In Charge, On Duty And Awake N0400 DHS 83.37(1)(a) Written Order For Medications, Supplements N0401 DHS 83.37(1)(b) Medication Label Permanently Attached N0416 DHS 83.37(2)(e) Other Administration Given Or Delegated By Rn N0419 DHS 83.37(3)(c) Medication Storage: Locked Cabinet N0431 DHS 83.38(1)(g) Health Monitoring N0439 DHS 83.39(1) Infection Control Program	N 196		

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{N 214}	Continued From page 8	{N 214}		
{N 214}	83.15(3)(a) Administrator shall supervise daily operation The administrator shall supervise the daily operation of the CBRF, including but not limited to, resident care and services, personnel, finances, and physical plant. The administrator shall provide the supervision necessary to ensure that the residents receive proper care and treatment, that their health and safety are protected and promoted and that their rights are respected. This Rule is not met as evidenced by: Based on record review and interview, the administrator did not supervise the daily operation in a way that ensured residents received adequate care and services and staff were properly trained. This is a repeat deficiency. See Statement of Deficiencies (SOD) 8G0P11, dated 10/12/2023. Findings include: The provider is licensed to care for 17 residents in the client groups advanced aged and irreversible dementia/Alzheimer's disease. On 09/05/2024 and 10/21/2024, the Department received complaints related to resident care and treatment. Both complaints identified concerns with the provider's follow through on resident care concerns.	{N 214}		

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{N 214}	Continued From page 9 On 09/16/2024 at 10:48 AM, Surveyor interviewed Administrator E and Licensed Practical Nurse (LPN) A. Administrator E stated s/he and LPN A had been in their roles for about 7 months. Administrator E said s/he was the executive director at the assisted living facility (ALF), but the director (LPN A) was responsible for the daily operation at the ALF. This included daily operations, staff training, and resident care. On 09/16/2024 at approximately 11:50 AM, Surveyor interviewed Resident 2. Resident 2 discussed s/he had not had good interactions with Licensed Practical Nurse (LPN) A. Resident 2 stated, "[S/he's] overwhelmed. [S/he's] agitated and doesn't follow through on things... [S/he] says [s/he'll] follow up on something and you never see [him/her] again." Resident 2 stated s/he had a long-term care insurance carrier that funded his/her placement. The insurance carrier required documentation from the provider to continue his/her claim. Resident 2 stated s/he received multiple letters stating the insurance carrier had not received documentation. Resident 2 stated s/he contacted Director of Social Services (DSS) G today because Resident 2 got another letter and s/he wanted a witness when s/he presented the letter to LPN A. Resident 2 stated the last time s/he presented the letter to LPN A, LPN A got angry, argued with Resident 2, and talked over Resident 2. Resident 2 stated it made him/her uncomfortable. Surveyor reviewed the letter Resident 2 received on 09/16/2024. The letter, dated 09/06/2024, read, "[Insurance company] has not received any monthly invoices and corresponding continued monthly residence for services provided to you	{N 214}		

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{N 214}	Continued From page 10 beyond May 31, 2024... If we do not receive the missing information by October 4, 2024, we will close this claim." At 2:36 PM, Surveyor interviewed LPN A. LPN A stated Resident 2's insurance documentation was submitted today (09/16/2024). Surveyor asked LPN A when Resident 2 first talked to LPN A about his/her insurance carrier needing documentation. LPN A stated, "[S/he] didn't. [Resident 2] talked to [DSS G]." Surveyor asked again and LPN A continued to say s/he had not spoken with Resident 2 about his/her insurance documentation. When Surveyor stated s/he received evidence that LPN A was aware, LPN A stated Resident 2 brought LPN A a letter in June or July indicating the insurance carrier needed documentation. LPN A stated s/he submitted the information immediately and LPN A followed up with Resident 2 about this. LPN A stated the information requested in June or July was different from what was requested in the 09/06/2024 letter. Surveyor requested a copy of the June/July letter LPN A was referencing. Surveyor reviewed the letter, dated 05/20/2024. The letter read, "In order to receive payment for eligible expenses, the following items must be submitted by you or your provider: ... complete and submit a Continued Monthly Residence (CMR) form at the end of each month, which must be completed by your service provider... an itemized invoice must accompany the CMR form." The letter on 05/20/2024 and the letter on 09/16/2024 were requesting the same documentation. On 10/08/2024, Surveyor reviewed an Adult Protective Services (APS) investigation report. The report included the following interview between APS staff and Resident 2 on 09/11/2024:	{N 214}		

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{N 214}	Continued From page 11	{N 214}		

"[Resident 2] reported that [LPN A] 'came in and read me the riot act. [S/he] came in, said it wasn't [his/her] fault and said, why don't you look for another place to live.'

From [Resident 2]'s notes, 'Trouble with insurance company... My insurance company wants a CCNA (Claimant Care Needs Assessment) and a MAR (Medication Administration Record) done every spring.' [Resident 2] received 4 separate requests from [his/her] insurance company on April 19, 2024, April 29, 2024, May 7, 2024, and May 13, 2024, stating that they hadn't received the requested information from the Oaks. [Resident 2] received additional letters from [his/her] insurance company on May 20, 2024, and May 22, 2024, stating that they needed the requested information by June 4, 2024, or 'claim would be closed.' [Resident 2] stated that [s/he] showed [LPN A] each of the letters when [s/he] received them. '[S/he] continued to say [s/he] took care of it, blame was placed on others. No apologies just a [sic] shouting and talking a mile a minute, no way one can respond-[s/he] talks over you. I was told [s/he] would give me names of other places I could live. This is verbal abuse -- being shouted at is abuse. I don't feel [s/he] respects the residents. Words won't cut it. Anyone can say the words but if you don't show us -- what's the use?' [Resident 2] stated, 'My insurance pays over $100,000 for me to be here. Can't [LPN A] get them what they need?' [Resident 2] reported that [LPN A] has shouted at [him/her] more than once."

The APS investigation summary, dated 09/20/2024 read, "To this date, the investigation has revealed many red flags regarding issues with management and staff at the Oaks... If the

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{N 214}	Continued From page 12 allegations are true, it is recommended that the Oaks Management and Staff receive more training to be able to provide safer and more compassionate care to the residents of the Oaks." Between 09/16/2024 and 10/22/2024, the Department substantiated 2 complaints and identified the following concerns: - The provider did not notify legal representatives when residents experienced a significant change in condition. - New employees were not screened for communicable illness prior to working with residents. - Staff did not complete minimum training requirements. - Residents did not receive prompt and adequate treatment. - Individual service plans were not complete or updated when resident needs changed. - Staff were not provided in sufficient numbers to meet the needs of residents. - The facility did not have a qualified staff on site at all times. - Medications were administered without written orders from prescribing physicians. - Medications were obtained from the affiliated skilled nursing facility rather than coming from a pharmacy with proper labeling. - Staff performed nursing tasks without delegation. - Medications were not stored securely. - Resident health was not assessed or monitored. Documentation with medical providers was not maintained. - Staff did not practice infection control in accordance with industry standards. Cross references:	{N 214}		

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OAKS AT NORTHERN LIGHTS(THE)	702 BRATLEY DRIVE WASHBURN, WI 54891

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{N 214}	Continued From page 13 N0169 DHS 83.12(5)(a) Notification: Incident, Injury, Changes N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies With Laws N0220 DHS 83.17(2)(a) Employees Screened For Communicable Disease N0230 DHS 83.19 Orientation N0239 DHS 83.20(2)(a)-(d) Department-Approved Training Courses N0247 DHS 83.22(1)-(4) Task Specific Training N0353 DHS 83.32(3)(i) Rights Of Residents: Adequate Treatment N0389 DHS 83.35(3)(d) Service Plans Updated Annually Or On Changes N0397 DHS 83.36(1)(b) Qualified Staff In Charge, On Duty And Awake N0400 DHS 83.37(1)(a) Written Order For Medications, Supplements N0401 DHS 83.37(1)(b) Medication Label Permanently Attached N0416 DHS 83.37(2)(e) Other Administration Given Or Delegated By Rn N0419 DHS 83.37(3)(c) Medication Storage: Locked Cabinet N0431 DHS 83.38(1)(g) Health Monitoring N0439 DHS 83.39(1) Infection Control Program	{N 214}		
{N 220}	83.17(2)(a) Employees screened for communicable disease. The CBRF shall obtain documentation from a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse indicating all employees have been screened for clinically apparent communicable disease including tuberculosis. Screening for tuberculosis shall be conducted using centers for disease control and prevention standards. The screening and documentation shall be completed within 90	{N 220}		

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{N 220}	Continued From page 14 days before the start of employment. The CBRF shall keep screening documentation confidential, except the department shall have access to the screening documentation for verification purposes. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 2 of 2 staff sampled (Caregiver C and Caregiver D) were screened for communicable disease, including tuberculosis (TB). This is a repeat deficiency. See Statement of Deficiencies (SOD) 8G0P11, dated 10/12/2023. Findings include: The Department of Health Services publication Tuberculosis Screening and Testing: Health Care Personnel (HCP) and Caregivers (including assisted living staff) states: "Perform baseline testing for all HCP and caregivers without documented evidence of prior LTBI [latent tuberculosis] or TB disease... IGRA [blood test] or TST [tuberculin skin test] may be performed; IGRA is preferred... - If testing is positive, obtain chest x-ray and refer HCP or caregiver to provider for additional workup for TB disease. - In the absence of newly identified risks or symptoms, previous documented negative IGRA or TST results (within 12 months) may be used. - If TST is used as the baseline testing, 2-step testing is recommended for HCP and caregivers who have not had TST testing previously or have only had one negative TST test greater than 12 months ago. If 2 or more TST tests have been previously performed, all results are negative,	{N 220}		

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{N 220}	Continued From page 15 and documentation of results is available, a one-step TST may be performed before hire." (Retrieved 2/22/2023 from https://dhs.wisconsin.gov/publications/p02382.pdf) On 09/16/2024 at 12:46 PM, Surveyor requested employee records for review from Licensed Practical Nurse (LPN) A and Administrator E. At 2:30 PM, Human Resources Director (HR) F provided the requested records to Surveyor and stated s/he was aware items were missing. Surveyor reviewed records for 2 employees hired after the previous survey: Caregiver C was hired on 07/29/2024. Caregiver C was screened for communicable disease on 08/08/2024. His/her file did not include evidence of a baseline TB test. Caregiver D was hired on 06/18/2024. Caregiver D was screened for communicable disease on 06/25/2025. His/her file did not include evidence of a baseline TB test. On 09/16/2024 at 4:57 PM, Surveyor received an email from HR F that read, "I apologize for not getting the TB screenings over to you before you left for the day. I have attached them in this email. I am aware that there is no second step completed on these forms." Surveyor reviewed the attached document, which indicated Caregiver C was administered Tubersol on 08/08/2024 and Caregiver D was administered Tubersol on 06/25/2024. The record did not indicate either employee returned within 48 to 72 hours to have their skin test evaluated.	{N 220}		

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N 230	Continued From page 16	N 230		
N 230	83.19 Orientation Before an employee performs any job duties, the CBRF shall provide each employee with orientation training which shall include all of the following: (1) Job responsibilities; (2) Prevention and reporting of resident abuse, neglect and misappropriation of resident property; (3) Information regarding assessed needs and individual services for each resident for whom the employee is responsible; (4) Emergency and disaster plan and evacuation procedures under s. HFS 83.47(2); (5) CBRF policies and procedures; (6) Recognizing and responding to resident changes of condition. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 3 of 3 employees sampled, completed orientation training. Findings include: On 09/16/2024 at 12:46 PM, Surveyor requested employee records for review from Licensed Practical Nurse (LPN) A and Administrator E. At 2:30 PM, Human Resources Director (HR) F provided the requested records to Surveyor and stated s/he was aware items were missing. Surveyor reviewed Certified Nurse Assistant (CNA) B's (hired 05/04/2022), Caregiver C's (hired 07/29/2024), and Caregiver D's (hired 06/18/2024) records. None of the records included evidence of orientation training.	N 230		

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N 230	Continued From page 17 On 10/08/2024 at 1:00 PM, Surveyor interviewed LPN A and Administrator E. LPN A stated the provider revised their training system a few months prior to include a 4 or 5 page training checklist that new employees worked through with LPN A and an experienced floor staff within the first 2 weeks of employment. Surveyor asked when staff received training on the required orientation topics such as abuse and neglect, facility policies, emergency procedures, etc. LPN A stated staff should receive this training from a nurse educator on their first day. On 10/09/2024 at 11:00 AM, Surveyor interviewed Caregiver N. Caregiver N stated, "I train a lot of staff... there was a checklist a while back... I'd initial and then the trainee would initial... I haven't seen a checklist lately."	N 230		
N 239	83.20(2)(a)-(d) Department-approved training courses. Standard Precautions. All employees who may be occupationally exposed to blood, body fluids or other moist body substances, including mucous membranes, non-intact skin, secretions, and excretions except sweat, whether or not they contain visible blood shall successfully complete training in standard precautions before the employee assumes any responsibilities that may expose the employee to such material. Fire safety. Within 90 days after starting employment, all employees shall successfully complete training in fire safety. First aid and choking. Within 90 days after starting employment, all employees shall successfully complete training in first aid and procedures to alleviate choking. Medication administration and management. Any	N 239		

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N 239	Continued From page 18 employee who manages, administers or assists residents with prescribed or over-the-counter medications shall complete training in medication administration and management prior to assuming these job duties. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 3 employees sampled completed Department-approved training. Caregiver D did not complete fire safety or first aid and choking within 90 days of hire. Findings include: On 09/16/2024 at 12:46 PM, Surveyor requested employee records for review from Licensed Practical Nurse (LPN) A and Administrator E. At 2:30 PM, Human Resources Director (HR) F provided the requested records to Surveyor and stated s/he was aware items were missing. Surveyor reviewed Caregiver D's record. Caregiver D was hired on 06/18/2024. His/her record indicated s/he completed 1 Department-approved class, standard precautions. On 09/16/2024, Surveyor reviewed the Wisconsin Training Registry which confirmed Caregiver D had not completed fire safety or first aid and choking trainings. On 09/16/2024 at approximately 2:35 PM, LPN A stated the reason Caregiver D had not completed	N 239		

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N 239	Continued From page 19 the courses yet was s/he was hired less than 90 days ago. LPN A stated Caregiver D did not have training exemptions. On 10/08/2024 at 1:00 PM, Surveyor interviewed LPN A and Administrator E. LPN A stated Caregiver D had not completed fire safety or first aid and choking yet, but s/he would be completing the courses next week. On 10/22/2024, Surveyor reviewed the Wisconsin Training Registry which indicated Caregiver D had still not completed fire safety or first aid and choking trainings.	N 239		
N 247	83.22(1)-(4) Task specific training. The CBRF shall provide, obtain or otherwise ensure adequate training for employees performing job duties in all of the following: Assessment of residents. All employees responsible for resident assessment shall successfully complete training in the assessment of residents prior to assuming these job duties. Specific training topics shall include: assessment methodology, assessment of changes in condition, sources of assessment information, and documentation of the assessment. Individual service plan development. All employees responsible for service plan development shall successfully complete training in individual service plan development prior to assuming these job duties. Specific training topics shall include: identification of the resident ' s needs and desired outcomes, development of goals and interventions, service plan evaluation and review of progress. Provision of personal care. All employees responsible for providing assistance with activities	N 247		

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N 247	Continued From page 20 of daily living shall successfully complete training prior to assuming these job duties. Specific training topics shall include, as appropriate: bathing, eating, dressing, oral hygiene, nail and foot care, toileting and incontinence care, positioning and body alignment, and mobility and transferring. Dietary training. All employees performing dietary duties shall complete dietary training within 90 days after assuming these job duties. Specific training topics shall include: determining nutritional needs, menu planning, food preparation and food sanitation. This Rule is not met as evidenced by: Based on record review and interview the provider did not ensure 2 of 2 employees sampled (Caregiver C and Caregiver D) received training on the provision of personal care. Findings include: The provider is licensed to care for 17 residents in the client groups advanced aged and irreversible dementia/Alzheimer's disease. On 09/16/2024 at 12:46 PM, Surveyor requested employee records for review from Licensed Practical Nurse (LPN) A and Administrator E. At 2:30 PM, Human Resources Director (HR) F provided the requested records to Surveyor and stated s/he was aware items were missing. Surveyor reviewed employee training records. Caregiver C was hired on 07/29/2024 and	N 247		

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N 247	Continued From page 21 Caregiver D was hired on 06/18/2024. Neither employee record included evidence of training on provisions of care. At approximately 2:35 PM, LPN A stated Caregiver C and Caregiver D did not have training exemptions. On 10/08/2024 at 1:00 PM, Surveyor interviewed LPN A and Administrator E. LPN A stated the provider revised their training system a few months ago to include a 4 or 5 page training checklist that new employees worked through with LPN A and an experienced floor staff within the first 2 weeks of employment. Surveyor asked when staff received training on provisions of care such as transfer techniques and personal care tasks. LPN A stated staff should receive this training from an experienced caregiver within the first 2 weeks of hire.	N 247		
N 353	83.32(3)(i) Rights of Residents: Adequate treatment 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. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Resident 1 was provided prompt and adequate treatment on 08/31/2024. Resident 1 was left in bed for over 9 hours due to combative behaviors before emergency services were contacted.	N 353		

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N 353	Continued From page 22 Findings include: The provider is licensed to care for 17 residents in the client groups advanced aged and irreversible dementia/Alzheimer's disease. On 09/05/2024, the Department received a complaint related to resident care and treatment. On 09/16/2024 and 09/18/2024, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the facility on 11/15/2021, with a primary diagnosis of Alzheimer's disease. Based on Resident 1's progress notes, staff charting, and incident reports, Resident 1 displayed aggressive behaviors. Behaviors included general agitation (kicking doors, yelling, wandering) and physical aggression toward staff during cares (hitting, pinching, biting, slapping, kicking). Resident 1's record included the following progress notes written by Licensed Practical Nurse (LPN) A: 08/29/2024 at 4:03 PM - "Writer spoke with [Social Worker (SW) L], APS (adult protective services), in regard to residents increased behaviors with no ability to redirect and the families [sic] continued refusal to allow the provider to increase and or change the medications. Resident kicked a pregnant staff member in the stomach, staff member was seen in the ER (emergency room) and monitored for 6 hours on 8/28 d/t contractions. APS spoke with their legal counsil [sic] and they gave the following directive: If [Resident 1] is a danger to [him/herself] or others due to [his/her] violent behavior, they should call law enforcement and have [him/her]	N 353		

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put on an emergency protective placement at the hospital. We will need to have a hearing within 72 hours (not counting weekend and holiday)."

08/31/2024 at 7:30 PM - "LATE ENTRY
Note Text: writer had been called by staff 5 times since approximately 10am about the residents [sic] combative behavior when they attempted to change [him/her] in bed/attempt to get [him/her] cleaned up and in [his/her] w/c (wheelchair) for meals. Each time staff was met with being hit, kicked, grabbed, [s/he] dug [his/her] nails into one staff member leaving marks. So [s/he] was left in bed w (with) a brief inproprly [sic] placed. By 1920 resident was screaming in [his/her] room and again staff attempted to get [him/her] up and [s/he] screamed louder and punched ...called non-emergency Washburn PD and EMS to have the resident placed on an 'emergency placement hold' in the hospital until the court could intervene."

On 09/17/2024 at 7:28 AM, Surveyor interviewed healthcare power of attorney (POA), POA I. POA I stated LPN A implemented a rule around mid-August that Resident 1 was not allowed to have food or medications if s/he remained in bed.

On 10/08/2024 at 1:00 PM, Surveyor interviewed LPN A and Administrator E. LPN A stated, "If we can't get them (residents) set up into safe sitting position, they don't get meds... same thing with food."

On 10/09/2024 at 9:00 AM, Surveyor interviewed POA J. POA J stated that 2 days before Resident 1 was admitted to the hospital, POA J was informed by a staff member that staff were directed by LPN A not to get Resident 1 out of bed. POA J stated s/he went to the facility around

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noon and found Resident 1 in bed. POA J stated Caregiver N came to Resident 1's room and stated, "Your [mom/dad] is under orders not to get out of bed." POA J stated that if Resident 1 was not to get out of bed, then s/he was not able to get meals and medications per LPN A's previous direction. POA J stated Caregiver N replied, "I'm just the messenger" and left.

According to Resident 1's medication administration record (MAR), Resident 1 was prescribed the following medication:
- Alive gummy vitamin, take 1 tablet at bedtime (supplement)
- Cholecalciferol 50 mcg tablet, take 1 tablet at bedtime (supplement)
- Hydroxyzine HCL 2.5 mg for anxiety, "this dose is to be given at 10am... when [s/he] is in WC (wheelchair)."
- Hydroxyzine HCL 5 mg for anxiety, "this dose is to be given at 6pm"
- Levothyroxine Sodium 75 mcg, for hypothyroidism, take in morning
- Lexapro 10 mg for dementia, scheduled for the morning
- Namenda 5 mg for Alzheimer's disease, scheduled for morning
- Probiotic, give 1 capsule at bedtime for urinary tract infection prevention
- Turmeric 500 mg, take 1 capsule at bedtime (supplement)
- Acetaminophen 650 mg for knee pain, given in morning and evening
- D-Mannose powder for urinary tract infection prevention, give 2.5 ml by mouth in morning and evening

Staff charted that Resident 1's medications and supplements were not given on 08/29/2024, 08/30/2024, and 08/31/2024. Reasons the

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treatments were not given included, "sleeping," "drug refused," "hold," and "other/see nurse notes." Staff documented on 08/31/2024 at 12:22 PM, "resident was very combative, would not get out of bed. meds held."

Resident 1's record did not include documentation indicating the provider notified Resident 1's physician when s/he missed consecutive days of medications.

On 10/09/2024 at approximately 11:30 AM, Surveyor interviewed Caregiver N. Caregiver N stated Resident 1 was a full assist with cares, transfers, and at times, required feeding assistance. Caregiver N stated that if Resident 1 did not want to get up, s/he would scream, swing, pinch, and scratch staff. Caregiver N said Resident 1's behaviors were occurring almost daily the last 2 weeks of his/her placement. Caregiver N stated Resident 1 was not bed-bound; staff tried to get him/her up daily. Surveyor asked if LPN A directed staff to leave Resident 1 in bed near the end of his/her placement. Caregiver N stated, "If [s/he] was having a bad day, then yes." Caregiver N said staff would re-attempt throughout the shift and offer him/her sips of water. Caregiver N confirmed staff were directed not to give residents medication or food if they were in bed.

On 09/18/2024 at 11:55 AM, Surveyor interviewed Social Worker (SW) H from APS. SW H stated police and EMS reported Resident 1 was in bed on 08/31/2024, wearing only a shirt and an incontinence brief. SW H stated they reported Resident 1 was "very wet and soiled." Staff reported to EMS that they were unable to dress Resident 1. SW H stated Resident 1 was babbling constantly but appeared calm until

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N 353	Continued From page 26 hospital staff went to change his/her incontinence brief. On 10/08/2024, Surveyor received and reviewed SW H's investigation report. The report read, "Tuesday September 3, 2024, this writer talked with [LPN A]...[LPN A] reported that [his/her] staff tested and called [him/her] a total of 17 times on August 31, 2024, not knowing what to do with [Resident 1]. Staff reported to [LPN A] that they were unable to get briefs on [Resident 1] because [s/he] was kicking and screaming. Staff were upset and exhausted not knowing how to handle [Resident 1]. [LPN A] responded by calling law enforcement to see if [Resident 1] could be taken into protective custody. [LPN A] discussed [his/her] concerns of [the provider] not being able to care for [Resident 1] due to [his/her] increased agitation and aggressiveness." Resident 1 did not receive his/her medications on 08/29/2024, 08/30/2024, or 08/31/2024. On 08/31/2024, Resident 1 was combative during morning cares and staff were unable to get Resident 1 up for the day. Resident 1's behaviors placed staff and Resident 1 in danger. The provider did not seek out emergency services until 7:20 PM, over 9 hours after Resident 1's behaviors began on 08/31/2024. Cross reference: N0214 DHS 83.15(3)(a) Administrator Shall Supervise Daily Operation N0431 DHS 83.38(1)(g) Health Monitoring	N 353		
{N 389}	83.35(3)(d) Service plans updated annually or on changes Individual service plan review. Annually or when	{N 389}		

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{N 389}	Continued From page 27	{N 389}		

there is a change in a resident ' s needs, abilities or physical or mental condition, the individual service plan shall be reviewed and revised based on the assessment under sub. (1). All reviews of the individual service plan shall include input from the resident or legal representative, case manager, resident care staff, and other service providers as appropriate. The resident or resident ' s legal representative shall sign the individual service plan, acknowledging their involvement in, understanding of and agreement with the individual service plan.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure Resident 1's individual service plan (ISP) was updated when Resident 1's needs changed.

This is a repeat deficiency. See Statement of Deficiencies (SOD) 8G0P11, dated 10/12/2023.

Findings include:

The provider is licensed to care for 17 residents in the client groups advanced aged and irreversible dementia/Alzheimer's disease.

On 09/09/2024, the Department received a complaint related to the provider's response to a resident's change in condition.

On 09/16/2024 at 10:35 AM, Surveyor interviewed Certified Nurse Assistant (CNA) B. CNA B stated Resident 1 was discharged about 2 weeks ago. S/he displayed disruptive and aggressive behaviors that included punching, hitting, kicking, and spitting. CNA B stated

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{N 389}	Continued From page 28	{N 389}		

Resident 1 was unable to return due to his/her high behaviors. CNA B stated overnight staff witnessed the majority of Resident 1's behaviors.

CNA B described Resident 1 as a full-assist with dressing, bathing, and incontinence care. At times, s/he required feeding assistance. CNA B said Resident 1 required 2-assist pivot transfers, but once s/he was in his/her wheelchair, s/he could ambulate independently.

At approximately 12:30 PM , Surveyor interviewed Licensed Practical Nurse (LPN) A. LPN A stated Resident 1 always had displayed disruptive behaviors, but these behaviors began to increase near the end of June, and his/her primary care provider, Nurse Practitioner (NP) K, wanted to try medications. LPN A stated Resident 1's family interfered with the medication changes, frequently requesting alternatives to NP K's plan. LPN A discussed the many changes Resident 1 had to his/her hydroxyzine, including making it as-needed (PRN). LPN A stated that about 2 weeks prior to Resident 1's hospitalization, his/her behaviors were so frequent Resident 1 always required someone beside him/her.

Surveyor reviewed Resident 1's record. Resident 1 was admitted to the facility on 11/15/2021 with a primary diagnosis of Alzheimer's disease. On 08/31/2024, the provider contacted emergency services due to combative behavior. Resident 1 was admitted to the hospital on a protective placement order. Resident 1 did not return to the assisted living facility, and the provider discharged him/her on 09/06/2024.

Based on Resident 1's progress notes, staff charting, and incident reports, Resident 1 displayed aggressive behaviors 5 days in July

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{N 389}	Continued From page 29 2024 and 11 days in August 2024. Behaviors included general agitation (kicking doors, yelling, wandering) and physical aggression toward staff during cares (hitting, pinching, biting, slapping, kicking). An incident report dated 08/05/2024, indicated Resident 1 fell on 08/01/2024. The incident report indicated staff were alerted to the fall by Resident 1's motion detector alarm. Resident 1's individual service plan (ISP) was not complete. Multiple sections included the templated prompts from the provider's electronic charting system. For example, the section related to bladder and bowel function read, "Requires Assistance for: (specify: use of toilet, urinal or bedside commode)." This section did not specify the frequency or service needed for Resident 1's incontinence care. Additional examples include: - "EATING/MEALS/NUTRITION ...Assistance for: (specify - hand over hand, verbal/non-verbal cuing, encouragement, total feed; encourage food consumption and fluids)" - "MOBILITY ...Requires Assistance for: (specify needs, stairs, escorts or devices)" Resident 1's ISP did not specify the type of transfer assistance Resident 1 required. The ISP read, "TRANSFERRING ...Will be able to transfer safely with assistance ...Requires Assistance for: all transfers." The ISP did not include reference to disruptive or aggressive behavior, interventions for behaviors, need for a motion detector, or a PRN psychotropic medication for anxiety/agitation. At approximately 2:35 PM, Surveyor interviewed LPN A. LPN A stated s/he was responsible for	{N 389}		

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{N 389}	Continued From page 30 creating and updating ISPs. LPN A stated s/he reviewed ISPs every 6 months. Surveyor asked if LPN A received training on ISP development and LPN A replied, "Just what I've done with care planning at the SNF (skilled nursing facility)."	{N 389}		
N 397	83.36(1)(b) Qualified staff in charge, on duty and awake. The CBRF shall ensure all of the following: 1. An administrator or other designated qualified resident care staff in charge is on the premises of the CBRF daily to ensure the CBRF is providing safe and adequate care, treatment and services. 2. At least one qualified resident care staff is present in the CBRF when one or more residents are present in the CBRF. 3. At least one qualified resident care staff is on duty and awake if at least one resident in the CBRF is in need of supervision, intervention or services on a 24-hour basis to prevent, control or improve the resident ' s constant or intermittent mental or physical condition that may occur or may become critical at any time including residents who are at risk of elopement, who have dementia, who are self-abusive, who become agitated or emotionally upset or who have changing or unstable health conditions that require close monitoring. 4. At least one qualified resident care staff is on duty and awake if the evacuation capability of at least one resident is 4 minutes or more. This Rule is not met as evidenced by: Based on interview and record review, the provider did not ensure qualified resident care staff were present at the facility at all times. Findings include:	N 397		

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N 397	Continued From page 31 DHS 83 defines "qualified resident care staff" as an employee who has successfully completed all of the applicable training and orientation. Applicable training and orientation includes: - Training on job responsibilities, abuse/neglect, individual needs of residents, the provider's emergency procedures and general policies, and how to recognize and respond to changes in condition prior to working with residents. - Four Department-approved courses (standard precautions, fire safety, first aid and choking, and medication management) - Training on resident rights, the provider's license client group, and how to prevent/manage challenging behaviors within 90 days after hire. - Training on provisions of personal care. The provider is licensed to care for 17 residents in the client group advanced aged and irreversible dementia/Alzheimer's disease. On 09/16/2024 at approximately 12:35 PM, Surveyor interviewed License Practical Nurse (LPN) A and Administrator E. LPN A stated Resident 1 required full assistance with personal care tasks and transferring via 2-person pivot. LPN A stated Resident 1 displayed behaviors that were harmful to staff, and on 2 occasions, Resident 1 kicked Caregiver D in the stomach during the overnight (NOC) shift. LPN A stated Caregiver D required medical attention after the incidents. Surveyor reviewed Caregiver D's record. Caregiver D was hired on 06/18/2024. As of 09/16/2024, Caregiver D completed 1 training, standard precautions, on 06/26/2024. Caregiver D was not a qualified resident care staff.	N 397		

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N 397	Continued From page 32 At 2:30 PM, LPN A stated Caregiver D was not a medication passer. LPN A confirmed 1 staff was scheduled during NOC shift (10:00 PM to 6:00 AM). LPN A stated the provider relied on staff from the nearby skilled nursing facility to provide medication administration and assistance to residents who required a second caregiver during NOC shift. Surveyor reviewed the August 2024 staff schedule. Caregiver D worked at the facility alone during NOC shift 21 times. Surveyor reviewed Resident 1's record. Resident 1 was admitted on 11/15/2021 with diagnoses that included Alzheimer's disease. Resident 1 was hospitalized on 08/31/2024 due to his/her behavior. S/he did not return to the facility. On 08/14/2024 at 5:40 AM, Caregiver D charted in Resident 1's record, "...fighting and kicked me in the stomach leaving a red mark." The incident report, dated 08/14/2024 read, "...resident kicked [him/her] in the stomach while [s/he] was attempting to check and change [Resident 1] on the NOC shift." The incident report indicated there were no witnesses to the event, indicating Caregiver D was working with Resident 1 alone. On 10/09/2024 at 9:00 AM, Surveyor interviewed Power of Attorney (POA) I. POA I stated s/he met with LPN A after Resident 1 kicked Caregiver D in the stomach the 2nd time. POA I stated s/he asked why staff, especially Caregiver D, was working alone with Resident 1. POA I stated LPN A became defensive and blamed Resident 1's family for preventing LPN A from giving Resident 1 medication to address his/her behaviors.	N 397		

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N 400	Continued From page 33	N 400		
N 400	83.37(1)(a) Written order for medications, supplements. Practitioner ' s order. There shall be a written practitioner ' s order in the resident ' s record for any prescription medication, over-the-counter medication or dietary supplements administered to a resident. This Rule is not met as evidenced by: Based on record review and interview, the provider did not obtain written orders for medications or supplements administered to residents. Resident 1's record did not include written orders for hydroxyzine. Findings include: On 09/16/2024 at approximately 10:40 AM, Surveyor interviewed Certified Nurse Assistant (CNA) B. CNA B stated Resident 1 was a 2-person assist for transfers and cares. CNA B stated Resident 1 was discharged a couple weeks ago due to his/her aggressive behaviors. CNA B stated, "Family wouldn't work with us. [Licensed Practical Nurse (LPN) A] had a plan with [Nurse Practitioner (NP) K] to address behaviors... Family said the behaviors were our fault." At approximately 12:35 PM, Surveyor interviewed Licensed Practical Nurse (LPN) A and Administrator E. LPN A stated Resident 1 always had challenging behaviors but these behaviors increased around the end of June 2024. LPN A said Resident 1's physician, Nurse Practitioner	N 400		

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N 400	Continued From page 34 (NP) K, wanted to try medications to address the behavior but Resident 1's family interfered. LPN A stated Resident 1 had many medication changes in July and August 2024 as a result of Resident 1's family's wishes. On 09/16/2024, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the facility on 11/15/2021 with Alzheimer's disease. S/he was hospitalized on 08/31/2024 after ongoing behavioral concerns. According to Resident 1's medication administration record (MAR) and progress notes, the following medication changes were made to Resident 1's hydroxyzine between July and August: 07/08/2024 - started 5 mg TID (3 times daily) (8:00 AM, 2:00 PM, and 10:00 PM) for anxiety; this medication was discontinued on 07/30/2024 07/30/2024 - started 10 mg BID (twice daily) (8:00 AM and 10:00 PM) for anxiety; this medication was discontinued on 08/01/2024 07/30/2024 - started 5 mg PRN (as needed) to be given in the afternoon for anxiety/agitation; this medication was discontinued on 08/01/2024 08/01/2024 - started 5 mg BID (8:00 AM and 10:00 PM); this was discontinued on 08/13/2024 08/13/2024 - started 5 mg at 6:00 PM 08/13/2024 - started 2.5 mg PRN to be given only with nurse approval 08/14/2024 - started 2.5 mg @ 10:00 AM	N 400		

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N 400	Continued From page 35 Resident 1's record did not include written orders for medications. On 10/08/2024, Surveyor interviewed LPN A and Administrator E. LPN A stated s/he was not aware s/he needed to obtain written orders for medications and supplements. LPN A stated s/he made changes to Resident 1's medications based on verbal orders s/he received from NP K.	N 400		
N 401	83.37(1)(b) Medication label permanently attached. Medications. Prescription medications shall come from a licensed pharmacy or a physician and shall have a label permanently attached to the outside of the container. Over-the-counter medications maintained in the manufacturer ' s container shall be labeled with the resident ' s name. Over-the-counter medications not maintained in the manufacturer ' s container shall be labeled by a pharmacist. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure prescription medications came from a licensed pharmacy or physician with a pharmacy label permanently attached. The provider ran out of medications for residents and used medications from a Pyxis system, which dispenses medications without labeling. Findings include: The provider is licensed to care for 17 residents in the client groups advanced aged and irreversible dementia/Alzheimer's disease. On 09/05/2024, the Department received a	N 401		

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N 401	Continued From page 36 complaint related to the provider's medication supply. On 09/16/2024 at approximately 10:30 AM, Surveyor interviewed Certified Nurse Assistant (CNA) B. CNA B stated residents would run out of medications occasionally but when they did, Licensed Practical Nurse (LPN) A would get medications from the nearby skilled nursing facility (SNF). At approximately 1:45 PM, Surveyor interviewed LPN A. LPN A stated staff were supposed to reorder medications from the pharmacy when there were 6 days left in the resident's supply. LPN A stated, "We have access to the med (medication) bank next door at the SNF." On 09/17/2024 at 12:47 PM, Surveyor consulted Pharmacy Practice Consultant (PPC) P. PPC P stated, "...meds must come from a pharmacy with label permanently attached. Those meds are not labeled for the resident from contingency. What the LPN is doing is like walking down the street and breaking into the pharmacy ... They have violated pharmacy law in WI. If they happen to do controlled substances they also violated federal law." On 10/08/2024 at 1:00 PM, Surveyor interviewed LPN A and Administrator E. LPN A stated the medication bank s/he referred to on 09/16/2024 was a Pyxis system. LPN A stated s/he would type in the resident's name and information and the machine would dispense the medication. LPN A said the medication was dispensed without a label, so s/he wrote the resident's name and medication information on it with a permanent marker.	N 401		

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N 416	Continued From page 37	N 416		
N 416	83.37(2)(e) Other administration given or delegated by RN Other administration. Injectables, nebulizers, stomal and enteral medications, and medications, treatments or preparations delivered vaginally or rectally shall be administered by a registered nurse or by a licensed practical nurse within the scope of their license. Medication administration described under sub. (2)(e) may be delegated to non-licensed employees pursuant to s. N 6.03(3). This Rule is not met as evidenced by: Based on observation, interview, and record review, the provider did not ensure staff were delegated to complete nursing tasks. Findings include: On 09/16/2024 at approximately 10:30 AM, Surveyor observed Certified Nurse Assistant (CNA) B administer insulin to Resident 3 intravenously. At 12:46 PM, Surveyor requested training and delegation records for review from Licensed Practical Nurse (LPN) A and Administrator E. At 1:49 PM, Surveyor overheard LPN A on the phone with Human Resources Director (HR) F. LPN A stated s/he was not aware staff needed delegation. LPN A stated, "I'm going to print them... should I sign them or just leave them?... This is why I need training. I just got thrown into the position. I keep telling [Administrator E] I need training. I don't know this stuff." At 2:30 PM, Surveyor interviewed LPN A and HR F. HR F provided Surveyor with the requested	N 416		

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N 416	Continued From page 38 employee records. HR F stated s/he was aware nurse delegations were missing from the files. LPN A stated s/he was not aware employees needed delegation to perform nursing tasks. LPN A stated s/he would delegate staff. Surveyor informed LPN A that s/he was unable to delegate staff as an LPN, and LPN A stated s/he would reach out to the provider's registered nurse to get staff delegated.	N 416		
N 419	83.37(3)(c) Medication storage: locked cabinet. Administered by facility. The CBRF shall keep medicine cabinets locked and the key available only to personnel identified by the CBRF. This Rule is not met as evidenced by: Based on observation and record review, the provider did not implement a system that ensured medications were securely stored. Findings include: The provider is licensed to care for 17 residents in the client groups irreversible dementia/Alzheimer's disease and advanced aged. On 09/16/2024 at 10:20 AM, Surveyor entered the facility. Surveyor observed a medication cart in the dining area. The cart was unlocked and unattended. There were 3 residents present in the dining area, but there were no staff in sight. At 10:25 AM, Certified Nurse Assistant (CNA) B entered the dining room. Between 10:25 and 10:30 AM, Surveyor observed 2 instances of CNA B going to the cart to gather medication/supplies and leaving the cart unattended and unlocked. CNA B did not lock the medication cart until s/he	N 419		

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N 419	Continued From page 39 was done with his/her morning medication pass. On 09/23/2024, Surveyor reviewed documentation from Bayfield County Adult Protective Services. The documentation indicated Adult Protective Services Social Worker (SW) H and SW L conducted interviews at the facility on 09/11/2024. The report read, "The following are concerns reported by [Family Member (FM) M]... [FM M] has seen the medication room door left open and unattended several times. [S/he] discussed [his/her] concerns of residents who are vulnerable having access to the medications."	N 419		
N 431	83.38(1)(g) Health monitoring. 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: Health monitoring. 1. The CBRF shall monitor the health of residents and make arrangements for physical health, oral health or mental health services unless otherwise arranged for by the resident. Each resident shall have an annual physical health examination completed by a physician or an advanced practice nurse as defined in s. N 8.02(1), unless seen by a physician or an advanced practice nurse as defined in s. N 8.02(1) more frequently. 2. When indicated, a CBRF shall observe residents ' food and fluid intake and acceptance of diet. The CBRF shall report significant deviations from normal food and fluid intake patterns to the resident ' s physician or dietician. 3. The CBRF shall document communication with the resident ' s physician and	N 431		

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N 431	Continued From page 40 other health care providers, and shall record any changes in the resident ' s health or mental health status in the resident ' s record. This Rule is not met as evidenced by: Based on interview and record review, the provider did not ensure Resident 1 received health monitoring services to meet his/her needs. The provider did not provide or make arrangements for physical or a mental health evaluation or retain record of all communications with Resident 1's physician. Resident 1 was hospitalized on 08/31/2024 due to combative behaviors and was diagnosed with a urinary tract infection (UTI). Findings include: The provider is licensed to care for 17 residents in the client groups advanced aged and irreversible dementia/Alzheimer's disease. On 09/09/2024, the Department received a complaint related to the provider's response to a resident's change in condition. On 09/16/2024, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the facility on 11/15/2021 with a primary diagnosis of Alzheimer's disease. On 08/31/2024, the provider contacted emergency services due to combative behavior. Resident 1 was admitted to the hospital	N 431		

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on a protective placement order. Resident 1 did not return to the assisted living facility, and the provider discharged him/her on 09/06/2024.

Based on Resident 1's progress notes, staff charting, and incident reports, Resident 1 displayed aggressive behaviors 5 days in July 2024 and 11 days in August 2024. Behaviors included general agitation (kicking doors, yelling, wandering) and physical aggression toward staff during cares (hitting, pinching, biting, slapping, kicking).

Resident 1's individual service plan (ISP) was not complete. It did not include reference to Resident 1's behaviors or individualized interventions. His/her ISP, updated 08/01/2024, indicated Resident 1 had a history of UTIs.

Resident 1's record did not include evidence of assessment between June and August 2024.

On 09/16/2024 at approximately 12:30 PM , Surveyor interviewed Licensed Practical Nurse (LPN) A. LPN A stated s/he was put in the director role in February 2024. Surveyor asked how the provider documented resident changes and physician communication. LPN A stated the provider used an electronic charting system, PointClickCare (PCC), and paper charting. Surveyor asked if LPN A documented communication with the physicians in PCC or on paper. LPN A stated the provider's rounding physician, Nurse Practitioner (NP) K, charted in a separate electronic system, which LPN A could access. LPN A stated s/he did not retain access to this record after a resident was discharged.

LPN A stated Resident 1 always had displayed disruptive behaviors but these behaviors began to

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increase near the end of June, and his/her primary care provider, NP K, wanted to try medications. LPN A stated Resident 1's family would not allow the provider to make medication changes. LPN A stated that about 2 weeks prior to Resident 1's hospitalization, his/her behaviors were so frequent s/he required someone beside him/her at all times. LPN A attributed Resident 1's behavioral change to the natural progression of his/her dementia.

On 09/17/2024, Surveyor interviewed Power of Attorney (POA) I. POA I stated Resident 1 was nonverbal and sensitive to pain and medications. POA I also stated, "Combative behavior only happened when [Resident 1] was frightened or when [s/he] had a UTI." POA I stated the family asked LPN A "for over 1 month" to test Resident 1 for a UTI, but s/he did not do it. POA I said they were concerned that LPN A was not communicating their concerns to NP K, so they (Resident 1's family) had asked to meet with NP K directly. POA I said LPN A would tell them s/he would arrange the meeting, but it never happened.

POA I said s/he went to the facility on 09/01/2024 to visit Resident 1 and was informed Resident 1 was hospitalized the night before. POA I stated s/he went to the hospital and was told Resident 1 had an UTI.

On 09/18/2024 at 11:55 AM, Surveyor interviewed Social Worker (SW) H from adult protective services (APS). SW H stated Resident 1 had a unique POA situation where 4 of his/her children had equal healthcare authority. SW H stated this situation delayed decision making, which frustrated LPN A and NP K, who were advocating to address Resident 1's behaviors with

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medications. SW H stated APS became involved on 07/23/2024, when Resident 1's managed care organization (MCO) reached out for guidance on Resident 1's POA status. Resident 1's MCO, NP K, and the assisted living provider began questioning if a corporate guardianship would be more appropriate. SW H stated s/he spoke with POA I and POA J separately; both were oblivious to the fact there were concerns or issues with their ability to make healthcare decisions for Resident 1, but they did voice concern that LPN A was not accurately communicating their concerns or questions to NP K. SW H stated s/he spoke with LPN A, who stated s/he set up multiple meetings for the family to speak with NP K directly, but they fell through each time.

SW H stated POA I called APS in frustration one day and made a comment that s/he was going to take Resident 1. SW H stated this ramped things up, and the provider began to panic. SW H stated LPN A called APS and stated the provider was struggling to control Resident 1's behaviors and wondering what they could do. SW H stated SW L explained to LPN A that if Resident 1's behavior placed Resident 1 or others in imminent danger, the provider could call the police and pursue an emergency protective placement order. SW H stated this happened on 08/31/2024, when s/he was hospitalized. SW H stated the hospital found Resident 1 had a pressure injury and UTI.

On 09/18/2024 at 4:06 PM, Surveyor interviewed NP K. NP K stated s/he worked with Resident 1 for over a year. NP K said s/he was on site weekly at the affiliated skilled nursing facility (SNF), and s/he was not typically at the assisted living facility. NP K said, "I haven't actually seen [Resident 1], other than randomly seeing [him/her] at the table, for quite a while ... I got

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reports from the nurses ... I mostly heard about combative behaviors ... they wanted to know what we could do about it." NP K stated s/he did not speak with Resident 1's POAs directly when Resident 1's behaviors began to escalate. NP K stated, "I offered to be available to talk to the family ... there were times I should have been at a care conference maybe, but I was not invited ... [LPN A] was the go-between." NP K said Resident 1's behaviors increased significantly before s/he was hospitalized. NP K stated, "Turns out [s/he] had a UTI, which likely caused the behaviors."

Surveyor asked if the provider and NP K considered testing for a UTI when Resident 1's behaviors increased. NP K stated, "The only way to do that is through cath (catheter) or ER (emergency room), and that's what we did."

Surveyor asked if NP K kept record of his/her communication with LPN A. NP K stated, "Sometimes I don't get this done because I'm the only provider."

On 09/18/2024, Surveyor requested medical records from Resident 1's physician's office for dates 06/01/2024 through 08/31/2024. On 09/19/2024, Surveyor received a response that read, "The patient was last seen by [NP K] on 05/08/2024. The patient has not been under the care of this provider during the requested dates of service."

On 10/08/2024 at 1:00 PM, Surveyor interviewed LPN A and Administrator E. LPN A stated s/he was responsible for assessing residents. LPN A stated s/he did not assess Resident 1 in July and August when his/her behaviors increased "because [his/her] physical condition never

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changed. The change was behavioral. Maybe I was incorrect in not doing one." LPN A said that, in the last 2 weeks of Resident 1's placement, behaviors were occurring on a daily basis. Prior to this, behaviors were happening 3 to 4 times a week. Surveyor asked why Resident 1's record did not reflect this. LPN A responded that the provider did not document all of Resident 1's incidents.

Surveyor asked for clarification on NP K's role in Resident 1's care. LPN A stated Resident 1's primary care physician was technically Physician Q, but NP K did the face-to-face visits for Physician Q. LPN A confirmed NP K had not directly assessed Resident 1 since May 2024. LPN A stated, "[NP K] made med changes based on my assessments. It is pretty standard to send an email and the doctor develops a plan." Surveyor requested documentation of all communication LPN A had with NP K regarding Resident 1's changes and care planning between June 2024 and August 2024.

Surveyor asked if LPN A considered underlying physical conditions that could have contributed to Resident 1's behavioral changes. LPN A stated Resident 1's behavior was related to a normal progression of his/her dementia. Surveyor asked if Resident 1's POAs requested Resident 1 be tested for a UTI. LPN A stated Resident 1's family did not request Resident 1 be tested for a UTI at any time in July or August 2024.

On 10/09/2024 at 9:00 AM, Surveyor interviewed POA J. POA J stated s/he asked LPN A multiple times in July and August 2024 to test Resident 1 for a UTI. POA J said s/he started keeping notes on their conversations in August. POA J reviewed his/her notes and stated s/he asked LPN A on

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08/07/2024 and 08/08/2024, to test for a UTI. POA J stated the last time s/he asked LPN A about this was sometime between 08/25/2024 and 08/31/2024. POA J said, "[LPN A] emphatically said [Resident 1] did not have a UTI and they would not test." POA J said LPN A's response was "almost hostile." POA J stated, "I've asked so many times to have a sit-down with [NP K]... I'm not aware of any meetings set up with [NP K]... I never cancelled any."

On 10/09/2024 at 11:52 AM, Surveyor received an email from LPN A that read, "Here are the emails that I have between the provider (NP K) and myself that discuss the medications." LPN A indicated in the email that s/he also documented in Resident 1's progress notes when s/he spoke with NP K about Resident 1's care.

Surveyor reviewed the email communication and progress notes. Based on this documentation, the last time LPN A communicated with NP K via email was on 08/01/2024, to request a letter stating it was against medical advice for Resident 1 to leave the facility and to pass along POA J's concern about hydroxyzine. Progress notes between 08/01/2024 and 08/31/2024 included 3 references to LPN A communicating with NP K - once on 08/08/2024 to notify NP K that POA J agreed to re-start hydroxyzine, once on 08/13/2024, to request hydroxyzine be decreased, and once on 08/29/2024, to request approval to administer a CBD gummy to Resident 1 per POA J's request.

On 10/09/2024 at 4:22 PM, Surveyor sent LPN A an email with the following question: "You mentioned there were meetings set up between [NP K] and [Resident 1's] family, but the family cancelled each time. Did you set these meetings

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N 431	Continued From page 47 up? When were these meetings to take place?" LPN A replied at 5:38 PM, "These meetings were offered with [NP K] multiple times from February through August. Unfortunelty, [sic] [POA J] declined. [POA J] shared the reason [s/he] declined was [s/he] didnt [sic] want to 'Make waves' as [NP K] and [POA I] do not get along." SUMMARY: The provider did not accurately record Resident 1's changes. The provider did not provide or arrange for medical assessment as requested by Resident 1's POAs to rule out contributing factors to his/her increase in behaviors. According to LPN A, Resident 1's medical team was making treatment recommendations based on LPN A's assessments but LPN A stated s/he had not assessed Resident 1. Records were not maintained by the assisted living provider (or by Resident 1's physician). Resident 1's behavior increased significantly in the 2 weeks prior to discharge; there was no evidence the provider communicated this change to Resident 1's physician. Cross references: N0214 DHS 83.15(3)(a) Administrator Shall Supervise Daily Operation N0389 DHS 83.35(3)(d) Service Plans Updated Annually Or On Changes	N 431		
N 439	83.39(1) Infection control program. 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.	N 439		

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This Rule is not met as evidenced by:
Based on observation and interview, the provider did not establish and follow an infection control program based on current standards of practice when Certified Nurse Assistant (CNA) B administered insulin to Resident 3 without donning gloves or performing hand hygiene.

Findings include:

The CDC provides the following recommendations for hand hygiene and glove use in healthcare settings:
"Know when to clean your hands
- Immediately before touching a patient.
- Before performing an aseptic task such as 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 patient's surroundings.
- After contact with blood, body fluids, or contaminated surfaces.
- Immediately after glove removal...

Know when to wear (and change) gloves
Gloves are not a substitute for hand hygiene.
- If your task requires gloves, perform hand hygiene before donning gloves and touching the patient or the patient's surroundings.
- Always clean your hands after removing gloves...

When to wear gloves
- When needed for Standard Precautions (when you anticipate that you will come in contact with

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N 439	Continued From page 49 blood or other infectious materials, mucous membranes, non-intact skin, potentially contaminated skin, or contaminated equipment)." (Retrieved from https://www.cdc.gov/clean-hands/hcp/clinical-safety/index.html). On 09/26/2024 at 10:29 AM, Surveyor observed CNA B check Resident 4's blood pressure. After the task was completed, CNA B went back to the medication cart to gather Resident 3's insulin. CNA B administered Resident 3's insulin. CNA B did not don gloves or perform hand hygiene during the observation. At approximately 2:40 PM, Surveyor interviewed Licensed Practical Nurse (LPN) A and Administrator E. LPN A stated staff were expected to wear gloves when administering an injectable treatment and wash their hands before and after the task.	N 439		