STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	510311	A. BUILDING: _____ B. WING _____	C 07/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONROE MANOR	508 E MONROE AVE BARRON, WI 54812

(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 07/19/2023, Surveyors investigated 10 complaints at Monroe Manor. Data was collected through 07/31/2023. Six violations were identified. Three of 6 were repeat violations. See Statement of Deficiency (SOD) A12111, dated 10/03/2022, SOD 1UR212, dated 07/22/2019, SOD V3RD13, dated 05/30/2018, SOD V3RD12, dated 03/16/2018, and SOD V3RD11, dated 10/24/2017. Seven of 10 complaints were substantiated. Census: 56.	N 000		
N 158	83.12(2)(a) Caregiver: Investigating abuse & neglect Investigating and reporting abuse, neglect, or misappropriation of property. Caregiver. 1. When a CBRF receives a report of an allegation of abuse or neglect of a resident, or misappropriation of property, the CBRF shall take immediate steps to ensure the safety of all residents. 2. The CBRF shall investigate and document any allegation of abuse or neglect of a resident, or misappropriation of property by a caregiver. If the CBRF ' s investigation concludes that the alleged abuse, or neglect of a resident or misappropriation of property meets the definition of abuse or neglect of a resident, or of misappropriation of property, the CBRF shall report the incident to the department on a form provided by the department, within 7 calendar days from the date the CBRF knew or should have known about the abuse, neglect, or misappropriation of property. The CBRF shall	N 158		

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

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N 158	Continued From page 1 maintain documentation of any investigation. This Rule is not met as evidenced by: Based on record review and interview, the provider did not complete an investigation of misappropriation of property when resident funds were discovered missing from the safe. This is a repeat deficiency. See Statement of Deficiency (SOD) A12111, dated 10/03/2022. Findings include: The provider is licensed to care for 82 residents in the client groups irreversible dementia/Alzheimer's disease and advanced aged. On 07/19/2023 at approximately 9:30 AM, Surveyor interviewed Human Resource Manager (HRM) C. HRM C stated money was stolen from the resident trust accounts in February 2023, when approximately $3000.00 was discovered missing. HRM C stated Receptionist J, who was responsible for the resident trust accounts, had lost his/her safe keys and shortly after the money went missing. HRM C stated an audit was conducted of the resident trust accounts in March 2023 and there was a resident account ledger from March 2023 that reflected the audit of missing money. HRM C stated the missing resident funds were replaced by Licensee E. HRM C stated there was not a formal investigation and the police were not contacted. At approximately 12:00 PM, Surveyor interviewed Nurse Manager (NM) B. NM B stated Receptionist J managed the resident trust accounts and reported to him/her that money was	N 158		

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N 158	Continued From page 2	N 158		

missing. NM B stated the money was kept in a safe in Nurse K's office closet and the doors to the office and closet were locked. NM B stated approximately $2000.00 was missing. NM B stated Licensee E replaced the missing resident funds. NM B stated General Manager (GM) A would have been responsible to investigate. NM B stated no investigation was completed.

At approximately 12:56 PM, Surveyor interviewed Maintenance Director (MD) H. MD H stated that in March 2023, Receptionist J had informed him/her that the safe was missing money. MD H stated the safe was programmed with a code that at least 4 people had. MD H stated the office and closet doors were locked but the keys were the type that could be duplicated.

At approximately 3:15 PM, Surveyor interviewed General Manager (GM) A. GM A stated s/he was informed by Receptionist J that money was missing from the resident trust accounts. GM A stated s/he and Nurse K counted the money and found approximately $3,000.00 missing. GM A stated s/he gave all the documents regarding missing resident money to Licensee E. GM A asked Licensee E if the police should be contacted and was informed by Licensee E they would discuss it. GM A stated Licensee E went to the bank and withdrew funds to replace the missing resident money. GM A stated Licensee E asked GM A to take over responsibility for the resident trust funds. GM A stated s/he would if s/he was the only one with access to the safe.

On 07/26/2023, from 10:01 AM to 11:17 AM, Surveyor interviewed Licensee E. Licensee E was unable to recall the date the missing resident trust funds were discovered. Licensee E stated GM A informed him/her that Receptionist J had texted

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N 158	Continued From page 3	N 158		

him/her that "A whole bunch of resident money was missing." Licensee E stated s/he did not complete an investigation because 6-8 people had access to the safe and there was not much s/he could do.

On 07/26/2023, Surveyor reviewed a document titled MONTHLY AUDIT. An entry dated 02/09/2023 included:
-Feb (February) Audit, Bag 3741, Book 3741, Balance 3741 and was initialed by "[General Manager (GM) A and Nurse K]". There was no audit recorded in March 2023.

On 07/19/2023, Administrative Assistant (AA) D provided a document s/he indicated was an audit conducted on 06/20/2023. The handwritten document listed 34 resident names, indicated $259.00 was in the safe, and the number $2930.00 was circled at the bottom of the page. At approximately 11:00 AM, AA D stated the total amount missing was $2930.00.

On 07/31/2023, Surveyor requested a copy of the completed March 2023 audit from GM A. GM A stated Licensee E was going to look for it. On 08/01/20232, the audit had not been provided.

From 2:21 PM to 2:31 PM, Surveyor interviewed GM A. GM A confirmed missing resident money was discovered 03/09/2023. GM A stated s/he and Nurse K completed an audit that was documented on a single sheet of paper that s/he handed to Licensee E. GM A stated the missing money would not be reflected on the individual resident trust accounts tracking sheets.

On 07/31/2023, from 8:36 AM to 8:52 AM, Surveyor interviewed Officer L. Officer L stated they were not contacted in March 2023 regarding

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N 158	Continued From page 4 missing money. The provider did not conduct a misappropriation of property investigation when resident trust money was discovered missing on 03/09/2023.	N 158		
N 160	83.12(2)(c) Report to law enforcement and coroner Investigating and reporting abuse, neglect, or misappropriation of property. Other reporting. Filing a report under sub. (1) or (2) does not relieve the licensee or other person of any obligation to report an incident to any other authority, including law enforcement and the coroner. This Rule is not met as evidenced by: Based on record review and interview, the provider did not report 2 incidents of misappropriation of property to law enforcement when a significant amount of money was missing from the resident trust accounts. Findings include: The provider is licensed to care for 82 residents in the client groups irreversible dementia/Alzheimer's disease and advanced aged. On 07/19/2023 at approximately 9:30 AM, Surveyor interviewed Human Resource Manager (HRM) C. HRM C stated money was discovered missing from the resident trust accounts in Feb 2023 and on 06/19/2023, HRM C stated that law enforcement was not contacted for either incident.	N 160		

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N 160	Continued From page 5 At approximately 11:00 AM, Surveyor interviewed Administrative Assistant (AA) D. AA D was hired approximately May 2023. AA D stated that on 06/20/2023, s/he was asked by Nurse K and HRM C to count the resident trust accounts. AA D determined $2930.00 was missing. AA D stated the missing resident trust funds were not reported to law enforcement. At approximately 12:05 PM, Surveyor interviewed Nurse Manager (NM) B. NM B stated the first incident of missing resident trust funds occurred in March 2023 and that approximately $2000.00 was missing. NM B stated law enforcement was not contacted. NM B stated the second incident of missing resident trust funds occurred 06/19/2023. NM B stated Maintenance Director (MD) H had to break into the safe and s/he heard there was only $200.00 left in the safe. NM B was not aware if there was a police report filed. At approximately 3:15 PM, Surveyor interviewed General Manager (GM) GM A stated that when resident trust account money was found missing on 03/09/202,3 s/he contacted Licensee E, asking if law enforcement should be contacted. Licensee E stated they should talk about it but decided not to contact law enforcement. GM A stated they should have contacted law enforcement at that time. On 06/19/2023, the second incident of missing resident trust funds was discovered. GM A stated s/he thought Licensee E had spoken to law enforcement. On 07/26/2023, from 10:01 AM to 11:17 AM, Surveyor interviewed Licensee E. Licensee E stated there were 2 incidents when money was missing from resident trust accounts. Licensee E stated the first incident occurred earlier in the year. Licensee E stated Receptionist J had	N 160		

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N 160	Continued From page 6 contacted GM A about a significant amount of money appearing to be missing from the resident trust accounts. Licensee E stated the second incident occurred 06/19/2023 and s/he did talk to Officer L on approximately 06/28/23, outside of the police station. Licensee E asked Officer L if fingerprints could be taken from a document. Licensee E stated s/he did not report the $3000.00 of missing resident trust funds to law enforcement because s/he did not want it in the paper. Licensee E later said s/he did report the missing resident trust funds but Officer L stated there was nothing they could do. On 07/31/2023, from 8:36 AM to 8:52 AM, Surveyor interviewed Officer L. Officer L stated Licensee E stopped by the police department on 06/28/2023 and reported that 2 of his/her staff were causing problems. Officer L suggested Licensee E file a temporary restraining order. Officer L stated Licensee E did not mention missing resident money or ask to file a report. Officer L stated there was also no record of a police report filed in March 2023. Officer L stated reports of missing money were considered criminal complaints and would have been investigated had they been reported. The provider did not report 2 incidents of missing resident trust funds to law enforcement.	N 160		
N 170	83.12(5)(b) Notification: abuse and neglect allegations. The CBRF shall immediately notify the resident ' s legal representative when there is an allegation of physical, sexual or mental abuse, or neglect of a resident. The CBRF shall notify the resident ' s legal representative within 72 hours when there is	N 170		

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N 170	Continued From page 7 an allegation of misappropriation of property. This Rule is not met as evidenced by: Based on record review and interview, the provider did not notify residents or their legal representative for 2 incidents when money was found missing from the resident trust accounts. This is a repeat deficiency. See Statement of Deficiency (SOD) V3RD12, dated 03/16/2018. Findings include: The provider is licensed to care for 82 residents in the client groups irreversible dementia/Alzheimer's disease and advanced aged. On 07/19/2023 at approximately 10:05 AM, Surveyor interviewed Human Resource Manager (HRM) C. HRM C stated that in approximately February 2023, money was reported missing from the resident trust accounts. HRM C stated that to his/her knowledge, an investigation had not occurred and residents and their legal representatives were not notified. HRM C stated money was found missing from the resident trust accounts on 06/19/2023. HRM C stated that on 06/26/2023, letters regarding missing money were sent to the residents and legal representatives. On 07/19/2023, Surveyor reviewed a letter written on the provider's letterhead that read, in part, "Dear Residents and Employees of [FACILITY], I am writing this to inform you that we had money go missing last week but no resident lost any money whatsoever. We are continuing to investigate." The letter was signed by Licensee E.	N 170		

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N 170	Continued From page 8 On 07/19/2023, from 11:00 AM to 11:31 AM, Surveyor interviewed Administrative Assistant (AA) D. AA D stated that on 06/26/2023, s/he was asked to send the notification letters to residents and their representatives. AA D stated s/he did not agree the content of the letter was accurate. On 07/19/2023 at approximately 12:05 PM, Surveyor interviewed Nurse Manager (NM) B. NM B stated that in March 2023, s/he was informed by Receptionist J that approximately $2000.00 was missing from the resident trust accounts. NM B stated s/he did not believe the residents were notified. NM B stated money was also discovered missing from the resident trust accounts on 06/19/2023 and that a letter was sent to the residents. At approximately 3:30 PM, Surveyor interviewed General Manager (GM) A. GM A stated money was discovered missing from the resident trust accounts on 03/09/2023 and s/he was asked to complete a safe audit. GM A stated approximately $3,000.00 was missing. GM A stated the residents and families were not notified their money was missing. GM A stated money was discovered missing on 06/19/2023 and s/he questioned the accuracy of the notification letter because it included a sentence indicating no resident money was missing. GM A stated that for the 2 incidents of missing resident trust funds, Licensee E had replaced the missing money. On 07/26/2023, from 10:01 AM to 11:17 AM, Surveyor interviewed Licensee E. Licensee E stated there had been resident funds missing earlier in the year and on 06/19/2023. Licensee E stated s/he was not sure if residents or their legal representative had been notified of the missing	N 170		

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N 170	Continued From page 9 money that occurred earlier in the year. Licensee E stated that on 06/26/2023, s/he had letters sent to the residents and their legal representatives. Licensee E stated s/he worded the letter that resident money was not missing because Licensee E had replaced it. The provider did not ensure residents or their legal representatives were notified when money was found missing from the resident trust accounts on 03/09/2023. Money was discovered missing again on 06/19/2023 and the letters that were sent did not indicate resident money had been stolen.	N 170		
N 351	83.32(3)(g) Rights of Residents: Physical restraints In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Freedom from physical restraints. Be free from physical restraints except upon prior review and approval by the department upon written authorization from the resident ' s primary physician or advanced practice nurse prescriber as defined in s. N 8.02(2). The department may place conditions on the use of a restraint to protect the health, safety, welfare and rights of the resident. This Rule is not met as evidenced by: Based on observation, interview, and record review, the provider did not ensure Resident 1 was free from physical restraint. Staff locked Resident 1's wheelchair at the dining	N 351		

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N 351	Continued From page 10	N 351		

room table, which restricted Resident 1's mobility to move from the table.

Findings include:

The provider is licensed to care for 82 residents in the client groups of advanced age and irreversible dementia/Alzheimer's disease.

From 06/21/2023 to 07/12/2023, the Department received multiple complaints related to inadequate care and resident right violations.

On 07/19/2023 at 12:03 p.m., Surveyor observed Resident 1 in the dining room, propelling him/herself in a wheelchair with his/her feet. Resident 1 was asking for help. Caregiver F pushed Resident 1's wheelchair up to the table and locked the brake on the right side of the wheelchair. At 12:26 p.m., Resident 1 consumed the majority of his/her dinner plate and pushed the plate away. At 12:29 p.m., Resident 1 tried pushing back on his/her wheelchair with his/her feet, but the wheelchair did not move. Resident 1 waved his/her hand to Caregiver G. At 12:33 p.m., Resident 1 told Caregiver G, "I need to get out of here, but don't know how to do it." Caregiver G encouraged Resident 1 to eat his/her dessert. Resident 1 ate dessert. At 12:40 p.m., Resident 1 was pushing his/her wheelchair back and forth. The wheelchair would pivot back and forth with the right brake locked. Resident 1 stated, "I need to get out of here." Caregiver G was assisting another resident with their dinner. Caregiver G told Caregiver F that Resident 1 wanted to go back to his/her room. At 12:45 p.m., Caregiver F unlocked Resident 1's brake on his/her wheelchair and pushed Resident 1's wheelchair back to his/her room. Surveyor followed Caregiver F and asked if staff always

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N 351	Continued From page 11 locked Resident 1's brake at the dining room table. Caregiver F replied, "Sometimes." Caregiver F told Surveyor Resident 1 had a fall when s/he tried to stand next to the table, and staff locked the brake to prevent falls. On 07/19/2023 at approximately 4:45 p.m., Surveyor interviewed General Manager A, Nurse Manager (NM) B, and Human Resource Manager C. Surveyor asked if Resident 1 had a fall at the table. NM B said s/he did not recall Resident 1 falling at the table. Surveyor explained the observation of Caregiver F locking Resident 1's wheelchair brake at the table. Surveyor stated this restrained Resident 1's movement. Staff A, NM B, and Staff C confirmed and understood it was a restraint. On 07/24/2023, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the facility on 09/16/2022 with multiple diagnoses including Lewy body dementia. Resident 1's individual service plan (ISP), with a print date of 07/19/2023, indicated Resident 1 required 24-hour supervision, s/he was independent with eating and walked independently to/from the dining area in the memory care unit. The ISP did not state Resident 1 had any approved restrictive measures or restraints. The provider did not ensure Resident 1 was free from physical restraint.	N 351		
N 370	83.34(3) More than $200 personal funds from resident Funds in excess of $200. A CBRF receiving more than $200 of personal funds from a resident shall deposit funds in excess of $200 in an	N 370		

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N 370	Continued From page 12	N 370		

interest-bearing account in the resident ' s name in a savings institution insured by an agency of, or a corporation chartered by, this state or the United States.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure resident funds in excess of $200.00 were kept in an interest-bearing account in the resident's name, in a savings institution.

Findings include:

The provider is licensed to care for 82 residents in the client groups irreversible dementia/Alzheimer's disease and advanced aged.

On 07/19/2023, Surveyor reviewed a document titled RESIDENT PERSONAL ACCOUNT that included the following:
-Resident 3: from 05/01/2023 to 05/15/2023, had an account balance ranging from $370.00 to $215.00.
-Resident 4: on 02/09/2023, had an account balance of $244.00.
-Resident 5: from 03/10/2023 to 04/04/2023, had an account balance ranging from $286.00 to $205.00 and from 04/18/2023 to 05/09/2023, had an account balance ranging from $277.00 to $203.00.
-Resident 6: from 02/09/2023 to 04/26/2023, had an account balance ranging from $260.00 to $210.00.
-Resident 7: from 02/09/2023 to 05/10/2023, had account balance ranging from $275.00 to $225.00.
-Resident 8: from 02/09/2023 to 06/13/2023, had an account balance ranging from $292.00 to

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 370	Continued From page 13 $212.00. -Resident 9: from 02/09/2023 to 07/05/2023, had an account balance ranging from $305.00 to $508.77. On 07/31/2023, from 10:12 AM to 10:46 AM, Surveyor interviewed General Manager (GM) A. GM A stated there was not a policy on how resident funds were managed but s/he had requested that Administrative Assistant (AA) D develop one. On 07/31/2023, Surveyor reviewed a document titled PERONAL FUNDS that read, in part, "I, [RESIDENT NAME] give [ADMINISTRATIVE ASSISTANT], permission to manage my cash on hand ...(Dollar amount must not exceed $200.00)." The document includes a place for the resident, guardian, and manager to sign. The provider did not ensure resident trust accounts did not have a balance over $200.00.	N 370		
N 388	83.35(3)(c) Implement, follow the individual service plan Implementation. The CBRF shall implement and follow the individual service plan as written. This Rule is not met as evidenced by: Based on observation, interview, and record review, the provider did not ensure each resident's individual service plan (ISP) was implemented as written. Staff did not implement and respond to Resident 1's pressure alarm. Resident 1 fell and sustained a laceration to his/her head that required staples at the emergency department.	N 388		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	510311	A. BUILDING: _____ B. WING _____	C 07/31/2023

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Staff did not conduct 1-hour safety checks on Resident 2. Staff did not clean Resident 2's room according to his/her ISP. Feces were left smeared in Resident 2's room. Resident 2 did not have a clip alarm on his/her wheelchair.

This is being cited for the fourth time. See Statement of Deficiency (SOD) 1UR212, dated 07/22/2019; SOD V3RD13, dated 05/30/2018; and SOD V3RD11, dated 10/24/2017.

Findings include:

From 06/21/2023 to 07/12/2023, the Department received multiple complaints related to inadequate care and resident right violations.

RESIDENT 1

On 07/19/2023 at approximately 9:30 a.m., Surveyor interviewed Family Member (FM) I. FM I was Resident 1's legal representative. FM I told Surveyor Resident 1 had a diagnosis of Lewy body dementia and was very anxious. S/he said Resident 1 had a pressure alarm but it was "hit and miss" with staff using it. FM I told Surveyor a family member came daily to visit Resident 1. Each day they had to clean urine off the floor in Resident 1's bathroom. FM I said Resident 1 was ambulatory, but "misses" the toilet sometimes. FM I stated s/he cleaned the bathroom floor that morning and showed Surveyor the cleaning wipe in the garbage can. FM I stated that if Resident 1's alarm was used, staff would be alerted s/he was going to the bathroom and would be able to assist Resident 1.

On 07/19/2023 at 4:29 p.m., Surveyor entered the memory care unit. Surveyor heard an alarm

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sounding and discovered it was coming from Resident 1's room. Resident 1 was up walking around in his/her room. Surveyor went to Resident 1's room to observe staff respond to Resident 1's alarm. At 4:33 p.m., Maintenance Director H walked by Surveyor, then by Resident 1's room. Caregiver F responded to Resident 1's room at that time.

On 07/24/2023, Surveyor reviewed Resident 1's record.

Resident 1 was admitted to the facility on 09/16/2022 with multiple diagnoses, including Lewy body dementia and general weakness.

Resident 1's ISP, with a print date of 07/19/2023, read, in part: "06/29/23 Pressure alarm to chair at all times ... Per family request keep alarm box out of reach as much as able."

An incident report, dated 06/28/2023, for an unwitnessed fall, read: "Writer went to go get a answer call [sic] from a different resident and started hearing 'help me, help me' from resident room outside [his/her] room on [his/her] bottom in a [sic] up right position [his/her] feet facing [his/her] bathroom, writer called another worker to help resident off the floor ... When calling POA (power of attorney) [s/he] wanted us to please put [his/her] chair alarm on for all shifts from now on please."

On 07/24/2023, Surveyor received a self-report from the provider. The report was for a fall Resident 1 sustained that resulted in injury on 07/23/2023. The report read, in part: "Resident has severe Lewy Body Dementia was resting on a chair in the common area. [S/he] stood up without assistance and fell backward hitting

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N 388	Continued From page 16 [his/her] head on the table next to the chair. [S/he] had a small gapping [sic] laceration to the area on [his/her] head. Resident complained of being dizzy and nauseous ... The resident received 3 staples to the back of [his/her] head ... Education has been provided to the staff to bring the pressure alarm to common areas when resident is not in [his/her] room. This is so if [s/he] stands up staff can walk with [him/her] and ensure safety ..." The provider did not ensure staff implemented and responded promptly to Resident 1's chair alarm at all times. Resident 1 fell and sustained a laceration to the back of his/her head. RESIDENT 2 On 07/19/2023 at 10:15 a.m., Surveyor observed Resident 2 in bed in [his/her] room. Surveyor observed Resident 2's room until 11:51 a.m. Surveyor did not observe staff enter Resident 2's room during that hour and 36 minutes. At 12:04 p.m., Surveyor observed Resident 2 sitting on the edge of his/her bed. There was no alarm sounding. At 12:14 p.m., Resident 2 was in his/her bathroom with the door closed. At 12:23 p.m., Resident 2 propelled self with his/her feet in a wheelchair out to the dining room for lunch. On 07/19/2023 at 3:13 p.m., Surveyor observed Resident 2 in his/her room sitting in his/her wheelchair. The clip alarm was on the nightstand, next to the bed. There was feces smeared on the floor and on the bed linens (Photo 1). There was feces on napkins on the nightstand next to an empty bowl, banana peel, and water mug (Photo 2). On 07/19/2023 at 4:34 p.m. (an hour and 21	N 388		

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minutes after previous observation), Surveyor observed Resident 2's room. Resident 2 was in bed. Feces remained smeared on the bed linens and the floor (Photos 4 and 5). The feces was cleaned off Resident 2's nightstand. The clip alarm remained on the nightstand (Photo 3).

On 07/24/2023, Surveyor reviewed Resident 2's record.

Resident 2 was admitted to the facility on 05/21/2022. Resident 2 had multiple diagnoses, including: major neurocognitive disorder without behavior disturbance, ongoing diarrhea, and repeated falls.

Resident 2's ISP, with a print date of 07/19/2023, read, in part: "Resident has been identified as a fall risk. 6/29/22 Resident on 1 hour safety checks for safety. Proper lighting, footwear and room free of clutter have been implemented for safety. 7/2/22 Alarms added (chair/bed alarms) ... Resident may at times have BM (bowel movement) on [his/her] hands, fingernails, and will wipe it on the walls by [his/her] bed, bathroom walls, sink, and bedding. Please be mindful of this and clean up any BM found on the walls, floor, bedding, and not limited to the sink. This is a sanitary issue and can cause illness if it isn't cleaned up properly ... Hourly safety checks, check for soiled linen, floor, dirty fingernails, and depends (clean these areas as needed.) [sic]."

On 06/13/2023 at 11:00 p.m., staff documented: "Writer was heading to laundry room and found resident walking towards [his/her] room from [another resident's] room. Writer helped [him/her] find [his/her] bed as that is what [s/he] was looking for. Also turned on [his/her] bed alarm ..."

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N 388	Continued From page 18 On 07/14/2023, Nurse Manager B documented: "Please make sure to clean resident's room of any BM covered areas. [S/he] has been wiping BM on [his/her] table, walls, BM covered toilet paper thrown where ever, [sic] and the bathroom has had BM wiped everywhere too. If you clean up messes when you do the hourly safety checks the mess won't get out of hand." The provider did not ensure Resident 2's ISP was implemented as written. On 07/19/2023, Surveyor observed Resident 2's room for over an hour, staff did not enter Resident 2's room during that time. Surveyor observed feces smeared on Resident 2's linens and floor. Surveyor returned over an hour later and feces remained smeared on the linens and floor. Surveyor observed Resident 2's clip alarm not in use on Resident 2's chair.	N 388		